COMMITTEE ON HEALTH

CHRISTINA HENDEROSN, CHAIRPERSON
FISCAL YEAR 2026 COMMITTEE BUDGET REPORT

TO: Members of the Council of the District of Columbia

FROM: Councilmember Christina Henderson
Chairperson, Committee on Health

DATE: June 23, 2025

SUBJECT: Report and Recommendations of the Committee on Health on the Fiscal Year 2026 Budget for Agencies Under Its Purview

The Committee on Health ("Committee") having conducted hearings and received testimony on the Mayor's proposed operating and capital budgets for Fiscal Year 2026 ("FY 2026") 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 2026 Budget Support Act of 2025, as proposed by the Mayor.

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Executive Summary

This report of the Committee on Health on the Fiscal Year 2026 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 2026 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

- Extend the Substance Use and Behavioral Health Services Targeted Outreach Grants to provide an additional **$800,000** from the Opioid Abatement Fund to support outreach services at four priority locations in Wards 1, 5, 7, and 8; **$200,000** through a transfer from the Committee on Transportation and the Environment for a fifth site in Ward 6; and **$750,000** through a transfer from the Committee on Public Works and Operations for a sixth site in Ward 1.
- Extend 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
- Fully fund the "Child Behavioral Health Services Dashboard Amendment Act of 2024," (D.C. Law 25-0279) which improves access to behavioral health resources for children, through a transfer of **$111,599** in recurring funds for 1 FTE from the Committee on Youth Affairs
- Fully implement the "Counseling Compact Approval Act of 2024," (D.C. Law 25-0238) by working with the Department of Health to absorb the costs of the legislation
- Fully fund B25-0692, the "Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024" (D.C. Law 25-0304), which will enhance processes and transparency for the District's involuntary psychiatric hospital admissions, by providing **$662,700** in recurring funds to the Department of Behavioral Health

Increase Healthy Food Access

- Extend the 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
- Restore **$200,000** in one-time funds to backfill the cancellation of the federal Local Food Purchase Assistance Cooperative Agreement grant program for purchases of locally grown produce from Dreaming Out Loud, to ensure an on-time opening of the new Marion Barry Avenue Market, which will provide fresh food and job opportunities in Ward 8
- Fully fund the "Farmers Market Support Amendment Act of 2025," (B26-0109) which will support the operations of farmers markets in low food access areas, including streamlining the application to operate a farmers market in the District, by providing **$493,829** to DC Health and **$225,000** to the Department of Licensing and Consumer Protection through a transfer to the Committee on Public Works and Operations

Improve Health for Birthing Parents and Families

- Increase home visiting services for first time parents by approving a $100,000 increase, and accepting a transfer of $300,000 from the Committee on Public Works & Operations, for a total of **$625,000** for the Nurse Family Partnership
- Approve **$500,000** in recurring funds for the distribution of diapers, formula, and other essential supplies via a grant to the DC Diaper Bank

Enhance Patient Care and Outcomes

- Restore **$3,727,219** in FY 2026 and **$12,112,538** over the financial plan to strike several provisions in the Mayor's proposed subtitle *DC Health Care Alliance Reform Amendment Act of 2025* in the Budget Support Act that imposes limits on eligibility and benefits for Alliance beneficiaries.
    - **The Committee made the following changes to the subtitle:**
        - Remove the face-to-face recertification requirement for adults (no cost);
        - Allow public school enrollment to count as proof of residency (no cost);
        - **$1,801,051** to increase the moratorium age for new Alliance beneficiaries from 21 to 26 in FY 2026;
        - **$3,124,949** to remove the face-to-face recertification requirement for youth under 19 (youth) through the financial plan;
        - **$2,864,988** to remove the recertification every 6 months requirement for youth through the financial plan (return to annual recertification);
        - **$2,649,353** to restore coverage of durable medical equipment (DME) for all adults through FY 2027;
        - **$1,672,196** to restore coverage of DME for youth through the financial plan.
- Approve the creation of a Basic Health Program within the DC Health Benefit Exchange Authority in order to maintain health care coverage for the approximately 25,500 residents who will no longer be eligible for Medicaid due to eligibility changes
- Partially restore **$1,270,598.75** in recurring funding for critical HIV prevention and surveillance grants, previously funded by the U.S. Centers for Disease Control and Prevention, including a $150,000 transfer from the Committee on Executive Administration and Labor
- Increase access to HIV, STI, and tuberculosis testing and treatment by allocating **$410,681** in recurring funding to DC Health for the DC Health and Wellness Center to expand hours to one evening per week and two Saturdays per month
- Expand the role of the Office of the Health Care Ombudsman and Bill of Rights to include other public benefits, including the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families (TANF) programs by adding an additional **2 FTEs** within Department of Health Care Finance

Strengthen the Health Care Workforce

- Fund the "Certified Nurse Aide Workforce Support Amendment Act of 2025" included in the Budget Support Act by providing **$150,000** to the Office of the State Superintendent of Education to partner with a local university to train at least 25 District high school students to become certified nurse aides (CNAs) through a transfer to the Committee of the Whole

- Fund the "Department of Health Licensure Pathways Program Amendment Act of 2025" included in the Budget Support Act by adding **1 FTE** at DC Health to assist internationally trained health professionals in obtaining licensure and credentials to practice in the District
- Strengthening the long-term care workforce to support seniors and other District residents who use long-term care services in the District by creating a Long-Term Care Strategic Coordinator role in the Deputy Mayor for Health and Human Services

Promote Student Health and Achievement

- Approve an extension of the 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
- Approve the transfer of the School Health Services Program and the School Based Health Centers from outside grants to in-house administration at DC Health, in order to improve school health services, including plan to create **222 FTEs** at DC Health
- Require DBH to award grants for the operation of the SBBH Program at a rate of no less than **$120,000** per clinician, and mandate that the agency submit a comprehensive improvement plan to the Council and Mayor by October 15, 2025, outlining its strategy to strengthen and transform the program.

Improve Access to Critical Health Care Infrastructure

- Fully fund the "Certificate of Need Improvement Amendment Act of 2025" (D.C. Law 26-0007), which will make it easier for new health care providers to locate in the District, by providing **$586,000** to DC Health
- Restore **$907,000** for the Court Urgent Care Clinic located within the Superior Court of the District of Columbia Moultrie Courthouse
- Approve the rightsizing of the DC Health contract to provide critical animal rescue and animal control services, for a total of **$8,268,068**

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 26 Rules of Organization and Procedure for the Council of the District of Columbia.

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 2026 Sources and Uses Summary

This table provides a summary of the changes the Committee recommends to the Fiscal Year 2026 Budget and Financial Plan. **Detailed information about each change, including budget attributes, can be found in Attachment A**.

HOW TO READ THIS TABLE

This table structures the Committee's recommendations into the funds available to be spent by the Committee, or "Sources," and how those funds were spent, or "Uses." Sources are listed as positive numbers, and the Uses of those funds are listed as negative numbers. The "Overall Balance" of the table is the sum of the Sources and the Uses entries, and if all available Sources have been allocated to various Uses, the Overall Balance is $0. Per Council Rule 703, a Committee cannot have a negative Overall Balance.

The Sources portion of this table includes recommended policy changes generating revenue, as well as a transfer of funds into the committee from another committee. The Sources portion of the table also includes a line that combines all of the Committee's recommended budget reductions, as reductions in an agency's budget are a Source of additional funds that can be used by the committee elsewhere, thus, **a recommendation that agencies *reduce their budgets* by $500,000 will appear as a *positive* entry on this table as that reduction is a new Source of funds that are now available to the Committee to be allocate to a various Uses.** Please note that a disaggregated list of all reductions will be in Attachment A.

The Uses portion of the table details how the funds from the Sources portion of the table are allocated. As the Uses are spending available Sources, the entries are negative, thus, **a recommendation that an agency receive an *additional* $500,000 will appear as a *negative* entry on this table because the enhancement is a Use that is reducing the Sources of funds available to the Committee**.

SOURCES AND USES SUMMARY TABLE

SOURCES	FY 25	FY 26	FY 27	FY 28	FY 29
Budget Reductions		$ 24,133,120	$ 23,528,185	$ 21,886,419	$ 21,939,051
Fund Balance Conversion		$ -	$ -	$ -	$ -
Fund Balance Use					
Special Fund Sweeps					
Other Revenue Adjustments		$ 92,511,021	$ 91,728,699	$ 91,802,950	$ 90,588,621
Transfers In (See Note 1 - Transfers In)		$ 1,511,599	$ 1,185,005	$ 1,208,780	$ 1,233,031
TOTAL SOURCES	**$ -**	**$ 118,155,740**	**$ 116,441,889**	**$ 114,898,148**	**$ 113,760,703**
USES - REVENUE EXPENDITURES	**FY 25**	**FY 26**	**FY 27**	**FY 28**	**FY 29**
Transfers Out (See Note 2 - Transfers Out)		$ (875,000)	$ (760,000)	$ (520,200)	$ (530,604)
TOTAL USES - REVENUE EXPENDITURES	**$ -**	**$ (875,000)**	**$ (760,000)**	**$ (520,200)**	**$ (530,604)**
USES - BUDGET EXPENDITURES	**FY 25**	**FY 26**	**FY 27**	**FY 28**	**FY 29**
Legislation: B25-0692 - Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024		$ (665,000)	$ (331,762)	$ (338,519)	$ (345,414)
Legislation: B25-0759 - Child Behavioral Health Services Dashboard Amendment Act of 2024		$ (111,599)	$ (114,005)	$ (116,360)	$ (118,763)
Legislation: B26-0109 - Farmers Market Support Amendment Act of 2025		$ (493,829)	$ (503,930)	$ (514,238)	$ (524,757)
Legislation: B26-25, Certificate of Need Improvement Amendment Act of 2025		$ (381,000)	$ (302,622)	$ (308,365)	$ (314,233)
Legislation: BSA Subtitle: "Department of Health Licensure Pathways Amendment Act of 2025"		$ (132,856)	$ (131,636)	$ (134,357)	$ (137,135)
Legislation: BSA Subtitle: "Grocery Access Pilot Program"		$ (120,000)			
Legislation: BSA Subtitle: "Health Care and Public Benefits Ombudsman Program Amendment Act of 2025"		$ (150,208)	$ (153,446)	$ (156,755)	$ (160,135)
Legislation: BSA Subtitle: DC Health Care Alliance Reform Amendment Act of 2025		$ (4,833,939)	$ (3,978,885)	$ (2,698,108)	$ (2,727,958)
Department of Behavioral Health					
Transfer in from PWO for Substance Use Disorder and Behavioral Health Services Targeted Outreach		$ (750,000)	$ (765,000)	$ (780,300)	$ (795,906)
Tranfer in from T&E to continue the opioid outreach team in the Greenleaf Community in Southwest		$ (200,000)			

USES - BUDGET EXPENDITURES	FY 25	FY 26	FY 27	FY 28	FY 29
Department of Health					
Partially restore the federal CDC HIV Prevention and Surveillance grant		$ (1,270,599)	$ (1,296,011)	$ (1,321,931)	$ (78,876)
To provide 3 additional FTEs for the Health and Wellness Centers to operate one evening per week and two Saturdays per month (One RN, One APRN, One Med Tech) - Salary		$ (281,048)	$ (286,950)	$ (292,689)	$ (298,543)
Partially restore the federal grant within CHA for Local Food Purchasing Cooperative Agreement to open the Marion Barry Ave market		$ (200,000)			
To provide 3 additional FTEs for the Health and Wellness Centers (One RN, One APRN, One Med Tech) - Fringe		$ (71,380)	$ (73,093)	$ (74,811)	$ (76,569)
To provide NPS for the Health and Wellness Centers (Medical supplies, medications, LabCorp, shift differential, security guard) - NPS		$ (58,253)	$ (59,418)	$ (60,606)	$ (61,819)
Department of Health Care Finance					
To conform to the updated FY 2026 ACR projection and State Directed Payments.		$ (107,052,589)	$ (107,052,589)	$ (107,052,589)	$ (107,052,589)
Transfer in from PWO to fund Home Visiting/Nurse Family Partnership		$ (300,000)	$ (306,000)	$ (312,120)	$ (318,362)
TOTAL USES - BUDGET EXPENDITURES	**$ -**	**$ (117,072,300)**	**$ (115,355,348)**	**$ (114,161,748)**	**$ (113,011,058)**
OVERALL BALANCE	**$ -**	**$ 208,440**	**$ 326,542**	**$ 216,201**	**$ 219,041**

NOTE 1 - TRANSFERS IN	FY 25	FY 26	FY 27	FY 28	FY 29
Tranfer in from T&E to continue the opioid outreach team in the Greenleaf Community in Southwest		$ 200,000			
Transfer in from CEAL to increase HIV Prevention and Surveillance grant		$ 150,000			
Transfer in from CYA to To satisfy the FIS for B25-0759 - Child Behavioral Health Services Dashboard Amendment Act of 2024 - Salary and Fringe		$ 111,599	$ 114,005	$ 116,360	$ 118,763

NOTE 1 - TRANSFERS IN	FY 25	FY 26	FY 27	FY 28	FY 29
Transfer in from PWO to fund Home Visiting/Nurse Family Partnership		$ 300,000	$ 306,000	$ 312,120	$ 318,362
Transfer in from PWO to fund Ward 1 locations for SUD Outreach Grants		$ 750,000	$ 765,000	$ 780,300	$ 795,906
TOTAL TRANSFERS IN	**$ -**	**$ 1,511,599**	**$ 1,185,005**	**$ 1,208,780**	**$ 1,233,031**

NOTE 2 - TRANSFERS OUT	FY 25	FY 26	FY 27	FY 28	FY 29
Transfer out to COW for engage 20-30 HS students a summer in this programming, would cover tuition costs, administrative expenses, and allow students to earn higher hourly wages.		$ (150,000)			
Transfer out to HS to restore collections budget at DC Public Library		$ (500,000)	$ (510,000)	$ (520,200)	$ (530,604)
Transfer Out to PWO for implementation of B26-109 Farmers Market Support Amendment Act of 2025 for DLCP to Establish a centralized application system for licensing and permitting of farmers markets by modifying its D.C. Business Portal system so that it integrates with other District agency systems.		$ (225,000)	$ (250,000)		
TOTAL TRANSFERS OUT	**$ -**	**$ (875,000)**	**$ (760,000)**	**$ (520,200)**	**$ (530,604)**

Fiscal Year 2026 Agency Operating Budget by Program Parent Level 1

DIFS Program (Parent Level 1)	FY 2024 Actuals	FY 2025 Approved	Mayor's FY 2026 Proposed	Committee Variance	Committee's FY 2026 Recommendation	Committee Percent Change
Department of Behavioral Health						
AFO002 - AGENCY ACCOUNTING SERVICES	($52,376)	$690,651	$755,461	$0	$755,461	9.38%
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$1,701,996	$1,119,890	$809,802	$0	$809,802	(27.69%)
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$293,067	$567,230	$517,183	$0	$517,183	(8.82%)
AFO010 - PAYROLL DEFAULT	$0	$0	$0	$0	$0	n/a
AFO011 - P-CARD CLEARING	($9,148)	$0	$0	$0	$0	n/a
AMP002 - CLAIMS SERVICES	$725,991	$844,135	$804,644	$0	$804,644	(4.68%)
AMP011 - HUMAN RESOURCE SERVICES	$2,822,592	$2,790,285	$2,729,708	$0	$2,729,708	(2.17%)
AMP012 - INFORMATION TECHNOLOGY SERVICES	$5,239,760	$5,066,119	$4,938,358	$0	$4,938,358	(2.52%)
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT	$5,695,027	$3,426,861	$3,205,978	$0	$3,205,978	(6.45%)
AMP022 - RECORDS MANAGEMENT	$676,094	$807,991	$775,750	$0	$775,750	(3.99%)
AMP023 - RESOURCE MANAGEMENT	$10,920,764	$7,828,841	$10,919,079	$0	$10,919,079	39.47%
H04201 - ACCOUNTABILITY ADMINISTRATIVE SERVICES	$101,676	$175,037	$106,618	$0	$106,618	(39.09%)
H04202 - CERTIFICATION SERVICES	$1,162,270	$1,128,219	$1,071,743	$0	$1,071,743	(5.01%)
H04203 - INCIDENT, MANAGEMENT AND INVESTIGATION SERVICES	$545,034	$536,194	$483,046	$0	$483,046	(9.91%)
H04204 - LICENSURE SERVICES	$628,727	$576,868	$553,787	$0	$553,787	(4.00%)
H04205 - PROGRAM INTEGRITY SERVICES	$1,089,036	$381,301	$263,381	$0	$263,381	(30.93%)
H04301 - 35 K STREET ADULT CLINICAL SERVICES	$3,196,900	$2,058,635	$1,977,529	$0	$1,977,529	(3.94%)
H04302 - ACCESS HELPLINE	$2,215,292	$2,630,514	$4,482,604	$0	$4,482,604	70.41%
H04304 - ASSESSMENT AND REFERRAL CENTER SERVICES	$1,680,359	$2,393,309	$2,042,706	$0	$2,042,706	(14.65%)
H04305 - CO-LOCATED SERVICES	$322,621	$292,557	$270,387	$0	$270,387	(7.58%)
H04306 - COMMUNITY RESPONSE TEAM	$9,504,700	$9,982,467	$9,184,744	$665,000	$9,849,744	(1.33%)
H04308 - HOUSING SUPPORT SERVICES	$28,271,855	$29,894,329	$27,194,329	$0	$27,194,329	(9.03%)
H04310 - MENTAL HEALTH AND REHAB SERVICES	$63,644,076	$20,213,562	$8,885,434	$0	$8,885,434	(56.04%)
H04311 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)	$15,238,768	$15,588,644	$17,378,851	$950,000	$18,328,851	17.58%
H04312 - PROVIDER RELATIONS SERVICES	$696,958	$1,152,206	$1,245,035	$0	$1,245,035	8.06%
H04313 - RESIDENTIAL SUPPORT AND CONTINUITY OF CARE SERVICE	$460,614	$599,614	$573,689	$0	$573,689	(4.32%)
H04314 - SPECIALTY SERVICES	$7,372,934	$5,514,618	$6,324,910	$0	$6,324,910	14.69%
H04315 - SUBSTANCE USE DISORDER TREATMENT SERVICES	$1,000,065	$1,197,609	$1,077,325	$0	$1,077,325	(10.04%)
H04316 - STATE OPIOID RESPONSE PROGRAM	$21,115,930	$36,014,647	$36,217,526	$0	$36,217,526	0.56%
H04317 - BEHAVIORAL HEALTH REHABILITATION - LOCAL MATCH	$0	$44,638,076	$44,502,648	$0	$44,502,648	(0.30%)
H04402 - CONSUMER AND FAMILY AFFAIRS	$1,013,302	$1,018,515	$954,077	$0	$954,077	(6.33%)
H04403 - EXECUTIVE DIRECTOR	$2,225,707	$2,609,773	$2,509,925	$0	$2,509,925	(3.83%)

Committee on Health
Fiscal Year 2026 Budget Recommendations

DIFS Program (Parent Level 1)	FY 2024 Actuals	FY 2025 Approved	Mayor's FY 2026 Proposed	Committee Variance	Committee's FY 2026 Recommendation	Committee Percent Change
Department of Behavioral Health						
H04404 - LEGAL SERVICES	$1,031,707	$1,046,625	$942,738	$0	$942,738	(9.93%)
H04405 - LEGISLATIVE AND PUBLIC SERVICES	$817,788	$917,518	$850,734	$0	$850,734	(7.28%)
H04406 - OMBUDSMAN	$398,695	$401,154	$392,740	$0	$392,740	(2.10%)
H04501 - BEHAVIORAL SERVICES - HOWARD ROAD	$234,638	$217,385	$199,845	$0	$199,845	(8.07%)
H04502 - CHILD/ADOLESCENT/FAMILY SERVICES ADMINISTRATIVE SE	($12,445)	$0	$0	$0	$0	n/a
H04503 - COURT ASSESSMENT SERVICES	$1,327,654	$1,063,032	$1,032,845	$0	$1,032,845	(2.84%)
H04504 - CRISIS SERVICES	$1,336,293	$1,366,544	$135,334	$0	$135,334	(90.10%)
H04505 - EARLY CHILDHOOD SERVICES	$2,844,125	$3,425,700	$3,219,488	$0	$3,219,488	(6.02%)
H04506 - EVIDENCE BASED PRACTICES SERVICES	$1,223,764	$1,258,065	$1,214,318	$0	$1,214,318	(3.48%)
H04507 - MH/SUD BEHAVIORAL HEALTH SERVICES (CHILD & FAMILY)	$978,330	$1,349,674	$1,661,147	$0	$1,661,147	23.08%
H04508 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES	$28,229,782	$27,768,629	$25,438,188	$0	$25,438,188	(8.39%)
H04509 - SPECIALTY SERVICES	$906,146	$941,013	$856,595	$0	$856,595	(8.97%)
H04601 - BEHAVIORAL HEALTH SERVICES	$292,770	$490,080	$387,680	$0	$387,680	(20.89%)
H04602 - BEHAVIORAL HEALTH SERVICES-PHARMACY	($84,349)	$202,510	$202,510	$0	$202,510	0.00%
H04603 - COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES	$7,042,786	$7,737,546	$8,745,888	$0	$8,745,888	13.03%
H04604 - DISASTER BEHAVIORAL HEALTH SERVICES AND SUPPORT S	($15,500)	$0	$0	$0	$0	n/a
H04605 - FORENSICS SERVICES	$4,285,131	$4,102,385	$4,024,827	$0	$4,024,827	(1.89%)
H04701 - BEHAVIORAL HEALTH GRANT OVERSIGHT SERVICES	$7,949,958	$2,092,987	$3,784,785	$0	$3,784,785	80.83%
H04702 - DATA AND PERFORMANCE MEASUREMENT SERVICES	$2,383,861	$2,386,854	$2,409,475	$0	$2,409,475	0.95%
H04703 - STRATEGIC PLANNING AND POLICY SERVICES	$348,854	$351,351	$332,375	$0	$332,375	(5.40%)
H04704 - TRAINING INSTITUTE SERVICES	$938,249	$989,902	$1,020,881	$0	$1,020,881	3.13%
H04801 - CLINICAL ADMINISTRATIVE SERVICES	$12,461,334	$12,824,484	$13,358,379	$0	$13,358,379	4.16%
H04802 - CLINICAL AND MEDICAL SERVICES	$28,418,877	$27,140,416	$24,738,872	$0	$24,738,872	(8.85%)
H04803 - ENIGINEERING AND MAINTENANCE SERVICES	$5,824,471	$4,813,984	$3,495,306	$0	$3,495,306	(27.39%)
H04804 - FISCAL AND SUPPORT SERVICES	$807,394	$874,419	$793,725	$0	$793,725	(9.23%)
H04805 - HOSPITAL ADMINISTRATIVE SERVICES	$979,494	$1,391,101	$10,105,810	$0	$10,105,810	626.46%
H04806 - HOUSEKEEPING SERVICES	$3,076,073	$2,659,363	$2,529,259	$0	$2,529,259	(4.89%)
H04807 - MATERIAL MANAGEMENT SERVICES	$1,460,479	$1,506,996	$1,475,407	$0	$1,475,407	(2.10%)
H04808 - NURSING SERVICES	$58,274,340	$50,248,168	$45,794,215	$0	$45,794,215	(8.86%)
H04809 - NUTRITIONAL SERVICES	$4,138,974	$3,414,479	$3,226,919	$0	$3,226,919	(5.49%)
H04810 - QUALITY AND DATA MANAGEMENT SERVICES	$1,448,615	$1,564,072	$1,460,069	$0	$1,460,069	(6.65%)
H04811 - SECURITY AND SAFETY SERVICES	$5,472,988	$4,940,873	$5,008,853	$0	$5,008,853	1.38%
H04812 - TRANSPORATION AND GROUNDS SERVICES	$735,703	$621,231	$721,697	$0	$721,697	16.17%
H05201 - DIRECTOR AND COMMISSION SUPPORT	$1,135,114	$14,655,500	$16,000,000	$0	$16,000,000	9.17%
PRG001 - NO PROGRAM	($17,227)	$0	$0	$0	$0	n/a
TOTAL GROSS FUNDS	**$376,175,456**	**$386,502,734**	**$378,317,166**	**$1,615,000**	**$379,932,166**	**(1.70%)**

Committee on Health
Fiscal Year 2026 Budget Recommendations

DIFS Program (Parent Level 1)	FY 2024 Actuals	FY 2025 Approved	Mayor's FY 2026 Proposed	Committee Variance	Committee's FY 2026 Recommendation	Committee Percent Change
Department of Health						
AFO002 - AGENCY ACCOUNTING SERVICES	$1,281,853	$1,383,475	$1,534,154	$0	$1,534,154	10.89%
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$1,231,491	$1,314,053	$1,394,414	$0	$1,394,414	6.12%
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$779,399	$857,559	$829,187	$0	$829,187	(3.31%)
AFO011 - P-CARD CLEARING	$96,390	$0	$0	$0	$0	n/a
AMP003 - COMMUNICATIONS	$996,028	$1,135,580	$1,220,144	$0	$1,220,144	7.45%
AMP005 - CONTRACTING AND PROCUREMENT	$670,328	$1,241,399	$1,245,324	$0	$1,245,324	0.32%
AMP011 - HUMAN RESOURCE SERVICES	$1,864,048	$2,060,721	$1,948,978	$0	$1,948,978	(5.42%)
AMP012 - INFORMATION TECHNOLOGY SERVICES	$5,289,093	$8,290,145	$8,651,052	$0	$8,651,052	4.35%
AMP013 - LABOR RELATIONS	$116,274	$170,800	$168,777	$0	$168,777	(1.18%)
AMP014 - LEGAL SERVICES	$2,597,282	$2,702,454	$2,718,467	$0	$2,718,467	0.59%
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT	$17,208,252	$16,991,359	$17,087,698	($153,873)	$16,933,825	(0.34%)
AMP024 - RISK MANAGEMENT	$129,158	$132,119	$136,378	$0	$136,378	3.22%
AMP030 - EXECUTIVE ADMINISTRATION	$1,604,683	$1,704,916	$2,253,420	$0	$2,253,420	32.17%
H00401 - CANCER AND CHRONIC DISEASE PREVENTION	$10,528,262	$12,327,307	$11,124,749	$0	$11,124,749	(9.76%)
H00403 - COMMUNITY OF HEALTH SUPPORT SERVICES	$9,125,354	$9,118,486	$9,537,989	$0	$9,537,989	4.60%
H00405 - FAMILY HEALTH	$36,766,986	$41,873,912	$39,691,713	$111,599	$39,803,312	(4.94%)
H00406 - HEALTH CARE ACCESS	$20,599,014	$10,362,356	$7,415,031	($128,022)	$7,287,008	(29.68%)
H00407 - NUTRITION AND PHYSICAL FITNESS	$21,813,512	$23,243,173	$27,146,393	$813,829	$27,960,222	20.29%
H00408 - PERINATAL AND INFANT HEALTH	$264,884	$334,864	$0	$0	$0	(100.00%)
H00601 - FOOD, DRUG, RADIATION, AND COMMUNITY HYGIENE	$13,694,978	$13,989,586	$0	$0	$0	(100.00%)
H00701 - COMMUNITY BASED PARTNERSHIP, RESEARCH AND POLICY	$47	$254,888	$260,030	$0	$260,030	2.02%
H00702 - HEALTH EQUITY PRACTICE AND PROGRAM IMPLEMENTATIO	$8,071	$12,333	$12,333	$0	$12,333	0.00%
H00703 - MULTI SECTOR COLLABORATION	$496,859	$695,024	$1,102,343	$0	$1,102,343	58.60%
H00801 - DIRECT CARE SERVICES FOR TUBERCULOSIS	$1,920,145	$2,005,395	$1,764,672	$410,681	$2,175,353	8.48%
H00802 - DRUG ASSISTANCE	$9,366,511	$10,782,274	$13,011,433	$0	$13,011,433	20.67%
H00803 - GRANTS AND CONTRACTS MANAGEMENT	$1,457,332	$1,698,647	$943,670	$0	$943,670	(44.45%)
H00804 - HIV HEALTH AND SUPPORT SERVICES	$38,197,113	$38,162,308	$39,796,759	$0	$39,796,759	4.28%
H00805 - HIV/AIDS DATA AND RESEARCH	$2,489,869	$3,991,618	$3,682,365	($12,899)	$3,669,466	(8.07%)
H00806 - HIV/AIDS HOUSING AND SUPPORTIVE SERVICES	$12,097,523	$13,980,418	$13,521,866	$0	$13,521,866	(3.28%)
H00807 - HIV/AIDS POLICY AND PLANNING	$4,815,181	$6,126,224	$2,645,307	$0	$2,645,307	(56.82%)
H00808 - PREVENTION AND INTERVENTION SERVICES	$11,646,771	$12,334,332	$9,923,950	$1,270,599	$11,194,549	(9.24%)
H00809 - STD CONTROL	$2,685,739	$3,168,803	$2,384,089	$0	$2,384,089	(24.76%)
H00902 - PUBLIC HEALTH EMERGENCY OPERATIONS AND PROGRAM	$5,827,779	$4,799,908	$0	$0	$0	(100.00%)
H00903 - PUBLIC HEALTH EMERGENCY PREPAREDNESS	$2,221,635	$1,481,355	$0	$0	$0	(100.00%)
H01101 - HEALTH CARE FACILITIES REGULATION	$6,199,938	$7,372,921	$0	$0	$0	(100.00%)
H01201 - HEALTH LICENSING	$18,093,980	$12,599,294	$0	$0	$0	(100.00%)

Committee on Health
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DIFS Program (Parent Level 1)	FY 2024 Actuals	FY 2025 Approved	Mayor's FY 2026 Proposed	Committee Variance	Committee's FY 2026 Recommendation	Committee Percent Change
Department of Health						
H01301 - EMERGENCY MEDICAL SERVICES REGULATION	$17,181	$303,020	$0	$0	$0	(100.00%)
H01401 - EPIDEMIOLOGIC STUDIES AND OUTBREAK INVESTIGATION	$758,386	$3,314,419	$0	$0	$0	(100.00%)
H01501 - DEVELOPMENT OF THE STATE HEALTH PLAN AND ANNUAL IN	$1,300,955	$1,795,798	$0	$0	$0	(100.00%)
H01601 - BIRTH AND DEATH RECORD COLLECTION, PROCESSING, A	$15,070,418	$35,915,620	$0	$0	$0	(100.00%)
H02027 - POLICY AND PLANNING	$0	$0	$466,092	$0	$466,092	n/a
H02028 - DATA MANAGEMENT AND ANALYSIS	$0	$0	$1,533,675	$0	$1,533,675	n/a
H02029 - INFORMATICS	$0	$0	$647,818	$0	$647,818	n/a
H02030 - FINANCE AND GRANTS - POLICY, PLANNING, AND EVALUATI	$0	$0	$975,751	$0	$975,751	n/a
H02031 - FINANCE AND GRANTS - HEALTH SYSTEMS AND PREPAREDN	$0	$0	$674,169	$0	$674,169	n/a
H02032 - HEALTH AND MEDICAL COALITION	$0	$0	$1,115,957	$0	$1,115,957	n/a
H02034 - INDOOR ENVIRONMENT	$0	$0	$1,573,877	$0	$1,573,877	n/a
H02035 - OUTDOOR ENVIRONMENT	$0	$0	$328,385	$0	$328,385	n/a
H02036 - FOOD SANITATION	$0	$0	$2,498,757	$0	$2,498,757	n/a
H02037 - COMMUNITY HYGIENE	$0	$0	$553,698	$0	$553,698	n/a
H02038 - ANIMAL SERVICES	$0	$0	$10,318,211	($223,154)	$10,095,056	n/a
H02039 - RODENT AND VECTOR CONTROL	$0	$0	$2,108,322	$0	$2,108,322	n/a
H02040 - POLICY AND PLANNING - ENVIRONMENAL HEALTH SERVICE	$0	$0	$362,119	$0	$362,119	n/a
H02041 - FINANCE AND GRANTS - ENVIRONMENTAL HEALTH SERVICE	$0	$0	$550,345	$0	$550,345	n/a
H05401 - EPIDEMIOLOGIC STUDIES AND OUTBREAK INVESTIGATION -	$0	$0	$36,977,660	$0	$36,977,660	n/a
H05402 - BIRTH AND DEATH RECORD COLLECTION, PROCESSING, A	$0	$0	$2,939,652	($95,000)	$2,844,652	n/a
H05403 - DEVELOPMENT OF THE STATE HEALTH PLAN AND ANNUAL IN	$0	$0	$1,294,571	$281,000	$1,575,571	n/a
H05404 - HEALTH LICENSING - FY26	$0	$0	$14,316,951	($54,463)	$14,262,487	n/a
H05405 - HEALTH CARE FACILITIES REGULATION - FY26	$0	$0	$6,980,575	($171,222)	$6,809,353	n/a
H05406 - PUBLIC HEALTH EMERGENCY OPERATIONS AND PROGRAM	$0	$0	$3,926,719	($111,158)	$3,815,561	n/a
H05407 - EMERGENCY MEDICAL SERVICES REGULATION - FY26	$0	$0	$1,411,267	$0	$1,411,267	n/a
H05408 - PUBLIC HEALTH PLANNING, TRAINING AND EXERCISE - FY26	$0	$0	$222,010	$0	$222,010	n/a
PRG001 - NO PROGRAM	($243,580)	$0	$0	$0	$0	n/a
TOTAL GROSS FUNDS	**$281,085,123**	**$310,028,863**	**$314,929,262**	**$1,937,916**	**$316,867,178**	**2.21%**
Department of Health Care Finance						
AFO002 - AGENCY ACCOUNTING SERVICES	$3,926,825	$7,249,272	$6,466,981	($3,541)	$6,463,440	(10.84%)
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$750,546	$835,970	$889,215	$0	$889,215	6.37%
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$353,611	$368,559	$373,810	$0	$373,810	1.42%
AFO011 - P-CARD CLEARING	$4,644	$0	$0	$0	$0	n/a

DIFS Program (Parent Level 1)	FY 2024 Actuals	FY 2025 Approved	Mayor's FY 2026 Proposed	Committee Variance	Committee's FY 2026 Recommendation	Committee Percent Change
Department of Health Care Finance						
AMP003 - COMMUNICATIONS	$816,672	$36,000	$36,000	$0	$36,000	0.00%
AMP005 - CONTRACTING AND PROCUREMENT	$1,575,589	$2,076,000	$1,868,893	$0	$1,868,893	(9.98%)
AMP006 - CUSTOMER SERVICE	$2,845,918	$0	$0	$0	$0	n/a
AMP010 - GRANTS ADMINISTRATION	$1,692,058	$0	$0	$0	$0	n/a
AMP011 - HUMAN RESOURCE SERVICES	$982,456	$1,514,471	$1,518,624	($275,000)	$1,243,624	(17.88%)
AMP012 - INFORMATION TECHNOLOGY SERVICES	$5,619,949	$12,240,360	$13,787,370	($450)	$13,786,920	12.63%
AMP014 - LEGAL SERVICES	$1,221,472	$1,470,759	$1,480,239	$0	$1,480,239	0.64%
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT	$6,082,619	$3,978,484	$3,792,765	$0	$3,792,765	(4.67%)
AMP021 - RATES, REIMBURSEMENT, FINANCIAL ANALYSIS	$4,224,953	$0	$0	$0	$0	n/a
AMP030 - EXECUTIVE ADMINISTRATION	$971,521	$1,445,209	$1,690,707	$0	$1,690,707	16.99%
AMP037 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR	$0	$4,108,191	$14,145,813	$0	$14,145,813	244.33%
AMP038 - SENIOR DEPUTY DIRECTOR/FINANCE	$0	$6,394,842	$6,602,309	$0	$6,602,309	3.24%
AMP039 - CHIEF OPERATING OFFICE	$0	$2,494,200	$1,467,933	$0	$1,467,933	(41.15%)
AMP040 - DATA ANALYTICS AND RESEARCH ADMINISTRATION	$0	$2,014,839	$2,688,427	($165,000)	$2,523,427	25.24%
AMP041 - PROGRAM INTEGRITY	$0	$4,754,289	$5,564,504	$0	$5,564,504	17.04%
AMP042 - HEALTH CARE OMBUDSMAN	$0	$4,957,285	$5,169,735	$150,208	$5,319,943	7.32%
AMP043 - HEALTH CARE DELIVERY MGT SUPPORT SVCS	$0	$1,443,498	$1,508,970	$0	$1,508,970	4.54%
AMP044 - MANAGED CARE MGT	$0	$9,585,450	$9,425,181	$0	$9,425,181	(1.67%)
AMP045 - CHILDREN'S HEALTH SERVICES	$0	$1,291,675	$1,236,798	$0	$1,236,798	(4.25%)
AMP046 - HEALTH CARE QUALITY AND HEALTH OUTCOMES	$0	$2,948,407	$2,634,962	$0	$2,634,962	(10.63%)
AMP047 - CLINICIANS, RX AND ACUTE CARE	$0	$9,565,521	$0	$0	$0	(100.00%)
AMP048 - LONG TERM CARE SUPPORT SERVICES	$0	$859,408	$809,005	$0	$809,005	(5.86%)
AMP049 - OVERSIGHT	$0	$2,100,082	$2,270,830	$0	$2,270,830	8.13%
AMP050 - OPERATIONS	$0	$12,358,242	$18,654,034	$0	$18,654,034	50.94%
AMP051 - INTAKE AND ASSESSMENT	$0	$9,840,574	$8,441,821	$0	$8,441,821	(14.21%)
AMP052 - HEALTH CARE POLICY	$0	$1,004,024	$1,021,132	$0	$1,021,132	1.70%
AMP053 - HEALTH CARE POLICY AND RESEARCH SUPPORT SERVICES	$0	$1,604,912	$1,279,949	($82,500)	$1,197,449	(25.39%)
AMP054 - ELIGIBILITY POLICY & OVERSIGHT	$0	$3,843,177	$4,402,490	$0	$4,402,490	14.55%
AMP055 - DCAS PROGRAM MANAGEMENT	$0	$1,807,361	$1,827,980	$0	$1,827,980	1.14%
AMP056 - DCAS PROJECT MANAGEMENT	$0	$4,327,756	$3,922,708	$0	$3,922,708	(9.36%)
AMP057 - DCAS HHS FUNCTIONAL	$0	$814,115	$851,451	$0	$851,451	4.59%
AMP058 - DCAS ORGANIZATIONAL CHANGE MANAGEMENT	$0	$13,202,557	$12,422,030	$0	$12,422,030	(5.91%)
AMP059 - DCAS INFORMATION TECHNOLOGY	$0	$57,268,167	$53,136,306	($58,402)	$53,077,904	(7.32%)
AMP060 - CLAIMS MANAGEMENT	$0	$59,722,222	$64,208,363	$0	$64,208,363	7.51%
AMP061 - HCOA SUPPORT SERVICES	$0	$454,445	$483,008	$0	$483,008	6.29%
AMP062 - PUBLIC AND PRIVATE PROVIDER SERVICES	$0	$3,664,604	$6,425,061	$0	$6,425,061	75.33%
AMP063 - HC REFORM AND INNOVATIVE SUPPORT SVS	$0	$454,012	$611,371	$0	$611,371	34.66%
AMP064 - GRANTS ADMINISTRATION FUNCTION	$0	$6,251,651	$9,907,535	$300,000	$10,207,535	63.28%

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DIFS Program (Parent Level 1)	FY 2024 Actuals	FY 2025 Approved	Mayor's FY 2026 Proposed	Committee Variance	Committee's FY 2026 Recommendation	Committee Percent Change
Department of Health Care Finance						
AMP065 - HIE: HEALTH INFORMATION EXCHANGE	$0	$11,321,423	$11,221,040	$0	$11,221,040	(0.89%)
H02301 - E & E SYSTEMS	$46,339,311	$98,671	$0	$0	$0	(100.00%)
H02302 - E&E OVERSIGHT & MANAGEMENT	$812,298	$0	$0	$0	$0	n/a
H02305 - E&E SUPPORT - PMO/SME - DCAS	$21,831,727	$0	$0	$0	$0	n/a
H02401 - HEALTH CARE AGENCY MONITORING AND KPIS	$1,594,222	$0	$0	$0	$0	n/a
H02402 - HEALTH CARE DATA ANALYTICS	$1,369,155	$0	$0	$0	$0	n/a
H02403 - HEALTH CARE INNOVATION	$7,682,237	$0	$0	$0	$0	n/a
H02501 - CLAIMS PROCESSING & QUALITY ASSURANCE/CONTROL	$47,021,074	$0	$0	$0	$0	n/a
H02601 - ASSESSMENTS AND CARE COORDINATION	$1,008,964	$0	$0	$0	$0	n/a
H02602 - FRAUD, WASTE, AND ABUSE	$4,154,736	$0	$0	$0	$0	n/a
H02603 - POLICY	$4,757,268	$0	$0	$0	$0	n/a
H02604 - PROVIDER OVERSIGHT	$40,646,558	$2,125,000	$0	$0	$0	(100.00%)
H02605 - QUALITY & HEALTH OUTCOMES	$3,291,655	$500,827	$394,779	$0	$394,779	(21.17%)
H02703 - 1115/1915 - MEDICAID	$413,218,010	$439,257,068	$498,997,873	$0	$498,997,873	13.60%
H02704 - FFS - CHILDLESS ADULTS (GROUP 8)	$9,732,818	$49,225,265	$69,895,558	$0	$69,895,558	41.99%
H02705 - FFS - CHIP	$8,368,102	$8,565,942	$13,375,074	$0	$13,375,074	56.14%
H02706 - FFS - MEDICAID	$1,449,062,759	$1,223,325,957	$1,428,001,260	$0	$1,428,001,260	16.73%
H02707 - MCO - ALLIANCE	$147,448,376	$132,644,102	$0	$0	$0	(100.00%)
H02708 - MCO - CHILDLESS ADULTS (GROUP 8)	$712,778,852	$931,881,864	$1,103,823,618	$25,571,053	$1,129,394,671	21.20%
H02709 - MCO - CHIP	$54,132,468	$73,587,341	$96,190,184	$7,567,901	$103,758,084	41.00%
H02710 - MCO - IMMIGRANT CHILDREN	$19,113,958	$18,284,131	$0	$0	$0	(100.00%)
H02711 - MCO - MEDICAID	$1,130,794,998	$1,529,115,559	$1,603,699,003	$54,877,159	$1,658,576,162	8.47%
H02712 - MCO- WAIVER	$151,402,080	$187,300,552	$196,846,228	$0	$196,846,228	5.10%
H02713 - HCBS ARPA INITIATIVE	$78,804,477	$224,775	$0	$0	$0	(100.00%)
H02714 - INDIGENT CARE	$0	$0	$120,527,110	$1,504,837	$122,031,947	n/a
PRG001 - NO PROGRAM	$15,068,725	$0	$0	$0	$0	n/a
TOTAL GROSS FUNDS	**$4,401,503,659**	**$4,867,809,070**	**$5,415,996,038**	**$89,386,264**	**$5,505,382,302**	**13.10%**
Health Benefit Exchange Authority						
AFO002 - AGENCY ACCOUNTING SERVICES	$170,735	$161,150	$172,340	$0	$172,340	6.94%
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$212,874	$206,407	$219,551	$0	$219,551	6.37%
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$359,114	$412,483	$420,346	$0	$420,346	1.91%
AFO011 - P-CARD CLEARING	$8,711	$0	$0	$0	$0	n/a
AMP005 - CONTRACTING AND PROCUREMENT	$716,095	$678,608	$537,382	$0	$537,382	(20.81%)
AMP011 - HUMAN RESOURCE SERVICES	$373,972	$386,089	$391,660	$0	$391,660	1.44%

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DIFS Program (Parent Level 1)	FY 2024 Actuals	FY 2025 Approved	Mayor's FY 2026 Proposed	Committee Variance	Committee's FY 2026 Recommendation	Committee Percent Change
Health Benefit Exchange Authority						
AMP012 - INFORMATION TECHNOLOGY SERVICES	$13,417,999	$14,141,599	$0	$0	$0	(100.00%)
AMP014 - LEGAL SERVICES	$917,600	$1,303,422	$1,604,351	$0	$1,604,351	23.09%
AMP016 - PERFORMANCE AND STRATEGIC MANAGEMENT	$7,115,367	$2,573,589	$2,434,540	$0	$2,434,540	(5.40%)
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT	$1,349,423	$1,492,410	$1,890,041	$0	$1,890,041	26.64%
H01901 - CONSUMER EDUCATION AND OUTREACH SUPPORT SERVIC	$1,087,915	$1,353,335	$1,326,747	$0	$1,326,747	(1.96%)
H01902 - MARKETING AND COMMUNICATION	$648,721	$963,451	$950,923	$0	$950,923	(1.30%)
H01903 - NAVIGATORS, CERTIFIED APPLICATION COUNSELORS AND	$934,990	$1,050,000	$1,050,000	$0	$1,050,000	0.00%
H02001 - CONTACT CENTER SERVICES	$3,622,823	$6,156,717	$0	$0	$0	(100.00%)
H02002 - DATA ANALYTICS AND REPORTING	$45,995	$181,932	$0	$0	$0	(100.00%)
H02003 - ELIGIBILITY AND ENROLLMENT	$1,478,452	$1,950,590	$0	$0	$0	(100.00%)
H02004 - MEMBER SERVICES	$2,509,015	$2,119,831	$0	$0	$0	(100.00%)
H02005 - PLAN MANAGEMENT	$2,021,977	$2,215,018	$0	$0	$0	(100.00%)
H02006 - S.H.O.P.	$2,985,767	$4,406,154	$0	$0	$0	(100.00%)
H02007 - PMO CONTACT CENTER SERVICES	$0	$0	$4,683,626	$0	$4,683,626	n/a
H02008 - PMO PLAN MANAGEMENT	$0	$0	$1,059,460	$0	$1,059,460	n/a
H02009 - PMO DATA ANALYTICS AND REPORTING	$0	$0	$151,043	$0	$151,043	n/a
H02010 - PMO S.H.O.P	$0	$0	$4,439,033	$0	$4,439,033	n/a
H02011 - PMO PERFORMANCE AND STRATEGIC MANAGEMENT	$0	$0	$624,638	$0	$624,638	n/a
H02015 - HCI CONTACT CENTER SERVICES	$0	$0	$759,811	$0	$759,811	n/a
H02016 - HCI PLAN MANAGEMENT	$0	$0	$201,964	$0	$201,964	n/a
H02017 - HCI DATA ANALYTICS AND REPORTING	$0	$0	$124,238	$0	$124,238	n/a
H02018 - HCI ELIGIBILITY AND ENROLLMENT	$0	$0	$2,747,406	$0	$2,747,406	n/a
H02019 - HCI PERFORMANCE AND STRATEGIC MANAGEMENT	$0	$0	$906,223	$0	$906,223	n/a
H02023 - OPERATIONS, MAINTENANCE AND DEVELOPMENT	$0	$0	$11,208,215	$0	$11,208,215	n/a
H02024 - INFORMATION TECHNOLOGY SECURITY	$0	$0	$1,105,897	$0	$1,105,897	n/a
H02025 - ELECTRONIC DATA INTERCHANGE (EDI)	$0	$0	$1,573,833	$0	$1,573,833	n/a
H02026 - IT PERFORMANCE AND STRATEGIC MANAGEMENT	$0	$0	$1,051,203	$0	$1,051,203	n/a
TOTAL GROSS FUNDS	**$39,977,544**	**$41,752,784**	**$41,634,470**	**$0**	**$41,634,470**	**(0.28%)**
Health Benefit Exchange Subsidy						
H02004 - MEMBER SERVICES	$0	$0	$0	$0	$0	n/a
TOTAL GROSS FUNDS	**$0**	**$0**	**$0**	**$0**	**$0**	**n/a**
Not-for-Profit Hospital Corporation						
C02001 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY	$0	$155,000,000	$0	$0	$0	(100.00%)
TOTAL GROSS FUNDS	**$0**	**$155,000,000**	**$0**	**$0**	**$0**	**(100.00%)**

DIFS Program (Parent Level 1)	FY 2024 Actuals	FY 2025 Approved	Mayor's FY 2026 Proposed	Committee Variance	Committee's FY 2026 Recommendation	Committee Percent Change
Not-for-Profit Hospital Corporation Subsidy						
C02101 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY FUNDING	$22,000,000	$17,200,000	$0	$0	$0	(100.00%)
TOTAL GROSS FUNDS	**$22,000,000**	**$17,200,000**	**$0**	**$0**	**$0**	**(100.00%)**
Office of the Deputy Mayor for Health and Human Services						
AMP030 - EXECUTIVE ADMINISTRATION	$1,976,920	$2,146,536	$2,301,936	$0	$2,301,936	7.24%
H01701 - AGENCY OVERSIGHT AND SUPPORT SERVICES	$115,535	$304,583	$208,284	$0	$208,284	(31.62%)
TOTAL GROSS FUNDS	**$2,092,456**	**$2,451,119**	**$2,510,221**	**$0**	**$2,510,221**	**2.41%**
GRAND TOTAL	**$5,122,834,238**	**$5,780,744,569**	**$6,153,387,157**	**$92,939,180**	**$6,246,326,337**	**8.05%**

Fiscal Year 2026 Agency Capital Budget Changes

The Committee made no changes to the Mayor's proposed capital budget.

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:

- All of the advisory committees and professional boards serving the Department of Health or Department of Behavioral Health
- Behavioral Health Planning Council
- Cedar Hill Hospital
- Commission on Health Equity
- Council on Physical Fitness, Health, and Nutrition
- Department of Behavioral Health
- Department of Health
- Department of Health Care Finance
- Deputy Mayor for Health and Human Services
- District of Columbia Health Benefit Exchange Authority
- Food Policy Council
- Health Information Exchange Policy Board
- Health Literacy Council
- Metropolitan Washington Regional Ryan White Planning Council
- Not-For-Profit Hospital Corporation
- 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 Wendell Felder, 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**
1/29/2025	Health Benefit Exchange Authority Food Policy Council
2/3/2025	Department of Behavioral Health (Public Witnesses)
2/5/2025	Department of Behavioral Health (Government Witnesses)
2/12/2025	Deputy Mayor for Health and Human Services Department of Health Care Finance
2/20/2025	Deputy Mayor for Health and Human Services and Department of Health Care Finance (Government Only)
2/24/2025	DC Health (3pm Public Witnesses) DC Health (10am Public Witnesses)
2/26/2025	DC Health (Government Witnesses)
3/5/2025	Board of Medicine Board of Pharmacy

Performance Oversight Hearings	
Date	**Title**
	Board of Psychology Board of Dentistry

Budget Oversight Hearings	
Date	**Title**
5/30/2025	Department of Behavioral Health (Public Witnesses)
6/2/2025	Department of Behavioral Health (Government Witnesses)
6/5/2025	Deputy Mayor for Health and Human Services (Public Witnesses) Department of Health Care Finance (Public Witnesses) Health Benefit Exchange Authority (Public Witnesses)
6/6/2025	Department of Health (Public Witnesses)
6/9/2025	Deputy Mayor for Health and Human Services (Government Witnesses) Department of Health Care Finance (Government Witnesses) Health Benefit Exchange Authority (Government Witnesses)
6/16/2025	Department of Health (Government Witnesses)

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, and J. 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 2026 Agency Recommendations

Summary information about the agency's recommended budget and related adjustments can be found in the earlier summary tables. A full list of all budget adjustments can be found in Attachment A.

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 6 divisions:

- Agency Management Program (AMP)
- HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)
- Center for Policy, Planning and Evaluation Administration (CPPE)
- Community Health Administration (CHA)
- Health Systems and Preparedness Administration (HSPA)
- Environmental Health Administration (EHA)

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 9 activities:

- Direct Care Services for Tuberculosis
- Drug Assistance
- Grants and Contracts Management
- HIV Health and Support Services
- HIV/AIDS Data and Research
- HIV/AIDS Housing and Supportive Services

- HIV/AIDS Policy and Planning
- Prevention and Intervention Services
- Sexually Transmitted Disease (STD) Control

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 7 activities:

- Policy and Planning
- Data Management and Analysis
- Informatics
- Finance and Grants Policy, Planning, and Evaluation
- Epidemiologic Studies and Outbreak Investigation
- Birth and Death Record Collection, Processing, Analyzing and Dissemination
- Development of the State Health Plan and Annual Implementation

Community Health Administration (CHA) – promotes healthy behaviors. 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 5 activities:

- Cancer and Chronic Disease Prevention
- Community of Health Support Services
- Family Health
- Health Care Access
- Nutrition and Physical Fitness

Health Systems and Preparedness Administration (HSPA) – This administration supports the steady state and emergent operations of the healthcare system within the District of Columbia. A core component is to provide regulatory oversight of healthcare professionals and entities operating within the District of Columbia. This administration supports the Department, healthcare system, and the public in public health emergency preparedness, resiliency, response, and recovery activities to ensure continuity of services and the well-being and health of residents of and visitors to the District of Columbia. This division contains the following 7 activities:

- Finance and Grants
- Health and Medical Coalition
- Health Licensing
- Health Care Facilities Regulation
- Public Health Emergency Operations and Program Support
- Emergency Medical Services Regulation
- Public Health Planning, Training, and Exercise

Environmental Health Administration - this program provides varied inspection and regulatory services on covered environmental health domains including food services, community sanitation, animal care and control, and lead services. This division contains the following 8 activities:

- Indoor Environment

- Outdoor Environment
- Food Sanitation
- Community Hygiene
- Animal Services
- Rodent and Vector Control
- Policy and Planning
- Finance and Grants

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. This includes the Office of Health Equity, which contains the following 3 activities:

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

2. COMMITTEE BUDGET RECOMMENDATIONS

a. FISCAL YEAR 2026 OPERATING BUDGET RECOMMENDATIONS

MAYOR'S FISCAL YEAR 2023 – 2026 OPERATING BUDGET SUMMARY

Description	*FY 2023 Actual*	*FY 2024 Actual*	*FY 2025 Approved*	*FY2026 Proposed*	*% Change from FY 2025*
Department of Health					
Operating Budget	$288,696,544	$281,085,123	$310,028,863	$314,929,262	1.6
FTEs	612.4	800.0	826.9	842.4	1.9
Capital Budget	$249,296	$0	$22,756,239	$0	-100
FTEs	0.0	0.0	0.0	0.0	N/A

The Mayor's FY 2026 proposed operating budget for DC Health is $314,929,262, which represents a 1.6% increase compared with the approved FY 2025 budget. This is due in part to a transfer of the Child Lead Poison Prevention Program from the Department of Energy and the Environment (DOEE) to DC Health and an overall increase in federal grants, offset by decreases in other federal grants, local funds, and one-time funding.

Although the FY 2026 proposed budget chapter only indicates a total of 842.4 FTEs at DC Health, a 1.9% increase from the FY 2025 approved level, an error was made in budget formulation and there should actually be an additional 172 FTEs added to the FY 2026 budget as DC Health brings the School Health Services Program, which was formerly on a grants/contracts line, in-house. Once that adjustment is made, DC Health will have 1,014.4 FTEs within the agency.

CON Reform

D.C. Law 26-7, the "Certificate of Need Improvement Amendment Act of 2025", was unanimously approved at the April 1, 2025 Legislative Meeting. Thirty-five states, including the District of Columbia, use Certificate of Need, or "CON" programs as a tool to regulate the supply of certain healthcare services. In the District, in order for a health care entity to open a new facility, expand an existing facility, or modify the services it provides, the facility must apply for a CON from the State Health Planning and Development Agency (SHPDA) within DC Health. The CON application process can take 6-9 months and the application

fee can range from $5,000 to $300,000, depending on the size of the project. Along with legal fees and potential loss of revenue from delayed openings, the costs of CONs are substantial for health care entities in the District. The District has one of the broadest CON programs in the country, requiring CONs for 25 different types of health care services. This has significantly impacted our ability to recruitment certain health facilities to locate in the District as opposed to on the border in neighboring jurisdictions.

D.C. Law 26-7 significantly streamlines the CON process by:

1. Exempting certain types of health care entities from the CON program to align with other jurisdictions, including virtual provider platforms and networks, primary care, office-based specialty care, dental care, outpatient and residential behavioral health services, and federally qualified health centers;
2. Exempting from CON certain types of capital projects, including nonpatient care projects (like HVAC upgrades and parking garages), facility renovations that do not affect health care services, and replacing major medical equipment;
3. Increasing the financial thresholds for CON review for capital expenditures and major medical equipment, to better align with inflation, and makes the project timeline for construction projects more flexible;
4. Increasing the threshold for the change in number of licensed beds that triggers CON review from 10% to 20% of total beds;
5. Expanding the definition of "uncompensated care" to allow for hospitals to count treatment of non-District residents towards their 3% uncompensated care requirements; and
6. Increasing transparency by requiring SHPDA to post on the DC Health website a complete list of CON applications from the previous 3 years.

Although the legislation will streamline the currently burdensome administrative process and decrease the workload for SHPDA, the OCFO has reported that the bill will cost $586,000 in FY 2026 and $2,130,000 over the financial plan. This includes the projected reduced revenue to SHPDA due to the exempted entities and projects. It also includes two FTEs and IT costs for DC Health to set up the registration process for entities exempt from CON. **The Committee is pleased to be able to fully fund D.C. Law 26-7, the "Certificate of Need Improvement Amendment Act of 2025", by allocating the amounts indicated in the OCFO's Fiscal Impact Statement (FIS) below to DC Health.** The following FIS is based on FY 2025-FY 2028, but the Office of Revenue Analysis confirmed that these costs would be the same for FY 2026- FY 2029.

Bill 26-25 - Certificate of Need Improvement Amendment Act of 2025 Total Cost ($ in thousands)					
	FY 2025	FY 2026	FY 2027	FY 2028	Total
CON Application Fee Reduced Revenue	$205	$205	$205	$205	$820
Salary[a]	$214	$218	$222	$227	$881
Fringe[b]	$47	$49	$51	$53	$201
IT Cost and Maintenance[c]	$120	$36	$36	$36	$228
Total	$586	$508	$515	$521	$2,130

Animal Care and Control Services

The animal care and control services program at DC Health underwent significant changes in FY 2025, including moving to a new contractor for the first time in over 40 years, and the opening of a new animal

shelter at 4 DC Village Avenue SW. This section provides more details on the contract. The subsection below on the Capital Budget provides more details on the new shelter location.

The Mayor's FY 2026 proposed budget provides $8,268,067.62 for the animal care and control contract under DC Health, including $7,544,940 in the contracts line and an additional $723,127.62 in personnel services funds that DC Health has informed the Committee they intend to transfer to the contracts line. The spending for this contract has varied significantly in the past 3 fiscal years as the District has transitioned to a new contractor. In FY 2024, the contract was funded at $5.9M; in FY 2025, the contract was funded at $11.7M. At the FY 2026 Budget Oversight hearing, DC Health testified that the FY 2026 funding level is adequate for this fiscal year and that there will not be any spending pressures or need for supplemental funding.

At the hearing, the Committee raised some complaints from residents regarding the performance of the new contractor, including reports of staff and volunteers being bitten by dogs, and some animal injuries from being confined in small spaces. DC Health testified that they do track bite incidents and that there has been no significant increase with the new contractor. They also testified that the agency is taking a more proactive approach to overseeing the new contract and have already done 5 inspections of each shelter location in this calendar year. In the pre-hearing responses, the agency also provided data on live release and euthanasia rates, indicating that the new contractor has had a higher live release rate and has had to euthanize far fewer animals that the previous contractor (see chart below).

Month	# of Animals Housed	# of Domestic Animals Euthanatized	Current Live release rate
October 2024	584	147	87%
November 2024	550	130	90%
December 2025	Data not submitted by Humane Rescue Alliance due to transition out of service. New contract started on January 1, 2025.		
January 2025	382	17	94%
February 2025	345	18	93%
March 2025	524	26	94%
April 2025	531	30	93%
May 2025	467	34	93%
Total		493	

The Committee recommends maintaining the Mayor's proposed FY 2026 budget for animal care and control services under the new vendor and that DC Health continues to proactively monitor the performance of the contractor.

<u>HIV/AIDS and Sexual Health</u>

HIV Prevention and Surveillance

The majority of the funding for DC Health's HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) is federal funding ($78.2 million of the $87.7 million total FY 2026 budget). In FY 2026, HAHSTA foresees a $4.6 million reduction in federal grants that support HIV prevention and surveillance,

ending the HIV epidemic (EHE), STI prevention, and treatment. DC Health subgrants the majority of these funds to community organizations, like the Women's Collective, who testified at the public hearing to the devastating impact of these cuts. This reduction is in part due to the District' decreasing rates of new HIV cases. In 2024, the District hit a milestone of less than 200 new HIV cases for the first time since the District started tracking cases over 30 years ago. Since the federal funding rate for treating HIV/AIDS is tied to incidence, the District is losing the funding that enabled us to lower our case rate, hampering 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.

In addition to these cuts based on case rate, DC Health is also facing tremendous uncertainty regarding the U.S. Centers for Disease Control and Prevention (CDC) grants, federally appropriated funding that the federal government has discontinued with no rationale. Specifically, the $2.4 million CDC grant PS24-0047 for HIV prevention and surveillance was not awarded as planned on June 1, 2025, and there has been no communication from the CDC about the grant. DC Health has had to issue stop work orders to the subgrantees for this grant. The Committee heard testimony from many advocates from the Women's Collective, one subgrantee on this grant, who have had to cease their critical work to educate women about preventative medication and lifestyle changes to prevent the spread of HIV. DC Health also testified that, if the funding does not come through, they will need to discontinue two other critical programs this summer, PrEP Housing, which provides housing to 8 individuals at high risk of contracting HIV, and the PEP Hotline, which provides 24-hour emergency resources for individuals exposed to HIV.

In short, the discontinuation of the $2.4M CDC HIV Prevention and Surveillance grant funding will lead to more District residents contracting HIV, and the District will lose ground on our progress to end HIV in the District. **The Committee is able to partially restore this grant funding with a recurring $1,270,598.75. Although the Committee was not able to fully restore this funding, it strongly recommends that the Committee of the Whole identify the additional $1,130,000 to restore this critical loss.**

DC Health and Wellness Center

DC Health operates the DC Health and Wellness Center (Center) at 77 P Street NE to provide HIV/STD care and treatment to District residents. In FY 2024, the Center saw 10,002 patients, including 7,547 STD patients and 2,455 TB patients, and prescribed PrEP to 790 individuals.

Although the Center is a lifeline for many residents at risk of or in treatment for HIV and other STDs, its efficacy is limited due to restraints on its hours and staffing. The Center is open Monday-Friday 8:30am-4:30pm, making it difficult for residents with full-time jobs or in school to access its services. The Committee visited the Center in the summer of 2024, and discussed with program leadership how extended hours could also help decrease visits to the emergency room for sexual health related issues, increase access to HIV and STI testing and treatment for residents, and better support District residents with harm reduction and health education resources. In the pre-hearing responses, DC Health provided the following estimates for allocating $410,681 annually to extend the Center's hours to include one evening per week and two Saturdays per month:

PS

DCHWC Staff	Salary	Fringe	Total each	# staff needed	Total Cost
RN	$ 97,212.00	$ 25,761.18	**$ 122,973.18**	1	**$ 122,973.18**
APRN	$115,000.0 0	$ 30,475.00	**$ 145,475.00**	1	**$ 145,475.00**
Med Tech	$ 68,836.00	$ 15,143.92	**$ 83,979.92**	1	**$ 83,979.92**
	Total Staffing Amount	**$ 352,428.10**			

NPS

Other Costs	Annual
Medical supplies	$ 10,000
Medications	$ 7,500
LabCorp	$ 25,000
10% shift differential for union employees	$ 5,113
Security guard	$ 10,640
Total	$ 58,253

On a tour of the Center in the summer of 2024, the Committee staff also spoke with leadership about their lack of behavioral health staff. They noted that many patients receive life-changing diagnoses at the Center, and that managing their mental health can make the difference between whether or not they choose to accept treatment. The Committee followed up in the performance and budget oversight pre-hearing questions and received the following cost estimates to add behavioral health staff (specifically, licensed independent clinical social workers) to the Center:

	Salary	Fringe	Total each	#	**Total Cost**
LICSW	$105,000.00	$27,825.00	**$ 132,825.00**	2	**$ 265,650.00**

The Committee allocates $410,681 in recurring funding to DC Health for the DC Health and Wellness Center to expand hours to one evening per week and two Saturdays per month. Although Committee did not have the resources to add social workers to the Center this year, it does believe these investments would be worthwhile and should be revisited in future fiscal years, particularly as the District loses federal support for HIV/STD prevention, testing, and treatment.

Child Behavioral Health Dashboard

The Council unanimously passed the "Child Behavioral Health Services Dashboard Amendment Act of 2024" (D.C. Law 25-154), to create an online dashboard to help families, school personnel, and service providers identify and connect with available behavioral health services across the District. The agency plans to integrate this information into its existing LinkU platform, which is operated by the HAHSTA Administration.[1] **The Committee is pleased to accept a transfer of $111,599 in FY 2026 and $436,466 across the financial plan from the Committee on Youth**

[1] LinkU, https://linku.findhelp.com/ (last visited June 20, 2025).

and Family Affairs to DC Health to implement this law and ensure a user-friendly, transparent, and effective resource for the public.

Food Access

Many District residents do not consistently have enough food to feed themselves or their families. According to the Capital Area Food Bank, 37% of District residents experienced food insecurity in 2024.[2] 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 residents eligible for SNAP benefits; and
- The Senior and WIC Farmers Market Nutrition Programs.

Healthy Food Access Grants

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 2026, these programs will be particularly critical as the federal government considers significant cuts to federal food security programs, such as the Supplemental Nutrition Assistance Program (SNAP). Therefore, the Committee is glad to see that none of the locally funded nutrition programs have significant reductions in the FY 2026 proposed budget. The following chart shows the proposed funding levels in FY 2026:

Healthy Food Access Grant Project	**FY25 Approved Budget**	**Proposed FY26 Budget**
Martha's Table Joyful Food Markets	$1,824,066 recurring	$1,774,066 recurring *($50,000 reduction)*
DC Central Kitchen Healthy Corners	$750,000 recurring	$750,000 recurring
FRESHFARM Produce Plus	$2,100,000 recurring	$2,050,000 recurring *($50,000 reduction)*
Food and Friends Medically Tailored Home Delivered Meals	$1,335,000 recurring	$1,335,000 recurring

[2] Capital Area Food Bank. "Hunger Report 2024." (Sept. 2024). Accessed June 17, 2025 at: https://hunger-report.capitalareafoodbank.org/report-2024/

Although the funding mostly remains flat in FY 2026, the Committee is concerned about the two proposed reductions to Produce Plus and Joyful Food Markets which total $100,000. Although this is not a significant cut, DC Health estimates that this reduction, if not restored, would lead to 200 fewer spots for Produce Plus, and 4,166 fewer Joyful Food Markets fresh produce bags. At the Budget Oversight hearing, DC Health testified that they would be able to backfill these reductions with other federal and private grants. **Therefore, the Council does not propose to restore the funding in FY 2026, but does plan to follow up to ensure the funding was restored to these critical programs.**

The federal Local Food Purchase Assistance Cooperative Agreement Program (LFPA), administered by the USDA's Agricultural Marketing Service (AMS), provided funding to states to purchase and distribute local and regional foods, before the program was cancelled in March 2025. In FY 2025, the District subgranted $720,000 of LFPA funding to Martha's Table and the Capital Area Food Bank (CAFB) to add locally grown produce to grocery bags for low-income residents through the Joyful Food Markets and Commodity Supplemental Nutrition Program, or "Grocery Plus" programs. Both Martha's Table and CAFB subgranted their funds to Dreaming Out Loud, a non-profit locally grown produce distributor. The District's three-year LFPA grant sunset in FY 2025, but DC Health testified that they had expected USDA to provide another opportunity to apply for continued funding, before the program was abruptly cancelled. Notably, Dreaming Out Loud had been relying on continued funding in order to open and operate its in-development Marian Barry Avenue Market in Ward 8, scheduled to open this summer. Without the funding, Dreaming Out Loud testified that they would face significant challenges to open the market. **The Committee does not want to see a delay in the opening of this critical healthy food access and job hub for the Anacostia community, and therefore recommends the partial restoration of $200,000 in one-time funds to DC Health for local produce purchases previously made with LFPA funding.**

The Committee is also concerned by the impact of rising food costs. Food & Friends testified that inflation on products like chicken breast has significantly increased their food costs, so even flat funding for these programs could mean a reduction in individuals served.

Farmers Markets

The Council unanimously approved Bill 26-0109, the "Farmers Market Support Amendment Act of 2025", at the June 17, 2025 Legislative Meeting. This bill will increase access to farmers markets across the District, with targeted support for markets in low food access areas. It will also create a streamlined, single farmers market permit, so that market operators no longer need to navigate the complicated web of agencies currently involved in farmers market licensing.

Farmers markets are essential for improving access to healthy, affordable food, supporting small farmers and District small businesses, and building community. There are currently 53 independently operated DC farmers markets operating across all 8 Wards, and almost all of them serve shoppers who use federal and local food assistance programs. The District offers a wide range of benefits administered by DC Health for low-income residents to shop at farmers markets, including Produce Plus and Farmers Market Nutrition Programs for women, children, and seniors.

Farmers markets are also a proven strategy to incubate District-owned small businesses, to boost the sales of nearby brick-and-mortar businesses, and to activate public spaces.

Many neighborhoods in the District do not have access to healthy food, with approximately 330,000 residents living in areas classified as low food access, including 111,000 earning less than 185% of the federal poverty line. As the District works to attract full service grocery stores to low food access areas, farmers markets can be an important part of the solution.

Specifically, B26-0109 takes several critical steps to encourage farmers markets to open, operate, and expand across the District, specifically in low food access areas. These include:

- Establishing a Farmers Market Support Program within the Department of Health to provide technical assistance to markets, provide guidance on licensing and permitting, and coordinate across agencies to support farmers markets;
- Creating a grant program of at least $250,000 to incentivize farmers markets to open and expand operations in low food access areas by funding operational costs, infrastructure, and year-round operations;
- Waiving all licensing and permitting fees for farmers markets, farm stands, and mobile markets operating in low food access areas;
- Requiring the District to create a centralized application system for farmers markets by January 2028. This system, created by the Department of Licensing and Consumer Protection (DLCP), would enable farmers market operators to submit their application to one government agency through an online portal. The portal would then make the application available to other relevant agencies for review; and clearly communicate to applicants the status of their application.

The Committee is pleased to fully fund Bill 26-0109, the "Farmers Market Support Amendment Act of 2025". The Committee allocates the amounts indicated in the OCFO's updated Fiscal Impact Statement below, provided to the Committee in June 2025, to DC Health and DLCP through a transfer to the Committee on Public Works and Operations.

DC Health	FY2026	FY2027	FY2028	FY2029	Total
Salary	$117,029	$119,487	$121,876	$124,314	$482,706
Fringe	$26,800	$28,019	$29,251	$30,537	$114,607
Grants	$250,000	$250,000	$250,000	$250,000	$1,000,000
Marketing	$50,000	$50,000	$50,000	$50,000	$200,000
Program Supplies	$50,000	$50,000	$50,000	$50,000	$200,000
Total	$493,829	$497,506	$501,127	$504,851	$1,997,313

DLCP	FY2026	FY2027	FY2028	FY2029	Total
IT Update	$225,000	$250,000	$0	$0	$475,000

Grocery Access Pilot

The Committee continues the critical work it began in the Fiscal Year 2025 budget to expand grocery delivery for low-income residents by continuing Grocery Access Grant Pilot Program (see "Grocery Access Grant Pilot Program Act of 2025" (found in Attachment G).

In the FY 2026 pre-hearing responses and at the Budget Oversight Hearing, DC Health testified that it had taken longer than usual to finalize the grant agreement for this program, so the pilot will start July 1, 2025. The grantee, Martha's Table, will contract with Instacart to distribute 1,000 Instacart+ Membership Codes to 1,000 residents. DC Health has also supplemented the program with federal funds so that Martha's Table will also provide $75/month in Instacart food funds to 200 residents for six months. DC Health testified that it would be helpful to continue the pilot for 2 years in order to understand the effectiveness of the intervention.

The Committee therefore recommends an enhancement of $120,000 in one-time local funds for DC Health to implement the Committee's BSA subtitle, "Grocery Access Pilot Program Amendment Act of 2025".

School Health

School Health Services Program

DC Health is in the midst of a significant transition of the School Health Services Program (SHSP), from a grant to Children's School Services (CSS) to in-house at DC Health. SHSP provides health professional staffing to manage the District's 183 school health suites for approximately 90,000 public school children. At the Budget Oversight hearing, DC Health Director Dr. Ayanna Bennett testified that this transition was spurred by several factors. In the current federal funding environment, Children's National Hospital, which oversees CSS, no longer wanted to focus on school health services. Second, DC Health wanted more control over the training curriculum for school health staff, the IT infrastructure, and the coordination among health suites in the same clusters.

On May 5, 2025, the Mayor introduced a $5.5M reprogramming within DC Health to transition SHSP in-house starting in June 2025. This gives DC Health and DC Human Resources the time to onboard and train all 222 FTEs so that the program can be operational by the beginning of School Year 2025-26. Dr. Bennett testified that over 200 of the CSS staff applied for the DC Health positions, and the agency hopes to keep on most of them at their current schools.

Although the funds were moved in the FY 2025 reprogramming, the FY 2026 proposed budget chapter only moves funding to create 50 new FTEs, leaving the $19.2 million in funding for the other 172 FTEs for this program on the contracts line. Dr. Bennett testified at the hearing that this was an error in the budget chapter and will be corrected by the beginning of FY 2026. The Committee urges DC Health and the OCFO to ensure a timely and smooth reprogramming so there are no disruptions to school health services at the beginning of the school year.

School-Based Health Centers

DC Health is also transitioning the majority of the School Based Health Centers (SBHCs) from grants to being administered in-house. Of the 7 total SBHCs, 5 will be operated in-house (Anacostia High School, Theodore Roosevelt High School, Ballou High School, Dunbar High School, and Calvin Coolidge Senior High School) and 2 will continue to be operated by Unity Health Care Inc. (Cardozo Education Campus and H.D. Woodson High School). The SBHCs will be operated within HAHSTA, given that Administration's experience with behavioral health, sexual health, and other health issues commonly experienced by high school students.

At the Budget Oversight hearing, DC Health testified that this transition is meant to create a more uniform health program across the high schools, which previously were operated by a number of different nonprofits with different models. They stated that Unity runs two of the most highly utilized SBHCs, and thus it makes sense for them to continue operations. Utilization for the 7 current operating SBHCs in FY 2024 is included in the chart below. DC Health also previously testified at the FY 2024 Performance Oversight hearing that they are working on becoming credentialed by Medicaid so that they can also bill for school health services in both the SHSP suites and the SBHCs, which will help in making the program financially sustainable. They anticipate that the process will be finalized ahead of the start of school year 2025-2026.

FY 2024 School-Based Health Centers Utilization by Service and School (SY 2023 – 2024)							
	Anacostia	Ballou	Cardozo	Coolidge	Dunbar	Roosevelt	Woodson
Total Visits	663	345	1790	1434	491	564	1346
Total number of students who visited SBHC (unduplicated count number as seen above)	554	285	1261	1082	212	436	844
Well Child Visits	185	0	308	169	0	165	263
Mental/ Behavioral Health Visits	106	64	1732	593	11	184	39
Sexual Health Visits	416	73	326	423	65	345	211
Oral Health Visits	87	55	244	524	43	64	94
Asthma Care Visits	36	0	41	35	0	35	86

Health Professional Licensure

Counseling Compact

The Council unanimously passed D.C. Law 25-0238, the Counseling Compact Approval Act of 2024, on October 1, 2024. This legislation was introduced by Councilmembers Gray, Frumin, Allen, and Henderson on May 5, 2023. The bill authorizes the Mayor to enter into and execute a Counseling Compact for the purpose of increasing access to licensed professional counseling. The main purpose of the Counseling Compact is to allow counselors licensed in any compact state to practice in another compact state without needing to obtain a separate license in that state. Additionally, the compact establishes requirements for states to conduct and report adverse actions and the consequences. It outlines that all compact states to share licensee information with other compact states and would establish the Counseling Compact Commission. This Commission will oversee the implementation and administration of the Counseling Compact, facilitating interstate practice of licensed professional counselors and ensuring compliance with established standards to improve public access to professional counseling services. It will manage a coordinated database of licensure and enforce the compact's rules across member states. Language in this legislation was required to mirror the language from other compact states.

At the FY 2026 Budget Oversight hearing, Dr. Bennett and her team testified that, although the District already appears as a compact state on the National Counseling Compact website, the District has not been able to fully participate because the bill remained subject to appropriations. She testified that she and her team would revisit whether the agency could absorb the costs of the legislation so that they could fully participate. In further conversation with the Committee, DC Health shared that the agency could absorb the cost of the Counseling Compact legislation if they received the additional FTE associated with the "Department of Health Licensure Pathways Program Amendment Act of 2025" subtitle. The Committee was able to fund that FTE, and received confirmation in writing from ORA that the agency can now absorb the costs of the legislation, and therefore the bill is no longer subject to appropriations.

Therefore, the Committee is pleased that D.C. Law 25-0238, the Counseling Compact Approval Act of 2024 is no longer subject to appropriations and can be fully implemented.

Pathways to Licensure for Internationally Trained Health Professionals

La Clinica del Pueblo conducted a community needs assessment in the summer of 2024 that highlighted key priorities for their clients, including that the District assist internationally trained health professionals in obtaining the licensure and credentials required to practice in the District. This program would support District residents who are qualified health professionals trained abroad, while also addressing the District's ongoing shortages across various health professions. Navigating the District's licensure landscape can be complex, and tailored assistance is essential to ensure that these professionals who bring valuable skills, experience, and cultural competence are able to contribute fully to the healthcare workforce.

Momentum for similar reforms is growing nationally, as twenty-five states have pending or proposed legislation to establish licensure pathways for internationally trained health

professionals. In conversations with the Department of Health, agency leadership confirmed the capacity to implement a Health Licensure Pathways program with one additional FTE.

The Committee therefore recommends funding one additional FTE and associated IT costs to implement the "Department of Health Licensure Pathways Program Amendment Act of 2025" BSA subtitle, which is explained in more detail in the BSA Chapter of this report.

b. FISCAL YEAR 2026 - 2031 CAPITAL BUDGET RECOMMENDATIONS

The Mayor's proposed FY 2026 – FY 2031 capital budget request for DC Health is $907,000. This represents a decrease of $21,923,000, from the FY 2024 – FY 2029 Capital Plan. The FY 2026 – FY 2031 Capital Plan includes one project for Fleet Replacement, which is funded at $0 in FY 2026 and a total of $907,000 over the capital plan.

New Animal Shelter

The DC Health capital budget also highlights several recent "accomplishments", including the DC Animal Shelter Renovation & Expansion. This capital project was funded in the FY 2025 capital budget at $22.5 million. As of May 23, 2025, this project had an available balance of $1,614705 and an unspent balance of $10,249,223.

The current District-owned animal shelter at 1201 New York Avenue NE is long overdue to be retired. The FY 2025 budget included $25 million for a capital project to build a new animal shelter at 4 DC Village Avenue SW. The new location for the shelter has garnered significant pushback from residents and advocates concerned that the lack of public transportation and distance from much of the District's residential areas will create barriers for residents to use the shelter's veterinary and adoption services. The location is also adjacent to Blue Plains, the District's water treatment facility which often emits unpleasant odors, which could cause hardship for dogs, staff and volunteers.

Given the significant pushback, the Executive informed the Committee that they would build a temporary shelter on DC Village Ave. while continuing to explore options for a permanent new shelter location in FY 2025. However, DC Health testified at the public budget hearing that it proved difficult to make the required upgrades to the DC Village Ave. location without expending the entire capital budget set aside for this project. The site needed expensive draining and air handling to make it habitable for animals and staff. DC Health has also testified that, after visiting many other potential sites for the shelter, the District could not identify a feasible site in a more centrally located part of the District.

Although the Committee continues to share the concerns of residents about the location, it is most concerned with the immediate need to fully open the DC Village Ave. location and close the New York Avenue shelter. The New York Avenue shelter poses hazards for animals and staff, with crumbling walls, rodent infestations, and other challenges. It also does not have sufficient space, leading to the contractor needing to turn away stray animals or house animals in confined pens. Although construction was supposed to be completed by June, supply chain delays have led to an updated timeline of September 30. The Committee recommends that DC Health and the Department of General Services prioritize the swift completion of this capital project. Further, the

Committee recommends that DC Health pursue a smaller location to facilitate adoptions that is closer into the central part of the city. After years of residents having the option to visit the New York Ave NE location or the prior contractors location in Ward 4, we are concerned that the DC Village location may deter residents from visiting.

3. COMMITTEE POLICY RECOMMENDATIONS

1. Modernize policies on the corporate practice of medicine.

Healthcare consolidation, including the merger of hospitals, physician groups, or health systems, as well as the purchase of health care organizations by private investors, has become increasingly common across the country, raising concerns about reduced competition, increased healthcare costs, and limited patient access. The National Academy for State Health Policy has developed model legislation that offers a framework for states seeking to regulate healthcare mergers and acquisitions.[3] Currently, seventeen states have introduced or enacted legislation to provide oversight and place conditions on such consolidations in order to protect consumers and maintain a competitive healthcare market.

During the FY 2024 performance oversight hearing on DC Health, Director Bennett noted that existing District laws on healthcare mergers were not crafted with the modern landscape of healthcare consolidations in mind. She emphasized that other jurisdictions are taking steps to more proactively protect patients from potential harms of health care consolidation, and that the District should continue similar measures. The Committee is interested in working with DC Health to consider strengthening the District's laws to protect patients.

2. Standardize CNA Training and Testing Protocols

The Committee has received consistent feedback from Certified Nursing Aide (CNA) and Home Health Aide (HHA) training program administrators across the District indicating that their students experience challenges in signing up to take their licensing exam after finishing the training course. The exams are administered by a third-party company, Credentia, with whom the District has a contract. DC Health shared during FY 2024 performance oversight hearings that the Board of Nursing, with information from Credentia, has begun sending out monthly emails with available testing spots in the District to training programs. Training providers indicated that while they have received these communications, some of the information has been incorrect. During follow-up communication, DC Health indicated that the Board of Nursing is working with Credentia to build out a more proactive report for open testing sites.

The Committee recommends DC Health streamline this communication with Credentia and share testing sites and times in a public and easily accessible format. DC Health should also develop and publish a standardized CNA testing schedule that aligns with the end dates of approved training programs, ensuring students have predictable and timely access to exams. This is critical, especially as the Board of Nursing finalizes development of the combined CNA/HHA license as legislated in B25-0565, the "Certified Nurse Aide Amendment Act of 2024".

[3] National Academy for State Health Policy, *Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency*, Blog Nov. 21, 2021, Updated July 26, 2024, https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/ (last visited June 20, 2025).

3. Streamline licensure process for shared kitchens to increase access to shared commercial kitchen space for small food businesses.

DC Health is tasked with implementing the microenterprise home kitchen permit and the cottage food permits in the District, both of which provide avenues for very small home-based food businesses to sell their products in the District. DC Health has expressed concerns at public hearings about the preparation of food for commercial sale at home, and has testified that the agency would prefer that more small businesses use shared commercial kitchen spaces.

However, many applicants who would like to start shared kitchen spaces are being denied. DC Health reported that in FY 2024, 90 businesses applied for a shared kitchen license and only 34 were approved. DC Health testified that the main challenge for approving these applications is space, since many of the kitchen spaces are small. However, DC Health could still approve small spaces as commercial kitchens, as long as there are restrictions for how many people can be in the kitchen at a time. For example, DC Health approved the Festival Center in Adams Morgan's application to be a shared kitchen space, but limited occupancy to 2-3 people at a time. Even a small kitchen can host multiple businesses over the course of the day, and create valuable, affordable space for new businesses to incubate.

The Committee urges DC Health to more proactively embrace its role in authorizing more shared commercial kitchen space. These spaces not only generate revenue for small businesses and for the city, but they also ensure that more local businesses are cooking in a certified commercial kitchen, assuaging DC Health's concerns about food safety for food cooked in the home and offered for sale.

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

The 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

The Department of Behavioral Health (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 Mental Health/Substance Use Disorder
    - 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 2026 Operating Budget Recommendations

MAYOR'S FISCAL YEAR 2023 – 2026 OPERATING BUDGET SUMMARY

Description	*FY 2023 Actual*	*FY 2024 Actual*	*FY 2025 Approved*	*FY2026 Proposed*	*% Change from FY 2025*
Department of Behavioral Health					
Operating Budget	$358,176811	$376,175,456	$386,502,734	$378,317,166	-2.1
FTEs	1,251.4	1,370.8	1,411.9	1,413.5	0.1
Capital Budget	$5,975,877	$6,059,716	$7,280,000	$0	-100
FTEs	0.0	0.0	0.0	0.0	N/A

The Mayor's FY 2026 proposed operating budget for the Department of Behavioral Health (DBH) is $378,317,166, which represents a 2.1% decrease compared with the approved FY 2025 budget. This is largely due to decreased funding for School-Based Behavioral Health Services, Youth Crisis Services, and Mental Health and Rehabilitative Servies (Local Only). The funding supports 1,413.5 Full-Time Equivalents (FTEs), a 0.1% increase from the FY 2025 approved level.

This chapter outlines the Committee's analysis and recommendations regarding DBH's Fiscal Year 2026 budget. It highlights several key areas within DBH's portfolio, including opioid response and the associated use of settlement funds, Saint Elizabeths Hospital, the School-Based Behavioral Health Program, and the Court Urgent Care Clinic. The Committee remains deeply concerned about persistent challenges across the agency's operations that raise questions about the overall direction and strategic vision of DBH. This chapter also includes detailed policy recommendations for the agency.

Opioid Response

In March 2024, the Mayor introduced *LIVE.LONG.DC 3.0* (LLDC 3.0)[4], the third iteration of the District's strategic plan to address the opioid epidemic. LLDC 3.0 continues to prioritize the development of a person-centered system of care, improved coordination across the continuum of services, and investments in a skilled behavioral health workforce. While earlier versions of the strategy did not produce a sustained decline in overdose fatalities, recent data indicates that the District's renewed efforts may be starting to yield results.

Since 2018, the District has lost 2,660 residents to fatal opioid overdoses. However, for the first time in several years, the number of fatal overdoses has declined significantly. According to the LIVE.LONG.DC dashboard, preliminary data show an encouraging reduction in opioid-related fatalities from March 2024 through early 2025. Specifically, the District reported approximately 344 fatal opioid overdoses in 2024, representing a nearly 33 percent decrease from the 516 deaths reported in 2023. Encouragingly, this trend has continued into 2025 and the Committee awaits updated data from the Office of the Chief Medical Examiner (OCME). Non-fatal overdoses also declined in 2024, with 4,798 reported, which was a 6.3 percent decrease from 2023.[5] While modest, this reduction reinforces the ongoing need for strategies for prevention and intervention.

OPIOID-RELATED OVERDOSES BY LOCATION

Displaying Counts of **Opioid Overdoses by Wards** based on Location of Injury and Opioid Overdose Rate per 100,000 Residents.

Geography	OD Count*	% of Total*	Non-Fatal Opioid Overdoses	Fatal Opioid Overdoses	Fatal Rate per 100K Residents
Washington, DC			4798 Non-fatal	333 Fatal	49.7 Rate
Unknown	325	6%	238	87	
Ward 1	634	12%	611	23	28.9
Ward 2	462	9%	443	19	24.4
Ward 3	95	2%	90	5	6.3
Ward 4	304	6%	278	26	30.2
Ward 5	704	14%	670	34	37.9
Ward 6	674	13%	644	30	37.1
Ward 7	881	17%	831	50	55.6
Ward 8	1052	21%	993	59	67.8

Table: Fatal and Non-Fatal Opioid Overdoses by Location, March 2024 – February 2025

Despite the overall decline, opioid overdoses continue to disproportionately affect older Black men, particularly those living in Wards 5, 7, and 8. Between February 2024 and January 2025, Black men accounted for 71 percent of all fatal overdoses. Nearly 60 percent of those who died were aged 50 or older.

The Committee recognizes the efforts of the 85 community-based organizations implementing LLDC strategies and acknowledges the life-saving impact of naloxone distribution and harm reduction services. As of 2025, over 367,000 naloxone kits have been distributed across the District, contributing to the reversal of over 16,000 suspected overdoses by Fire and Emergency

[4] https://livelong.dc.gov/node/1551981
[5] DC Overdose Dashboard
[6] DC Overdose Dashboard

Medical Services (FEMS) and community partners. Naloxone is now available at 130 sites across the city, including schools, pharmacies, the DC Jail, and community-based vending machines.

While naloxone remains a critical tool, the Committee is concerned that most fatal overdoses occur at home, where individuals are often unable to self-administer the medication. The District must continue investing in upstream interventions that address the root causes of substance use disorder, promote care continuity, and prevent overdoses before they occur. **Nearly half** of those who died from a fatal overdose had received treatment in the year prior to their death. This included 46 percent who had accessed mental health services, 29 percent who received treatment for substance use, and 7 percent who had been prescribed medication for opioid use disorder.

In 2023, in response to the Council's call to declare the opioid crisis a public health emergency, the Mayor issued two emergency orders authorizing expedited procurement, expanded harm reduction services, and targeted outreach efforts. The extended order remained in effect through September 15, 2024, during which time DBH used expedited procurement authority to fund a range of opioid abatement initiatives. These included grants to faith-based organizations for naloxone distribution as well as expanded outreach and education on prevention, harm reduction, and treatment; funding to Children's National Hospital to treat youth with substance use disorders; and a contract with the D.C.-based firm Octane Public Relations for a media campaign to raise awareness of opioid use disorder, promote prevention, educate the public on the dangers of opioids, and encourage positive mental health.

The Committee applauds several key opioid response investments in the proposed FY 2026 budget, including $36 million for the State Opioid Response (SOR) program and LIVE.LONG.DC (LLDC) initiatives that support prevention, harm reduction, treatment, and recovery. The budget also includes $16 million allocated to the Opioid Abatement Fund. However, the Committee remains concerned that the District's opioid response relies entirely on federal and opioid litigation settlement funds, both of which are time-limited and increasingly uncertain due to changes in the federal funding landscape, including the scaling back of SAMHSA grant programs.

The District expects to receive nearly $50 million over 18 years from opioid settlement agreements. These funds are deposited into the Opioid Abatement Fund, which was established in 2022 and is administered by the Office of the Attorney General. The fund supports initiatives that address the opioid crisis. The use of these funds is governed by the *Opioid Litigation Proceeds Amendment Act of 2022*, which required DBH to create an Office of Opioid Abatement and to work with the Mayor and the Council to establish an Opioid Abatement Advisory Commission.

Recent investments from the Opioid Abatement Fund have expanded access to treatment, peer support, and recovery housing. Notable FY 2025 initiatives include the extending youth treatment hours at DBH's Ward 8 Howard Road SE location, and the construction of a 24-bed youth facility. DBH also awarded grants for evidence-based trainings, harm reduction tools, a youth peer training program, and a 24-hour Overdose Prevention Hotline. Additional funds supported the expansion of recovery housing and the Fire and Emergency Medical Services Department (FEMS) Overdose Response Team, including new clinical staff and outreach infrastructure.

The Committee commends DBH and the Commission for prioritizing housing and community-based care and supports continued collaboration to ensure opioid settlement funds are used strategically to close gaps and meet emerging needs.

For the third consecutive year, the Committee recommends the BSA subtitle, the *Substance Use and Behavioral Health Services Targeted Outreach Grant Act of 2025,* which directs DBH to continue targeted outreach efforts in six areas of the District in Wards 1, 5, 6, 7 and 8. These communities have high rates of substance use, overdose, and unmet behavioral health needs. The subtitle requires DBH to award grants by October 31, 2025, to qualified 501(c)(3) nonprofit organizations with experience in harm reduction and community-based behavioral health services. **The subtitle provides $800,000 from the Opioid Abatement Fund to support outreach services at four priority locations:**

1. The vicinity of the 600 block of T Street, NW;
2. The vicinity of the of the 1300-1700 blocks of North Capitol Street, NW, and the 1600-1700 blocks of Lincoln, Road, NE.;
3. The 3800–4000 blocks of Minnesota Avenue, NE; and
4. The 1300–1800 blocks of Marion Barry Avenue, SE.

The Committee is please to accept a transfer of $200,000 from the Committee on Transportation and the Environment to DBH for a fifth site in Ward 6. These funds will be used by DBH to award a grant to an organization that will provide targeted outreach and support services in the vicinity of the King Greenleaf Recreation Center, located at 201 N Street, SW.

For a third year, the Committee is also pleased to accept a transfer of $750,000 in recurring funds from the Committee on Public Works and Operations to DBH. 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.

The Committee remains fully engaged in the work of the Opioid Abatement Advisory Commission and is committed to ensuring that opioid settlement funds are allocated strategically, equitably, and in alignment with the District's most pressing needs. **The Committee recommends dedicating $2,107,000 in Opioid Abatement Funds through the Budget Support Act Subtitle, the *Opioid Abatement Directed Funding and Opioid Abatement Advisory Commission Structure Amendment Act of 2025***, as follows:

1. **$800,000** to fund 4 existing sites in the Substance Use and Behavioral Health Targeted Outreach Grant in the subtitle *Substance Use and Behavioral Health Services Targeted Outreach Grant Act of 2025* ($200,000 per site) to include sites in Wards 1, 5, 7, and 8. As 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 use and behavioral health services at opioid use hotspots. See locations above.

2. **$907,000** to DBH to 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 as identified in the Mental Health Court Urgent Care Clinic Amendment Act of 2024. The UCC provides a vital entry point to treatment for court-involved individuals, many of whom have unmet mental health and substance use needs. Through same-day assessments and immediate referrals to detox, inpatient, and outpatient care, the UCC helps connect individuals to substance use disorder treatment services and reduce further justice system involvement.

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 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.

Opioid Abatement Advisory Commission

The Opioid Abatement Advisory Commission ("Commission"), established under D.C. Code § 7-3212, is charged with ensuring that opioid settlement funds are invested in effective, equitable, and evidence-based strategies to address the District's opioid crisis. Guided by its mission and informed by lived experience, data, and community expertise, the Commission adopted 14 priority areas spanning prevention, harm reduction, treatment, and recovery. These recommendations, developed by the Commission's subcommittees, align with the District's *LIVE.LONG.DC.* strategy and reflect the most urgent needs identified at the community level. Member lists, meeting minutes, and public materials are available on the DBH website.[7]

The 21-member Commission includes District agency leaders, healthcare professionals, community representatives, and individuals with lived experience. It is tasked with promoting transparency and public engagement in the use of the Opioid Abatement Fund. The Commission provides strategic recommendations to the Mayor and the Council on funding decisions aimed at reducing opioid-related fatalities and addressing disparities in access to care. In addition, the Commission helps establish procedures for grant applications and awards, sets performance indicators, and oversees the management of the Fund.

To date, the Commission has overseen the allocation of $14,428,989 in opioid settlement funds to initiatives that directly reach the people and neighborhoods most affected by the crisis. These

[7] https://dbh.dc.gov/page/opioid-abatement-advisory-commission-01

investments include the expansion of harm reduction vending machines, the development of new peer-supported drop-in centers, enhanced youth treatment services, transitional housing with wraparound supports, and pilot programs for mobile methadone delivery and contingency management.

However, despite these accomplishments, the Committee has identified several operational challenges that must be addressed to improve the Commission:

- **Lack of strategic grantmaking:** While many of the funded projects align with the Commission's recommendations, DBH's selection process resembles a general grant solicitation. As a result, it is unclear whether the funded initiatives reflect the highest-priority interventions or those most likely to have population-level impact.
- **Underutilization of subcommittees:** Although the Commission is organized into subcommittees on harm reduction, treatment and recovery, and prevention, their role in vetting proposals, advancing policy solutions, and engaging stakeholders has not been fully realized. The Committee believes these groups must be used more strategically and consistently to strengthen oversight and planning.
- **Need for stronger leadership:** The Committee urges the Office of Opioid Abatement, which supports the Commission, to take a more active leadership role, in closer partnership with the Commission's co-chairs and subcommittees, to provide direction, expertise, improve transparency, and ensure that resources are being used in a targeted and effective manner.

The Committee recognizes the Commission's vital role in managing a once-in-a-generation opportunity to make transformative investments in the District's behavioral health and recovery infrastructure. **In the Budget Support Act subtitle, *Opioid Abatement Directed Funding and Opioid Abatement Advisory Commission Structure Amendment Act of 2025*, the Committee proposes changes to the structure, leadership, and operations of the Opioid Abatement Advisory Commission to enhance its efficiency, strengthen its governance, and improve its ability to respond to the District's opioid crisis response.** Please see the Budget Support Act chapter of this report for a detailed description of those changes.

Saint Elizabeths Hospital

DBH's proposed FY 2026 budget for Saint Elizabeths Hospital is $112,709,000, a $709,000 increase from FY 2025. This increase primarily reflects overtime costs in nursing services and personnel expenses influenced by Collective Bargaining Agreements that do not fully cover associated costs. The Committee is pleased to see a modest increase in the proposed FY 2026 budget; however, it remains concerned that local funding for Saint Elizabeths has declined by approximately $10.4 million since FY 2024. This downward trend in funding raises serious questions about the hospital's ability to meet the growing needs of a primarily forensic population with increasingly complex care needs. The Committee supports maintaining the proposed increase and urges DBH to prioritize improvements in patient care and outcomes. Policy recommendations related to staffing, security, and inventory management are outlined in the Policy Recommendations section below.

Mental Health and Rehabilitation Services (MHRS)

The FY 2026 proposed budget reflects an $11.3 million reduction in local funding for Mental Health and Rehabilitation Services (MHRS), bringing the total local allocation to $8.8 million. This reduction is primarily a technical adjustment rather than a substantive cut to services. It is largely due to the expiration of one-time funding included in the FY 2025 budget, in which $9.2 million in local match funds were temporarily shifted to MHRS and now must be reprogrammed in FY 2026. An additional $1.7 million of the reduction is attributed to a projected revenue offset within MHRS. The Committee has requested further information from DBH on how the agency plans to achieve this offset while maintaining current service levels.

Further, the Committee is concerned by DBH's decision to reduce Community Support authorizations from 200 to 100 units per 180 days—a sharp decline from the 600-unit cap in place just 18 months ago. DBH has indicated that this reduction is intended to shift provider focus toward delivering more clinical care and supporting individuals' progress toward recovery, noting that many providers bill significantly more for Community Support than for clinical services. While the Committee supports the goal of promoting recovery-oriented care and reducing overreliance on non-clinical services, it is important that such a shift be informed by meaningful provider input and grounded in data.

According to the DC Behavioral Health Association (DCBHA), only 36 percent of consumers currently use 100 units or fewer in a 180-day period. This means the majority of consumers would lose access to the level of support they have relied on to remain stable and make progress in their treatment. DCBHA asserts that DBH has not provided sufficient justification for such a steep reduction and the number of units is inadequate for consumers with serious mental illness who often require regular assistance with housing, benefits, and daily living tasks.[8]

DBH has pointed to other services such as Clinical Care Coordination and Intensive Care Coordination as alternatives. However, DCBHA emphasized that these services are more limited in scope, must be provided by licensed professionals, and are not viable substitutes for the broader support available through Community Support. Providers across the network have consistently warned that the 100-unit cap is not operationally feasible and would severely limit access to care.

The Committee urges DBH to reconsider the proposed reduction, restore funding to maintain the current 200-unit level, and reengage with stakeholders to develop a clinically appropriate and sustainable model.

School-Based Behavioral Health Program

The FY 2026 proposed budget for the School-Based Behavioral Health (SBBH) program is $25,438,000, representing a $3,330,000 decrease from FY 2025. During her testimony at the DBH budget oversight hearing on June 2, 2025, Dr. Bazron stated that the proposed reduction includes a $2.3 million cut to support services at 25 high-need schools, as well as contract savings resulting from bringing mental health training in-house.

[8] LeVota, Mark. "Quick Question." Received by Marcia Huff, 2 June 2025.

Proposed FY 2026 Budget for School-based Services

Funding Area	Amount
CBO Core RFA (151 currently matched schools)	$12,203,669
Pilot 1B RFA (43 LEAs)	$3,475,217
Telehealth RFA	$750,000
Supplemental Clinical Supports	$292,312
DBH-hired Clinicians	$5,598,874
DBH Management/technical assistance	$2,379,574
DCPS/OSSE liaisons	$297,278
Training and Materials	$66,076
Evaluation	$375,000
Total FY 2026 SBBH Program Funding	**$25,438,000**

The proposed funding includes grants to Community-Based Organizations (CBOs) at a rate of $80,819.67 per clinician.

Proposed FY 2026 Funding Per Clinician

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 2026 Proposed Per School Clinician Funding	**$80,819.67**

The SBBH Expansion Program was designed to ensure that all public and public charter schools in the District of Columbia have access to behavioral health supports. Mandated by the South Capitol Street Memorial Amendment Act of 2012, the program aimed for full implementation by the 2016–2017 school year. However, program fidelity and service consistency have varied significantly since its inception.

The SBBH program relies on community-based organizations (CBOs) to place licensed clinicians in schools, delivering a tiered public health model of behavioral health supports: Tier 1 (universal prevention), Tier 2 (targeted early interventions), and Tier 3 (clinical services). In FY 2025, the program served 169 schools with an overall budget of $18.8 million and an average grant of $80,820 per school.

Despite its importance, the program faces serious challenges:

1. **Underfunded Grants**: The current average grant amount is insufficient to cover clinician salaries, supervision, fringe, overhead, and workforce development costs. According to data collected by members of the Strengthening Families Through Behavioral Health Coalition, CBOs often operate at a financial loss, with an average annual deficit of $167,156 per organization. The original funding formula assumed that CBOs would be able to fill the rest of their funding gaps for clinicians via billing Medicaid. However, as

one public witness pointed out during the hearing, that while CBOs need to bill at least $33,000 to be viable, most are currently doing an average of $13,000.

2. **Rigid Supervision Set-Aside**: Current grant rules mandate that $16,667 be set aside per clinician for supervision, even when clinicians do not require it for licensure. These funds cannot be reallocated for other programmatic costs, leading to inefficiencies and undermining hiring flexibility.
3. **Billing Burdens and Low Reimbursement**: CBOs report recouping only 30% of billed Medicaid and private insurance claims. Most CBO clinicians are expected to bill 20 hours per week, yet many essential services (e.g., school-wide prevention efforts, crisis support, coordination) are not reimbursable.
4. **Clinician Workload and Burnout**: Clinicians often work over 40 hours per week to balance billable services and non-billable school responsibilities. The strain undermines morale, retention, and service quality.
5. **Vacancies and Delayed Hiring**: As of January 2025, 63 schools had a provider match but no hired clinician, and 48 schools had no provider at all.
6. **Uncompensated SBBH Coordinators**: Each school designates a coordinator to manage referrals and support systems alignment, but these roles are uncompensated and inconsistently resourced, undermining effectiveness.

For the past two years, the Committee and stakeholders have repeatedly urged DBH to evaluate and revise the financial model supporting the SBBH program. In its budget pre-hearing responses and during the FY 2025 budget oversight hearing, DBH acknowledged the need for structural changes and indicated plans to reimagine the SBBH framework. Proposed strategies included clustering schools to share clinicians, employing non-clinicians for Tier 1 and Tier 2 services, and enhancing school engagement. DBH also stated it was working with the Department of Healthcare Finance (DHCF) and the Insurance Commissioner to assess billing challenges and identify opportunities to strengthen reimbursement for Tier 3 services.

During the 2023–24 and 2024–25 school years, DBH launched two pilot initiatives intended to address clinician hiring and retention challenges. One pilot, Pilot 1B, directed funding to public charter schools to hire full-time clinicians. Although there were early signs of success in the first year, as of January 2025, six of the eight participating schools still had unfilled vacancies. The agency also explored hybrid telework models for clinicians in public and public charter schools, as well as in early childhood education settings. Despite these stated intentions and pilot efforts, DBH has not implemented any meaningful improvements to the SBBH program. Community-Based Organizations (CBOs) continue to report a lack of support, persistent financial strain, and insufficient responsiveness from the agency. The Committee finds this continued inaction unacceptable and believes it is time for a new approach and leadership to ensure the program's success.

As a result, the Committee explored removing the SBBH Program from DBH and transitioning it to DC Health, with implementation beginning July 1, 2026. This consideration stemmed from years of oversight findings, stakeholder feedback, and persistent implementation challenges that have underscored the need for stronger leadership, clearer accountability, and better alignment between the District's physical and behavioral health infrastructure.

In response to this proposal, DBH Director Dr. Barbara Bazron submitted a letter to Councilmember Henderson on June 19, 2025, stating that she believed the proposed transition was "premature and does not consider the improvements underway and other innovative ideas under consideration as DBH implements a new vision for the program." Dr. Bazron further requested that the Committee provide DBH with a planning period to develop and articulate its revised vision—grounded in lessons learned, data collection, and findings from the recently completed environmental scan of public and public charter school resources.

In the letter, Dr. Bazron outlined several components of DBH's improvement strategy, including engaging a national expert in school behavioral health with experience in the District; reexamining the funding model and clinician subsidy levels; using school-level data to drive clinician assignments; assessing the program's oversight structure; strengthening supervision and performance standards; improving billing compliance; integrating school-based behavioral health clinicians with school nurses; and soliciting feedback from CBO and DBH clinicians. DBH also committed to evaluating its pilot initiatives and reassessing the role of the Coordinating Council.

The Committee rejects the suggestion that our proposal was premature as we have been requesting strategic program changes for years in response to concerns raised from schools, students, CBOs, and families. In response, DBH provided little to no admission that the SBBH program was struggling to meet its goals and resorted to gaslighting at several public oversight hearings. Only now, a few days before the Committee is scheduled to vote on this proposal, has DBH come to the table with a commitment to produce what the Committee has been asking for—a plan to address the pain points that has hindered the success of the SBBH program and a commitment for action.

However, after much consideration and further conversation with clinicians who have worked on the SBBH Program since its inception, the Committee has agreed to provide the agency with this additional time, but will require DBH to submit a comprehensive school-based behavioral health improvement plan to the Council and the Mayor. The Committee will hold regular oversight hearings on DBH's progress and remain actively engaged throughout the process. If DBH fails to submit the improvement plan or does not begin timely implementation, the Committee will revisit the proposal to transition the SBBH Program to DC Health for the start of the 2026–2027 school year.

The Committee recommends Budget Support Act subtitle, the *School-Based Behavioral Health Program Strengthening Act of 2025*, which requires DBH in FY 2026 to award grants to CBOs in an amount no less than $120,000 per school. The subtitle also requires DBH to collect salary information for all CBO clinicians and supervisors funded through the program, including data from the previous two school years. The Committee intends for this reporting requirement to improve transparency and accountability, and strongly encourages CBOs to use the increased grant funding to significantly raise clinician salaries and address longstanding workforce retention challenges.

In its pre-hearing responses, DBH submitted the above breakdown of the SBBH Program budget for FY 2026, which includes a proposal to allocate $3,475,217 for the agency's 1B Pilot to expand the initiative from 8 LEAs to 43. However, the agency has acknowledged that the pilot has not been successful and that it is currently reevaluating all pilot models. The Committee finds the

proposed expansion unrealistic, particularly given that 6 of the 8 current 1B Pilot LEAs have unfilled clinician positions. The Committee urges DBH to refrain from expanding the pilot at this time, focus on filling existing vacancies, and redirect funding to increase CBO grant awards in order to strengthen service delivery in schools.

The subtitle also requires DBH to submit to the Council and the Mayor a comprehensive improvement plan by October 15, 2025, outlining the agency's strategy to strengthen and transform the program that includes:

1. **A strategic vision for the SBBH program**, outlining how DBH will strengthen and transform the program to meet the behavioral health needs of students using a public health framework.
2. **Findings from the recent environmental scan** and an explanation of how those findings will inform clinician assignments, resource allocation, and the use of risk-based models.
3. **An evaluation of DBH's pilot initiatives**, including lessons learned and how those findings will shape future program design.
4. **A review and proposed revision of the SBBH funding model**, including strategies to improve Medicaid billing, adjust clinician subsidy levels, address financial sustainability for community-based providers, and address barriers to billing.
5. **A workforce development and supervision strategy**, addressing recruitment and retention, supervision for graduate-level staff, licensure issues, and professional development for both DBH and CBO clinicians.
6. **A framework for integration between behavioral health clinicians and school nurses**, developed in consultation with the DC Health, to support coordinated care in school settings.
7. **A review and potential update of clinician performance metrics, curriculum standards, and quality assurance protocols**, with a focus on accountability and improved service delivery outcomes.
8. **An assessment of the feasibility of a shared or interoperable electronic health record (EHR) system** for DBH and CBO clinicians to improve care coordination and data tracking.
9. **A summary of clinician feedback**, including perspectives from DBH-employed and CBO-employed staff on program strengths, challenges, and opportunities for improvement.
10. **A proposal to revise the structure and function of the SBBH Coordinating Council**, including its membership, responsibilities, and role in supporting program accountability and transparency.
11. **A timeline and implementation plan**, including major milestones, responsible entities, and any necessary legislative or budgetary changes to support the transformation of the program.

The Committee will remain actively engaged and is optimistic that DBH will submit a plan that reflects the commitments outlined in Dr. Bazron's June 19 letter and begin the work of transforming the SBBH Program into one that truly meets the needs of students in both public and public charter schools. Using a public health approach, the program must ensure that prevention, early intervention, and treatment services are accessible to all students—offering upstream

supports that address the stress and trauma many students experience and equipping them with the tools and skills to thrive in school and beyond.

Court Urgent Care Clinic

For a second consecutive year, the Mayor's proposed FY 2026 budget eliminates funding for the Mental Health Court Urgent Care Clinic (UCC). Last year in the proposed FY 2025 budget, the Mayor first sought to eliminate funding for the UCC located within the Superior Court of the District of Columbia's Moultrie Courthouse, which is operated by Pathways to Housing under a contract with DBH. In response, the Committee worked in coordination with the Committee of the Whole to secure $1.2 million in one-time funding to allow the UCC to continue providing critical services in FY 2025.

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 UCC at DC Superior Court. According to data submitted to the Committee by UCC staff, the UCC is contractually required to minimally serve 600 unique referrals annually. In FY 2024, the UCC had 697 unique referrals, 821 assessments, and 4,157 follow up visits. In FY 2025, the Clinic is on pace for 845 unique referrals, 1,029 assessments, and 6,108 follow up visits. Demand has increased by 21% and the Clinic will exceed the contract requirements by 41% this year. 88% of UCC individuals reported that their involvement with the UCC had a positive impact on the outcomes of their court case. Sustaining the clinic's operation is crucial for ensuring equitable access to mental health services and preventing unnecessary crises.

In January 2025, Councilmember Henderson and Committee staff visited the UCC, meeting with a judge, court staff, and representatives from the UCC and its partner agencies, including staff from *Court Services and Offender Supervision Agency* (CSOSA) and Pretrial Services Agency (PSA). These stakeholders shared the positive impact the UCC has had on individuals involved in the court system and under supervision, and they emphasized the importance of the clinic's continued operation.

While DBH has previously stated that individuals in need of services provided by the UCC could instead go to the DBH urgent care center at 35 K Street NE or connect with a provider in the

community, maintaining the UCC's on-site presence at the courthouse remains essential. Having immediate access to behavioral health services and case management while individuals are physically present at court helps ensure they do not fall through the cracks. It also increases the likelihood that they will engage in mental health or substance use treatment and ultimately experience improved judicial outcomes.

At the FY 2026 DBH budget oversight hearing, Dr. Chad Tillbrook, DBH's Deputy Director of Forensic Services, reinforced the importance and impact of the UCC. In fact, DBH officials acknowledged that they visited the UCC and met with the Chief Judge to see if Superior Court could pay for the clinic themselves. Dr. Tillbrook acknowledged that while the clinic plays a critical role, the agency does not currently have funding to continue the contract.

Over the past year, the Committee has 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. "We have 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…The Urgent Care Clinic moves faster and is more effective at connecting people to treatment than PSA or CSOSA, reducing risk of recidivism. The Urgent Care Clinic is 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 the Clinic, court-involved individuals with mental illness are more likely to have an interruption in their access to care and face greater barriers in starting or resuming care."[9]

Further, the work of the UCC plays a critical role in the District's response to the opioid crisis. A significant number of court-involved individuals have underlying substance use disorders that contribute to their criminal justice involvement. The UCC provides same-day assessments for both substance use and mental health disorders and offers immediate connections to detoxification services, inpatient care, and outpatient treatment. For many individuals, contact with the court system serves as a pivotal moment that motivates them to seek help. Without the presence of the UCC at the courthouse, hundreds of District residents would likely continue to cycle through the legal system without receiving the substance use disorder treatment they need.

To maintain funding for the clinic in FY 2026, the Committee recommends directing funding from the Opioid Abatement Advisory Commission in the amount of $907,000, pursuant to the Budget Support Act subtitle *Opioid Abatement Directed Funding & Opioid Abatement Advisory Commission Structure Amendment Act of 2025*.

[9] Semyonova, Katerina. "Urgent Care Clinic at DC Superior Court-Funding Concerns." Received by Marcia Huff, 16 June 2025.

Emergency Mental Health Care

The "Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024," effective March 21, 2025 strengthens the District's mental health processes regarding involuntary hospitalization and voluntary commitment. This legislation will empower healthcare workers, residents, and the courts with comprehensive information, resources, and transparent processes and policies.

The filing of an Application for Emergency Hospitalization (also referred to as FD-12 petitions) by a physician, Metropolitan Police Department Officer, agent of DBH, or an individual authorized by DBH to file petitions initiates the process for involuntary hospitalization. According to the Office of the Attorney General for the District of Columbia, a total of 2,493 FD-12 petitions were filed in calendar year 2022, and 2,930 were filed in 2023. Involuntary hospitalization, also known as involuntary commitment or civil commitment, is a legal process authorizes the detention of individuals in a hospital or psychiatric facility for mental health evaluation and treatment without their consent. This process is usually initiated when an individual, due to a severe mental health condition, poses an immediate risk to themselves or others. Involuntary hospitalization serves as a crucial mechanism for emergency mental health intervention, facilitating the swift assessment and admission of individuals in immediate need of care.

b. Fiscal Year 2026 - 2031 Capital Budget Recommendations

The Mayor's proposed FY 2025 – FY 2030 did not include a DBH capital budget request. Previous allocations will carryover in the amounts of $8,500,000 for the second stabilization center and $19,7000,000 for facility projects at Saint Elizabeths Hospital.

3. COMMITTEE POLICY RECOMMENDATIONS

The challenges facing DBH extend far beyond budget issues. Over the past year, the Committee has heard not only through testimony but directly from individuals, providers, and stakeholders seeking help navigating serious problems with the agency. These ongoing concerns point to systemic failures in leadership, oversight, and service delivery. The following policy recommendations reflect the Committee's concern with DBH's continued lack of responsiveness. These are not small fixes—they are urgent reforms needed to restore accountability, improve care, and meet the behavioral health needs of District residents.

1. Address Operational Failures at St. Elizabeths Hospital.

St. Elizabeths Hospital, the District's only publicly operated mental health facility, is a vital part of the behavioral health care system. It provides treatment for individuals with serious and persistent mental illness, many of whom are involved in the criminal legal system and require specialized care. In recent years, the hospital's patient population has shifted significantly, with the vast majority of individuals now receiving care on a forensic basis.

Through public testimony and meetings with the Committee, DC Nurses Association (DCNA) and the AFSCME unit at St. Elizabeth's has voiced significant concerns from nurses and other

frontline professionals regarding staffing challenges, shortages of medical supplies, outdated equipment, and incidents of patient-on-staff assaults at the hospital. While DBH indicates that it is working to address these issues, many of the concerns remain unresolved, and further action is needed to ensure a safe and effective care environment.

Key challenges include:

- **Staffing**: There exist chronic vacancies among nurses, behavioral health technicians, and clinical personnel, particularly on high-acuity units. Staff have described frequent situations during emergency incidents, such as Code 13 responses, where there are not enough trained personnel on duty to respond safely. They also report high turnover and burnout, which they believe hinders the hospital's capacity to provide consistent, therapeutic engagement for patients.
- **Security Coverage**: According to staff accounts, there are not enough trained security officers on site to respond promptly and effectively to violence or disruption. This has become even more pronounced as the population at St. Elizabeth's has shifted to almost all forensic patients. Staff have reported that behavioral health technicians are often required to step into security roles, which increases their risk of injury and detracts from their clinical responsibilities.
- **Supply Shortages and Outdated Equipment**: Staff have shared concerns about routine shortages of essential items such as gloves, hygiene products, walkers, and wheelchairs. They have also cited reliance on outdated or malfunctioning medical equipment, including defibrillators and glucose monitors. According to these accounts, the hospital lacks a centralized inventory system to ensure timely tracking and restocking of critical supplies.
- **Lack of Stakeholder Engagement**: Staff and union representatives have indicated that they have made repeated efforts to raise concerns with DBH leadership, but report that their feedback has not led to meaningful change. They express frustration with what they perceive as a lack of responsiveness to frontline issues.

To address the persistent operational concerns at St. Elizabeths Hospital, the Committee urges DBH to make the following improvements:

1. **Increase Clinical and Security Staffing**: The Committee encourages DBH to establish and maintain appropriate staffing ratios for nurses, behavioral health technicians, and security personnel, using nationally recognized standards as a benchmark. DBH should employ recruitment and retention strategies to reduce vacancies, ensure sufficient coverage on all shifts, and minimize staff burnout.
2. **Implement a Centralized Inventory Management System**: The Committee recommends that DBH implement a hospital-wide inventory management system to track supplies and equipment in real time, improve stock availability, and reduce disruptions in care caused by shortages. The system should allow for proactive restocking and be regularly reviewed for effectiveness.
3. **Modernize and Maintain Medical Equipment**: The Committee recommends that DBH conduct a full audit of the hospital's medical equipment and prioritize the replacement or repair of outdated devices, such as automated external defibrillators (AEDs), glucose monitors, and

mobility aids. A regular maintenance schedule and an annual equipment update should be considered to ensure patients and staff have access to reliable and functional tools.

4. **Enhance Safety Protocols and Incident Response**: The Committee urges DBH to increase the number of trained security officers on high-risk units and enhance staff training in de-escalation techniques and trauma-informed care. DBH is encouraged to strengthen incident reporting and review procedures and to develop a formal process that includes input from frontline staff and supervisors.
5. **Establish a Formal Stakeholder Engagement Process**: The Committee recommends that DBH create an ongoing forum for engaging hospital staff, union representatives, and patient advocates to elevate concerns and collaboratively develop solutions. The Committee encourages DBH to publish biannual summaries outlining issues raised and steps taken in response.
6. **Develop and Submit a Corrective Action Plan**: The Committee urges DBH to develop a public corrective action plan that outlines how it intends to address operational deficiencies at St. Elizabeths. This plan should include clear timelines, assigned responsibilities, performance goals, and a process for quarterly progress updates to the Council.

The Committee emphasizes that meaningful and sustained improvements at St. Elizabeths are essential to ensuring the safety of patients and staff, restoring trust in the facility, and fulfilling the District's commitment to high-quality, person-centered behavioral health care. These recommendations reflect immediate priorities and long-needed changes that DBH must act upon in a timely and transparent manner.

2. Strengthen Oversight and Quality for Community Residential Facilities (CRFs).

Community Residential Facilities (CRFs) are a vital part of the District's behavioral health continuum of care. These facilities provide individuals with serious mental illness the opportunity to live in supportive, community-based settings rather than in hospitals or other institutional placements. CRFs are intended to promote recovery, stability, and independence by offering housing with embedded mental health services and staff support.

However, the Committee has heard concerns regarding ongoing gaps in oversight, program capacity, and discharge planning that may limit the effectiveness and sustainability of the CRF system. According to testimony from the District's Long-Term Care Ombudsman, Mark Miller, a number of CRFs have closed in recent years, putting additional pressure on the system and reducing available options for individuals in need of residential support. At the same time, there appears to be a lack of coordinated or strategic approach by DBH to preserve existing CRFs or encourage the development of new facilities.

The Committee is also concerned about variation in the quality of care across CRFs. While these settings are designed to support residents in achieving greater independence, DBH is not conducting sufficient oversight over the quality of care and outcomes for patients. In addition, when facilities close, residents report rushed and poor communication related to relocation, creating unnecessary disruptions to care and stability.

In light of these concerns, the Committee recommends that DBH take the following actions:

1. **Develop a CRF Capacity Strategy**: The Committee encourages DBH to take a more proactive approach to strengthening the CRF system, including efforts to recruit and support new and existing CRF operators. A forward-looking strategy would help ensure that the District has sufficient residential capacity to meet growing demand.
2. **Enhance Quality Assurance and Person-Centered Care**: The Committee recommends that DBH strengthen its quality assurance standards for CRFs, with an emphasis on ensuring that residents receive person-centered services and support in achieving their mental health and independence goals.
3. **Expand Oversight and Monitoring Infrastructure**: The Committee encourages DBH to expand its monitoring activities, including conducting regular site visits, gathering resident feedback, and establishing clear enforcement pathways for facilities that do not meet standards.
4. **Improve Transition and Discharge Planning**: The Committee recommends that DBH develop a more robust and resident-centered discharge planning protocol to guide transitions when a CRF closes or a resident moves to a new placement. Such protocols should ensure care continuity and meaningful resident involvement in decision-making.

CRFs are a critical element of the District's behavioral health system, offering a pathway to stability and community integration for many residents with serious mental illness. The Committee believes that by adopting these recommendations, DBH can strengthen the quality, capacity, and responsiveness of CRFs and better support residents in achieving long-term recovery.

3. Build a Continuum of Youth Behavioral Health Services.

The Committee continues to believe there are critical gaps in the District's youth behavioral health system. The system remains fragmented, often leading to repeated hospitalizations, delayed access to appropriate care, and increased trauma for youth and families. Over the past three years, including during the DBH FY 2024 performance oversight hearings, testimony has consistently highlighted that youth frequently cycle through inpatient units without timely transitions to community-based services, and that discharge planning is often poorly coordinated.

The Committee is particularly concerned about how these gaps in care can lead to broader system consequences, including police involvement in behavioral health crises, disruptions in foster care placements, and unnecessary reliance on inpatient or out-of-state residential treatment. A recent investigation by *The Washington Post* reports that youth in secure detention centers now wait over 60 days—up from 12 days in 2018—for placement in treatment programs.[10] Many adolescents currently remain detained at the Department of Rehabilitation Services (DYRS) Youth Services Center well beyond its intended use as a temporary holding facility, with care delays exacerbating trauma and contributing to rising incidents of violence inside the facility. Only 10 out-of-state facilities now accept DYRS referrals, down from 31 in 2013, and a proposed local Psychiatric Residential Treatment Facility (PRTF) has not been built.

[10] https://www.washingtonpost.com/investigations/interactive/2025/dc-dyrs-youth-crime-rehabilitation/?itid=sf_local-dc_article-list

Youth often cycle through acute hospital settings without timely access to follow-up or step-down care. The District lacks intermediate services such as Intensive Outpatient Programs (IOPs), Partial Hospitalization Programs (PHPs), and bridge clinics that could provide continuity and reduce reliance on inpatient treatment. These systemic problems and lack of inpatient step-down options force youth to remain in inappropriate settings, increasing the likelihood of crisis or justice involvement. The Committee held a hearing on this matter in [insert date] with DBH, DC Health, and the Deputy Mayor for Health and Human Services. While all parties agreed this was a priority issue, this budget does not make any significant investment to diversify the services offerings for pediatric behavioral health needs. Furthermore, no agency seems to be taking the lead on this issue.

In light of these concerns, the Committee recommends DBH take the following actions:

1. **Establish Intermediate Levels of Care**: The Committee encourages DBH to support the development of step-down programs such as Intensive Outpatient Programs (IOPs), Partial Hospitalization Programs (PHPs), and bridge clinics to fill the gap between inpatient and community-based services.
2. **Develop a Local Psychiatric Residential Treatment Facility (PRTF)**: To reduce reliance on out-of-state placements, the Committee recommends DBH explore establishing a local PRTF. A local facility would enable stronger family engagement, improve coordination with community providers, and support more effective transitions back to home and school.
3. **Assess and Strengthen Youth Crisis Response Capacity, Including ChAMPS and CRT**: The Committee urges DBH to conduct a thorough assessment of the current capacity and effectiveness of the District's youth crisis response infrastructure, including school-based behavioral health services, the Community Response Team (CRT), and the Child and Adolescent Mobile Psychiatric Services (ChAMPS). Specifically, the Committee encourages DBH to evaluate whether ChAMPS, in its current form, is the most appropriate and responsive model for addressing youth behavioral health crises and whether CRT has sufficient staffing and expertise to support children and adolescents effectively. Based on the findings, DBH should identify gaps in the system and determine whether ChAMPS should be restored to 24/7 operations, restructured, or replaced with a more suitable alternative.
4. **Strengthen Discharge Planning and Care Transitions**: DBH should consider adopting stronger discharge planning protocols that ensure a warm handoff from inpatient or residential settings to outpatient care. These protocols should include assigning a provider, ensuring medication continuity, and offering care coordination support.
5. **Implement Care Coordination Standards**: The Committee recommends that DBH align its care coordination efforts with the National Care Coordination Standards for Children and Youth with Special Health Care Needs, to guide transitions across programs and systems.

Youth and families in the District deserve a behavioral health system that is equipped to respond quickly in times of crisis and capable of supporting long-term recovery. The Committee believes that with strategic investment and coordination, DBH can strengthen the infrastructure needed to help children move from crisis to stability and wellness.

4. Strengthen the District's Behavioral Health Crisis Response System to Reduce Harm and Improve Access to Care.

The District of Columbia's behavioral health crisis response system remains critically under-resourced and over-reliant on law enforcement, failing to meet the needs of individuals in crisis, particularly Black and Brown residents and youth. In FY 2022, the Metropolitan Police Department (MPD) responded to over 36,000 behavioral health calls while DBH's CRT responded to fewer than 6,000. This imbalance continues to subject individuals in mental health crisis to unnecessary trauma, hospitalization, or criminalization.

The federal lawsuit *Bread for the City v. District of Columbia*, along with community-based testimony, highlights ongoing concerns about disparities in how the District responds to behavioral health emergencies. The lawsuit raises questions about whether current practices align with the Americans with Disabilities Act, particularly the frequent use of armed officers for mental health crises compared to medical personnel for physical health emergencies. These concerns point to a need for continued progress toward meeting the Substance Use and Mental Health Services Administration's (SAMHSA) standard of care: "someone to talk to, someone to respond, and a place to go."

In addition, the Committee remains concerned about persistent operational challenges within the District's behavioral health crisis response system. These include long wait times for calls to the 988 line and the DBH Access Helpline, under-resourced mobile crisis teams such as ChAMPS, and limited access to community-based stabilization options. As a result, residents are often left with few alternatives to calling 911 or seeking help in emergency departments. According to the Office of Unified Communications, in December 2024, 911 call takers experienced a 79 percent failure rate when attempting to transfer behavioral health-related calls to the Access Helpline, with only 7 of 36 calls successfully connected. The District's crisis response system remains largely reactive and continues to rely heavily on law enforcement rather than behavioral health professionals.

On February 28, 2025, Councilmember Henderson introduced PR26-0108, the *"Sense of the Council on Supporting Humane and Trauma-Informed Response to Behavioral Health Crises Resolution of 2025"*[11] that calls for a more coordinated and effective response to behavioral health crisis in the District.

In light of these concerns, the Committee recommends that DBH take the following actions:

1. **Improve 988 and Access Helpline Operations**: The Committee urges DBH to improve operations at the 988 line and the Access Helpline. Call centers should be staffed and managed to meet the national performance benchmark of answering at least 90 percent of calls within 15 to 20 seconds. In addition, warm handoff protocols should be implemented so that individuals diverted from 911 are directly connected to care providers without unnecessary delays or call transfers.
2. **Enhance Coordination with the Office of Unified Communications (OUC)**: The Committee recommends that DBH work closely with OUC to improve call triage and

[11] https://lims.dccouncil.gov/Legislation/PR26-0108

diversion processes. Additional training should be provided to call-takers and dispatchers to identify behavioral health calls and direct them to appropriate non-police responders. This coordination is critical to minimizing unnecessary MPD involvement in behavioral health crises.

3. **Invest in Non-Police Crisis Response Infrastructure**: The Committee urges DBH to build out a full continuum of non-police crisis response options. This includes investment in crisis stabilization beds, observation units, peer-led respite centers, and walk-in urgent care behavioral health clinics in all eight wards. A geographically distributed crisis infrastructure is key to ensuring equitable access and reducing avoidable hospitalizations and arrests.
4. **Ensure Culturally Competent and Trauma-Informed Crisis Services**: To better serve the District's diverse population, DBH should support the use of peer support specialists, multilingual providers, and ongoing provider training in trauma-informed and healing-centered engagement. These practices are essential to building trust and improving outcomes, particularly among communities historically underserved by the behavioral health system.
5. **Develop Individual Crisis Response Preference Plans**: The Committee encourages DBH to explore the creation of individualized crisis response preference plans, as recommended by the D.C. Police Reform Commission. These voluntary plans would allow individuals with behavioral health conditions to specify how they prefer to be treated during a behavioral health emergency, promoting person-centered care and reducing the likelihood of escalation.
6. **Collect and Publicly Report Crisis Response Data**: The Committee recommends that DBH collect and publish disaggregated data on behavioral health crisis responses. Data should include response times, the type of responder (police, CRT, ChAMPS), use of force, and the outcome of each call. Transparent reporting is necessary to evaluate system performance, identify disparities, and drive continuous improvement in behavioral health crisis care.

Without these investments, the District will continue to see preventable harm, unnecessary criminal justice involvement, and missed opportunities to connect residents to meaningful care. DBH must act decisively to transform crisis response into a system that centers care, dignity, and equity.

5. Address critical issues with the DBH housing voucher program.

Stable housing is essential to long-term recovery and well-being for individuals with behavioral health needs. However, many individuals face significant barriers when navigating the housing market and the voucher process. The Committee recommends DBH take the following actions:

1. **Develop a Training Program for Providers Supporting Individuals through the Housing Process**: Individuals receiving behavioral health services often struggle to identify available housing, complete voucher-related paperwork, and understand the rental market. These challenges are compounded by the complexity of the voucher process, which can lead to delays, stress, and missed opportunities for stable housing. The Committee encourages DBH to develop and implement a training program for behavioral health providers to better equip them to support individuals throughout the housing process. This training could include guidance on reading rental advertisements, identifying scams, understanding lease terms, completing forms accurately, and providing trauma-informed housing support. The program should be offered regularly, in virtual and in-person formats, with updated resources available online and optional refresher sessions.

2. **Increase Caseworker Engagement During the PSH Voucher Process**: The Permanent Supportive Housing (PSH) voucher process is often confusing and stressful for clients, particularly those experiencing mental health challenges. The Committee has heard from constituents who reported minimal contact with their caseworkers after voucher approval, leaving them uncertain about next steps. When caseworkers are not consistently engaged, critical documents can be delayed or misplaced, and the process may have to start over. The Committee recommends that DBH establish a standard requiring caseworkers to meet with individuals at least twice per week throughout the PSH process. More frequent engagement can help reduce confusion, provide emotional support, and improve the likelihood of successful and timely housing placement.

3. **Create a Secure Online Portal to Track PSH Documentation and Process**: Currently, PSH voucher documents are exchanged by email between clients, caseworkers, and property managers—a process that often results in lost or incomplete paperwork, unclear responsibilities, and significant delays. To address these challenges, the Committee recommends that DBH develop a secure, centralized online portal that allows clients, case managers, and property managers to upload, access, and track all documents related to the voucher process. The portal should display the status of each document, identify pending actions, and clarify who is responsible for each step.

On January 29, 2025, Councilmember Henderson introduced B26-0091, the *Behavioral Health Housing Voucher Transparency Amendment Act of 2025,*[12] which would require the creation of such a portal and establish a standardized checklist for applicants. This legislation is intended to improve transparency, reduce administrative burden, and provide individuals with greater clarity and peace of mind as they navigate the housing voucher process.

6. Restructure and strengthen the Opioid Abatement Advisory Commission.

The Committee has recommended a subtitle in the Fiscal Year 2026 Budget Support Act titled the *Opioid Abatement Directed Funding and Opioid Abatement Advisory Commission Structure Amendment Act of 2025* to strengthen the operations, structure, and impact of the Opioid Abatement Advisory Commission. The subtitle reflects the Committee's view that meaningful reform is needed to ensure the Commission functions in a strategic, coordinated, and transparent manner. In addition to the proposed legislative changes, the Committee offers the following policy recommendations for DBH and the Office of Opioid Abatement:

1. **Require Regular Meetings and Written Reports**
   Each subcommittee should meet at least six times per year on a regular schedule and be expected to submit written reports to the full Commission. The Committee has observed that the Commission's work has often lacked consistency and documentation. Predictable meetings and written outputs will ensure members are prepared, improve accountability, and allow recommendations to be tracked over time.

[12] https://lims.dccouncil.gov/Legislation/B26-0091

2. **Assign Subcommittees to Lead Research and Engagement**
   Each subcommittee should be charged with conducting research, reviewing District-specific data, identifying emerging best practices, and engaging with experts and peer jurisdictions. Subcommittees must play an active role in shaping the Commission's strategy, not just serve as discussion forums. Assigning these responsibilities will ensure a more evidence-informed and forward-looking approach to grantmaking and policy development.

3. **Explore Additional Subcommittees for Emerging Priorities**
   The Committee encourages the Commission to consider forming additional subcommittees to address emerging or specialized areas that may not fall squarely within the scope of the four standing subcommittees. Topics such as maternal health and opioid use disorder (OUD), recovery housing, and data and evaluation may warrant focused attention and dedicated expertise. Creating subcommittees in these areas could help the Commission stay responsive to evolving trends, strengthen its policy and funding recommendations, and ensure that settlement funds are aligned with both urgent and long-term community needs. The Committee recommends that the Commission explore this option through a majority vote when appropriate.

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 315,000 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 10 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 4 activities:
   - **Health Care Delivery Management Support Services** – provides administrative support functions to the Health Care Delivery Management division;
   - **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;
   - **Children's Health Services** – develops, implements, and monitors policies, benefits and practices for children's health care services, including HealthCheck/EPSDT, CHIP, and the Immigrant Children's Program; and
   - **Health Care Quality and Health Outcomes** – 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.

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 Research:** 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 contains the following 3 activities:
    - **Health Care Policy** – maintains the Medicaid State Plan, which governs the eligibility, scope of benefits, and reimbursement policies of the Medicaid and CHIP programs;
    - **Health Care Policy and Research Support Services** – provides administrative support to functions to the Health Care Policy and Planning Administration; and
    - **Eligibility Policy and Oversight** – serves as liaison to District and federal agencies regarding eligibility-related matters; ensures collaboration and coordination between the agencies and facilitates compliance by the Department of Human Services' Economic Security Administration with DHCF eligibility policy; interprets federal and state eligibility rules and regulation; establishes eligibility policies and criteria for the Medicaid and CHIP programs, as well as the Health Care Alliance and the Immigrant Children's Program and determines eligibility for long term care services and supports and special eligibility programs; interprets and helps draft legislative changes, rules and regulations for the District regarding eligibility requirements; and manages the Optional State Supplement Payment Program for eligible District of Columbia residents residing in an adult foster care home.

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 5 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 HHS Functional** – joint oversight development execution of DCAS.
    - **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 DCAS.

5. **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:
    - **Claims Management** – oversees MMIS operations; systems requests; member services;
    - **HCOA Support Services** – provides administrative support functions to the Health Care Operations divisions; and
    - **Public and Private Provider Services** – manages the Administrative Services Organization contract, provider enrollment and recruitment, and internal and external provider services and inquiries. The office also maintains positive ongoing coordination and continuity with all public provider agencies of the District of Columbia government to enhance each agency's understanding of Medicaid reimbursement policies; is the accountable office within DHCF for implementation of policy that directly impacts other District agencies that serve as Medicaid providers; identifies opportunities to improve the reimbursement procedures of each agency; and works closely with these agencies to review federal policy to ensure that federal reimbursement is being maximized and compliance assured through claims processing and through program development.

6. **Health Care Reform and Innovation**: 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 builds 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 3 activities:

- **Health Care Reform and Innovative Support Services** – is responsible for advancing the use of information technology among health care providers in the District. These activities include HCRIA's responsibility to design, develop, implement, and sustain Health Information Exchange (HIE) activities. HIE's infrastructure provides the technology, processes, and operations needed to facilitate exchange of health information between health stakeholders. HCRIA's Health Information Technology (HIT) program offers incentives, outreach, and technical assistance to drive the adoption and use of Certified Electronic Health Records Technology by District health care providers. The program aligns with CMS's Meaningful Use framework;
- **Grant Administration Function** – develops and executes strategies for payment and delivery system reform in the District, including developing, implementing, and monitoring practice transformation activities as well as developing demonstration projects and grants to support various value–based purchasing and practice transformation strategies; and
- **Health Information Exchange** – responsible for advancing the use of digital health among health care providers in the District. This Division serves as the state health IT coordinator and regulates health information exchange (HIE). It is also responsible for the design, development, implementation, and sustainability of DC HIE connectivity and infrastructure, which enables operations needed to facilitate exchange of health information across the District's health system. Lastly, this Division offers incentives, outreach and technical assistance to drive adoption and meaningful use of digital health tools by District health care providers.

7. **Program Oversight** – Provides reasonable and consistent oversight of the Medicaid program. This division contains the following activity:
    - Quality and Health Outcomes – ensures continuous improvements to the quality and performance.

8. **Provider Services** – Provides payment to providers in the following: the Medicaid program, the Children's Health Insurance Program (CHIP) and the Alliance program. This division contains the following 9 activities:
    - **1115/1915 - Medicaid** – waiver programs offered through 1915 and 1115 authority providing care for home and community based services (1915) or demonstration programs(1115) to expand care beyond the traditional Medicaid program;
    - **Fee for Services (FFS)** - Childless Adults (Group 8) – fee for Service provider payments for adults between the ages of 21 and 64 who do not have dependents;
    - **FFS - CHIP** – for Service provider payments for CHIP. This population is broken out due to a more favorable federal match percentage;
    - **FFS Medicaid** – fee for services provider payments for the general Medicaid population;
    - **MCO Childless Adults (Group 8)** – MCO payments for adults between the ages of 21 and 64 who do not have dependents;

- **MCO Chip** – MCO payments for CHIP. Provides coverage for children who are in families with income too high to qualify for Medicaid, but are too low to afford private overage;
- **MCO Medicaid** – MCO payments for the general Medicaid population;
- **MCO Waiver** – dual Eligible Special Needs Program (DSNP), Medicare Advantage; and
- **Other Programs** – serving those uninsured and otherwise not eligible for Medicaid.

9. **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.

10. **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 2026 Operating Budget Recommendations

MAYOR'S FISCAL YEAR 2023 – 2026 OPERATING BUDGET SUMMARY

Description	*FY 2023 Actual*	*FY 2024 Actual*	*FY 2025 Approved*	*FY2026 Proposed*	*% Change from FY 2025*
Operating Budget	$4,442,557,965	$4,401,503,659	$4,867,809,070	$5,415,996,038	11.3
FTEs	299.1	331.8	378.1	388.9	2.9
Capital Budget	$126,041,063	$147,131,622	$0	$0	N/A
FTEs	0.0	0.0	0.0	0.0	N/A

The Mayor's FY 2026 proposed budget for the Department of Health Care Finance (DHCF) is $5,415,996,038, an 11.3% increase from FY 2025 approved levels. This includes $1,051,730,000 in local funds - a 0.8% increase from FY 2025, and 388.9 FTEs - a 2.9% increase from FY 2025 approved levels.

Although the DHCF budget increases in FY 2026, this increase is modest compared to projected growth in spending without the significant policy changes proposed by the Executive. A key consideration in the budget development processes for DHCF was confronting the anticipated 15% growth in spending without District intervention in DHCF's local budget for the Medicaid and Alliance programs, juxtaposed against the District's declining four-year revenue estimates. Without the proposed changes, as cited in Deputy Mayor Turnage's FY 2026 budget testimony, the District would have had to allocate an additional $182 million to fund Medicaid and Alliance at their current levels of growth.

The District currently funds the highest Medicaid eligibility levels in the nation and a comprehensive set of benefits. See the chart below for a comparison of Medicaid eligibility between DC, Maryland and Virginia.

	Eligibility	
State	Parents (Household of 4)	Childless Adults (Household of 1)
DC in 2025	221% *$71,000*	215% *$32,000*
Maryland in 2025	138% *$44,367*	138% *$21,597*
Virginia in 2025	138% *$44,367*	138% *$21,597*

Because Medicaid is a federal entitlement program, DHCF has an obligation to maintain a minimum level of services for individuals below 138% of Federal Poverty Level (133% with a 5% income disregard), so the agency had to make decisions to ensure a minimum level of service for those enrollees while being responsive to a challenging economic environment.

There are three main ways to reduce costs for the Medicaid program: (1) limit eligibility, (2) reduce covered benefits and services, and (3) lower provider payment rates. Making changes to benefits or payment rates without adjusting eligibility could destabilize the program for all beneficiaries, so the proposed FY 2026 budget primarily focuses on adjusting eligibility. Specifically, it reduces Medicaid eligibility for childless adults and parents/caretakers from 221% of the Federal Poverty Level (FPL) to 135% FPL, impacting approximately 25,500 adults. These individuals will transition to the new Basic Health Program (BHP), which will be administered by the Health Benefit Exchange (HBX). This decision to create a BHP was driven by cost savings opportunities for the District. The BHP is less expensive for the District to administer because HBX will receive federal funding equal up to 95% of the amount of premium tax credits and cost sharing reductions that would have been available if this population enrolled in a qualifying health plan on the Exchange. In contrast, for most Medicaid services, the District pays 30% of costs and receives a 70% federal match.[13]

The Mayor, through consultation with DHCF and HBX, determined that transitioning this population to a BHP, rather than having them enroll in marketplace plans, would help maintain health care coverage retention and save the District money. Marketplace coverage would have been more expensive for individuals, likely causing many to forego insurance. Moving this group from Medicaid to the BHP is projected to save the District $42.8 million in FY 2026. More information about the BHP is available in the HBX chapter of this report.

[13] Councilmember Christina Henderson, "Committee on Health FMAP Explainer," 2/14/25. (Accessed 6/17/25). https://zacharyparkerward5.com/wp-content/uploads/2025/02/20250214-COH-FMAP-Explainer.pdf

The budget also proposes changes to the Alliance and Immigrant Children's Program, including reduced eligibility and benefits for adults in FY 2026, and a complete phase-out of adult eligibility by the end of FY 2027, detailed below.

The FY 2026 proposed budget also includes targeted increases, such as provider rate increases (described below) and additional revenue from dedicated tax funds, including the Healthy DC Fund and the Inpatient and Outpatient Directed Payment Funds. Additionally, recurring costs for the DC Access System (DCAS) software and equipment have been shifted to one-time funding. The budget also includes reductions within the Provider Services line, based on lower provider rates and expected declines in enrollment and service utilization.

Changes to the DC Healthcare Alliance and the Immigrant Children's Program

In the Fiscal Year 2026 Budget Support Act, the *DC Health Care Alliance Reform Amendment Act of 2025* proposes repealing the Immigrant Children's Program (ICP) and adding all ICP beneficiaries to the Alliance program. The Subtitle makes substantial changes to the Alliance program, detailed below.

DHCF administers the Immigrant Children's Program (ICP) and the DC Healthcare Alliance to provide vital health coverage to District residents who are ineligible for Medicaid due to immigration status. Alliance is a locally funded program designed to provide health care coverage to adult District residents who are not otherwise eligible for Medicaid or Medicare. The program is available to District adults with income at or below 210% FPL. Alliance provides health care services, including primary care, emergency services, hospital services, prescription drugs, behavioral health services, dental services, maternal services, non-emergency transportation, care coordination, and case management services. In FY 2025, Alliance served nearly 28,000 adults.

ICP serves children under the age of 21, offering comprehensive benefits including preventive care like immunizations and well-child visits, physician visits, dental and vision services, prescription drugs, and hospital-based care. The program is available to District children with household incomes at or below 200% of the FPL and who are not otherwise eligible for Medicaid or Children's Health Insurance Program (CHIP). In FY 2025, the ICP served nearly 5,000 children. All services for Alliance and ICP in FY 2025 are delivered through managed care plans to ensure coordinated, high-quality care at no cost to enrollees.

In his FY 2026 budget testimony, Deputy Mayor Turnage shared the growth trends in the Alliance program since 2011. In 2011, there were 28,282 adults and immigrant children in the Alliance and ICP program with an average per-enrollee cost of $1,803. The 2026 projected enrollment for these two programs is 37,024 adults and children, with an estimate per-enrollee cost of $6,671. These two programs experienced a 30% growth in enrollment while expenditures grew 384.3%. This growth can partially be explained by the fact that the average age of Alliance adults has increased, and as they aged their medical needs became more complex and expensive. Coupled with a negative city revenue growth projection in FY 2026, DHCF proposed savings initiatives which require significant changes to both Alliance and the Immigrant Children's program through the *DC Health Care Alliance Reform Amendment Act of 2025* in the Budget Support Act. These initiatives as proposed would save the District around $130 million in FY 2026. However, the

Committee has reservations around implementing these cost-saving initiatives as proposed without full consideration for the impacts it will have on these beneficiaries who have come to rely on health care in the district, and potential downstream effects.

First, the subtitle proposes limiting the services the Alliance program would provide to adult enrollees in FY 2026. For enrollees over the age of 21, services are limited to primary care services, inpatient and outpatient acute-care hospital services, emergency medical transportation services, and prescription drugs. For enrollees under the age of 21, services as written in the BSA are limited to primary care, dental care, and behavioral health services. However, DHCF has assured the Committee that children's services will remain essentially the same as those they received through ICP. This subtitle also establishes a limit on how many District residents may be served by the program. DHCF staff clarified with the Committee that this means as of August 1, 2025, the Alliance program is freezing enrollment for adults over 21 at either the current enrollment levels, or 28,000 people, whichever is lower.

The subtitle codifies the requirement that all Alliance enrollees meet non-financial eligibility factors that include (1) being a District resident and (2) providing a social security number if assigned and available. The subtitle creates a timeline for enrollees to meet financial eligibility factors as follows:

<u>Household Incomes for individuals aged 21+:</u>

- At or below 210% FPL if applying or enrolled before 9/30/25,
- At or below 133% FPL if enrolled between 10/1/25-9/30/26, and
- 19% if enrolled between 10/1/26-9/30/27.

<u>Household Incomes for individuals aged 19 or 20:</u>

- At or below 216% FPL.

<u>Household Incomes if aged 18 or below:</u>

- At or below 319% FPL.

The *DC Health Care Alliance Reform Amendment Act of 2025* also requires that beginning March 1, 2026, all applicants for Alliance will be required to complete a face-to-face interview to recertify eligibility every 6 months. Deputy Mayor Turnage explained DHCF's concerns that there are a number of Alliance beneficiaries who do not live in the District anymore and are still utilizing services. This change is meant to curb non-residents' use of this benefit, with the assumption that if people moved out of the District, they would be less likely to maintain the 6-month in-person certification process. The Committee requested claims data from DHCF for FY 2024 Performance Oversight, which showed that approximately 2% of Alliance beneficiaries (543 enrollees) have not had any clinical claims in the past 3 years, and 15% (3,922 enrollees) have no claims in history.[14] Although it may seem like having no claims history would save money, the Alliance program was designed to be served by managed care organizations, where the District pays a monthly fee per member regardless if they ever seek care. The shift of Alliance to a fee-for-service

[14] The 15% number is less reliable, because it does not consider the fact that the beneficiary could have recently enrolled and not yet been to a doctor, pharmacy, etc.

program will address this potential over-spend; therefore, the Committee questions whether this change on recertification is necessary. The Committee believes that this policy change will unnecessarily harm Alliance beneficiaries who are District residents and could lead to an outsized number of people falsely losing their health insurance due to factors outside of their control. In the past, there were long wait times at service centers, which lead to some people lining up before dawn with no guarantees they could get an appointment to be seen.

The subtitle also proposes new requirements to prove residency for the Alliance Program. Previously, providing just a DC One card was sufficient. However, the District is moving away from using the DC One card as a form of identification because once issued the card was valid for 5 years. Moving forward, applicants must provide two forms of identification from a list (with exceptions for exceptional circumstances including homelessness, domestic violence, instances where a noncustodial parent refuses to release documentation germane to verification and other case-by-case examples), including:

- Voter registration cards with an address in the District of Columbia;
- Cancelled checks or receipts for mortgage payments for a property within the District of Columbia within the past two months;
- Non-expired automobile insurance policy with District of Columbia residency address;
- A D.C. One Card;
- An unexpired homeowner's or renter's insurance policy for real property located in the District of Columbia; and
- A completed form designated by the Department to verify residency.

Finally, the subtitle proposes that beginning in FY 2028, individuals over the age of 21 will be phased out of coverage through the Alliance program (October 1, 2027). Those under age 21 who enroll in coverage will be terminated from coverage upon turning 21.

See the chart below for a timeline including proposed dates and associated program changes:

Date	Change
August 1, 2025	Enrollment freeze on new Alliance enrollment for adults 21 and over either at current enrollment or 28,000 individuals, whichever is lower.
October 1, 2025	DHCF will shift payments from Managed Care per member per month payments to Fee for Service reimbursement.
October 1, 2025	Reduce income eligibility for age 21+ from 210% FPL down to 133% FPL.
October 1, 2025	Limit benefits in Alliance program for individuals over 21 to: primary care services, inpatient and outpatient acute-care hospitals services, emergency medical transportation services, and prescription drugs. Enrollees under 21 will have access to those services + behavioral health and dental.
October 1, 2025	DHCF will shift children from Immigrant Children's Program coverage to Alliance coverage.
March 1, 2026	DHCF will begin face-to-face interviews to certify eligibility for all enrollees every 6 months
October 1, 2026	Reduce income eligibility for age 21+ from 133% FPL down to 19% FPL.
October 1, 2027	Adults will no longer be covered by Alliance, only children up to age 21.

Although the Committee understands the spending pressures faced by the agency, it has serious concerns about the proposed changes to Alliance. Since its inception in 2001, the District has committed to providing health coverage for residents and their families, regardless of immigration status. Reducing benefits and ending adult coverage after FY 2027 could leave many without access to regular health care. This population, often in low-wage, gig-based jobs, may be forced to forgo primary and preventive care and rely solely on urgent care and emergency departments for health care, which may strain the whole healthcare system. While DHCF has indicated that children's coverage will remain largely unchanged, the Committee is concerned about the chilling effect these policy proposals will have on both adults and children on their ability and willingness to seek coverage and health care.

The Committee worked with the Office of the Chief Financial Officer and DHCF to parse out the savings from the various policy decisions made in the Alliance subtitle. Specifically, the Committee wanted to understand the savings that could potentially be reversed by the Council to minimize harm, since it is unlikely the Council will be able to restore the entire $130 million cut to Alliance.

The Committee is pleased to note that several of the Committee's proposed changes have no costs attached to them. Notably:

- Remove requirement for face-to-face recertifications for adults;
- Allow public school enrollment to count as proof of residency;

The Committee is also pleased to be able to fund the following changes:

- Increase the moratorium age for new Alliance beneficiaries from 21 to 26 in FY 2026;
- Not require in-person recertifications for youth under 19 over the financial plan;
- Not require recertification every 6 months for youth over the financial plan;
- Cover durable medical equipment (DME) for all adults through FY 2027;
- Cover DME for youth under over the financial plan.

Alliance subtitle costs	**FY 2026**	**FY 2027**	**FY 2028**	**FY 2029**	**Total**
Increase moratorium age for new Alliance beneficiaries from 21 to 26	$1,801,051	$4,437,712	$8,724,471	$8,907,685	$23,870,920
Not require in-person certification for adults	$0	$0	$0	$0	$0
No in-person recertification for youth under 19 (no face-to-face)	$197,678	$776,966	$1,019,335	$1,130,969	$3,124,949
Not require recertification every 6 months for youth under 19	$0	$760,435	$997,647	$1,106,906	$2,864,988
Include DME for all adults	$1,379,202	$1,270,151	$0	$0	$2,649,353
Include DME for youth *(Includes assumption for no face-to-face recert and no 6-month recert)*	$345,287	$395,117	$441,709	$490,083	$1,672,196
Allow for public school enrollment to count as proof of residency	$0	$0	$0	$0	$0
Total:	$3,723,218	$7,640,381	$11,183,162	$11,635,643	$34,182,406

The Committee could not identify funds to push back the August 1, 2025 moratorium for new Alliance enrollees and is looking to the Committee on the Whole to identify additional funding to push that deadline to FY 2026 or later.

Inpatient and Outpatient Hospital Directed Payments

In FY 2025, DHCF proposed 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. DHCF officially submitted the preprint in June 2025 for the FY 2025 preprint.

Once approved by CMS, the District will tax each qualified hospital on their inpatient net revenue at a universal rate (the ACR). The Committee expects retroactive payments dating back to October 1, 2024. The tax generates 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.

DHCF will be submitting their FY 2026 preprint, which the agency estimates will lead to an additional $2,734,587 to the District retention in FY 2026.

Increasing and Standardizing Provider Reimbursement Rates

The FY 2026 proposed budget makes a variety of changes to provider reimbursement rates including funding a $6.5 million one-time enhancement for Direct Support Professionals (detailed in the section below) and a $7.9 million enhancement for a dental rate increase. The Committee was pleased to see this enhancement for dental rates since the Fee for Service (FFS) rates had not been increased since 2007, as dental providers testified in the FY 2024 performance oversight hearing and the FY 2025 DHCF budget oversight hearing. This led to a number of dental providers in the District exiting the Medicaid program altogether. In his testimony, Deputy Mayor Turnage cited that goal of this dental increase was to better align dental rates with those paid in Maryland and Virginia. This increase applied to over 125 dental codes and will result in rates higher than those in Maryland and Virginia. DHCF also funded a requirement that the MCOs pay at minimum the FFS rate to dental providers, which addresses a payment parity issue dental providers have been raising to the Committee over the last year.

Another change in provider reimbursement rates is delaying the Federally Qualified Health Center (FQHC) rebasing until 2027. Rate rebasing is the process of adjusting reimbursement rates to account for changes in cost, utilization, and inflation. DHCF rebases different providers on different schedules. Providers that are reimbursed based on their reported costs, like FQHCs, have their costs audited and adjusted every 4 to 5 years based on actual cost of services. The Medicaid

state plan does allow for some provider rates to be adjusted off-schedule in the case of industry-wide cost changes. A delay in rate rebasing for FQHCs means that (1) the current rates do not match the current costs, and (2) that facilities will not be able to provide extended hours, because DHCF built in an increase to the FQHC rates that would have allowed them to pay staff additional wages for working extended hours.

The Committee does not have sufficient funding this fiscal year to move forward with the rebasing as planned for the upcoming year but recommends DHCF prioritize this rate rebasement for FY 2027. This increase in funding will continue to be essential for health centers who will bear additional responsibility in the coming years to support patients affected by health insurance changes including both Alliance and Basic Health Program.

Addressing Long Term Care Workforce Challenges

The Committee is pleased that the FY 2026 proposed budget continues to fund the Direct Support Professional Payment Rate Act of 2020. However, the Committee is concerned that the rate increase freezes at the end FY 2026 while the District is in a health care workforce crisis and because Council funded this law with recurring funds.

The Direct Support Professional Payment Rate Act of 2020 provides an annual additional payment to eligible providers of direct services to individuals with intellectual and developmental disabilities, for the purpose of ensuring direct support professionals (DSPs) earn an appropriate wage. The bill increased payments to DSPs to, on average, the greater of either 117.6% of the District minimum wage or the living wage. Over the past several years, disability service providers have faced challenges in maintaining their DSP workforce. This bill increases the average wage for DSPs, which was meant to help with recruitment and retention of the DSP workforce. In 2025, this amounted to approximately $20.58/hour, and the FY 2026 proposed budget would increase the enhanced hourly wage to $21.11 in July 2025 for the remainder of FY 2026.

Following the passage of the Direct Support Professional Payment Rate Act of 2020, the Committee continued conversations with stakeholders including District agencies and advocates around how best to support the health care workforce, to ensure both sufficient quantity and quality of the workforce. In 2024, the Committee passed D.C. Law 25-232, the Certified Nurse Aide Amendment Act of 2024, which, among other provisions, amended the Direct Support Professional Payment Rate Act of 2020 to increase the minimum wage and tiered payment scale for direct support workers to, on average, 120% of the District living or minimum wage, whichever is higher.

Raising the minimum wage to 120% through this bill was estimated to cost DHCF $8.7 million local in FY26 and $26.7 million local over the financial plan to implement. The FY 2026 Budget Support Act freezes any further wage increases in FY 2026 and removes the enhanced wages for DSPs in FY 2027. The subtitle to freeze the DSP wage increases past FY 2026 generates savings of $3.9 million in FY 2026 and $270.2 million over the financial plan. **The Committee on Health does not have sufficient funds to fund the Direct Support Professional Payment Rate Act of 2020 past FY 2026, or fund the Certified Nurse Aide Amendment Act of 2024, but urges**

DHCF and other relevant labor-related agencies like DOES to consider non-financial incentives to support this critical workforce and prevent further workforce shortages.

The Committee on Health is committed to building and strengthening the District's direct care workforce to meet the growing needs of its aging population. According to PHI, the District's direct care workforce is project to grow by 17% by 2032, enough to only meet about 10% of job openings in that same timeframe. Currently, the District has fewer than 10,000 certified CNAs and HHAs but will need around 25,000 by 2032. To address this gap, the District must expand and improve hiring pathways, ensuring residents, especially youth, are aware of those opportunities and feel empowered to take advantage of them. Early exposure to healthcare careers is essential to cultivating interest in clinical professions.[15] **To support this effort, the Committee is transferring $150,000 to the Committee of the Whole to support OSSE's summer CNA training program. This funding will enable more than 25 additional students to participate in the Advanced Technical Centers Career Readiness Internship, complete the CNA training program over the summer and earn their certification.**

Supporting Maternal Health through Home Visiting

During the FY 2025 budget oversight hearings, the Committee discussed with DHCF the need for the agency to consult with home visiting providers to establish criteria and processes for billing and reimbursement for home visiting, with the goal to begin reimbursing eligible evidence-based home visiting programs on January 1, 2025. However, DHCF did not submit the relevant state plan amendment to CMS to add home visiting as a Medicaid-reimbursable service. The Committee is disappointed in this inaction and emphasizes the need for continued support for home visiting in the District. These programs significantly improve health outcomes by providing critical Early Intervention supports like education and coaching for expecting parents and families with young children. Research shows a return of up to $5 for every $1 invested in home visiting.[16]

Although home visiting is not currently a reimbursable Medicaid service, the FY 2026 DHCF budget included a $325,000 grant to support home visiting for first time parents, a $100,000 increase from FY 2025. This grant is typically awarded to Mary's Center Nurse-Family Partnership (NFP) program. At the FY 2026 budget hearings, Mary's Center staff reported that they expanded their home visiting program through a program called NFPx, which operates in Wards 7 and 8. However, their FY 2025 grant was reduced by 50% in the FY 2025 supplemental and to reach full capacity and serve 100 families, they require $300,000 additional funding.

Home visiting is also an optional policy pillars in the Transforming Maternal Health (TMaH) model, in which DHCF is participating. The TMaH model which is federally funded through the Centers for Medicare and Medicaid Innovation, aims to integrate community-based supports, improve care coordination, and reduce disparities in maternal health outcomes. DHCF has an

[15] Muncan, B, et. Al, "From high school to hospital how early exposure to healthcare affects adolescent career ideas," Nov. 6, 2016. National Center for Biotechnology Information (accessed 6/12/25).
[16] Society for Research in Child Development, "Increasing Support for Home Visiting Innovation is Critical for Young Children and Their Families," July 22, 2022. (Accessed 6/19/25). https://www.srcd.org/research/increasing-support-home-visiting-innovation-critical-young-children-and-their-families

opportunity to strengthen and align existing home visiting work as they expand their reach through TMaH.

The Committee on Health is pleased to accept a $300,000 transfer in recurring funds from the Public Works and Operations Committee to expand the important home visiting work Mary's Center does in supporting first time parents.

Establishing the Office of the Health Care and Public Benefits Ombudsman

The Office of the Health Care Ombudsman ("the Ombudsman") was officially established in 2009, operating with full autonomy and independence to help District residents access and understand their health care plans and options, educate them about their rights and responsibilities as health care plan members, and help them resolve problems with their bills and coverage.[17] Specifically, the Ombudsman and her staff of 23 people are tasked to help resolve complaints on behalf of consumers and assist them with the filing, pursuit, and resolution of formal and informal complaints and appeals.

In 2023, they served 15,849 residents across all eight wards - a 36% increase from 2019.[18] For those residents covered by government-provided healthcare plans, 50% of the concerns filed with the Ombudsman related to eligibility, and another 30% related to access/coverage.[19] Importantly, over 80% of these cases filed are resolved on the same day with 99% found in favor of the consumer.

The Ombudsman's decades of experience and track record of effectively helping thousands of District residents get connected with and access their health benefits makes them uniquely equipped to address the challenges residents experience accessing public benefits at the Department of Human Services (DHS) Economic Security Administration (ESA).

ESA is responsible for administering many of the District's public benefits, including the Supplemental Nutritional Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). They are also responsible for making benefit determinations and processing applications and recertifications for programs administered by other District agencies, such as the DC Health Care Alliance Program, Medicare and Medicaid, and the DC Child Care Subsidy Program, among others. To do so, ESA relies primarily on the District Access System (DCAS), which is owned, managed, and largely funded by DHCF, and which functions as the District's central processing system for most income-based public benefits.

Both ESA and DCAS have faced significant difficulties in recent years. In 2024, the US Department of Agriculture Food and Nutrition Service (FNS), who manage federal funding and oversight of SNAP, fined the District $4.4 million for Payment Error Rates - the number of over

[17] DC Law 15-331, "DC Official Code § 7–2071.01 *et seq.". (*Accessed 6/21/25). https://code.dccouncil.gov/us/dc/council/laws/15-331#:~:text=Law%2015%2D331%2C%20the%20%E2%80%9C,the%20Committee%20on%20Human%20Services
[18] *District of Columbia Health Care Ombudsman Annual Report: Fiscal Year (FY)* 2023, 20, DCCOUNCIL.GOV (Dec. 6, 2024), https://lims.dccouncil.gov/Legislation/RC25-0280.
[19] *Id.* at 23.

and under payments made - at or exceeding 20% in 2022 and 2023.[20] The District also underperformed in the number of SNAP applications processed within the Federally required 30 days, at 43%.[21]

These trends are not the sole the fault of ESA when the system they rely upon has had significant operational challenges. The District has invested over $700 million in DCAS since its inception in 2012 and nearly $77 million in FY 2025 alone. However, DHS staff and the public report frequent flaws and errors that result in the delay or denial of critical benefits that District's most vulnerable residents depend on to get health care, childcare, and food-related benefits. This Committee has held two joint roundtables with the former committee of jurisdiction over DHS over the past two years to discuss the challenges facing DCAS and public benefits enrollments more generally. It should be noted that when this was discussed at the most recent budget hearing for the Department of Healthcare Finance, the agency that manages DCAS, their staff reported that the issues with regard to SNAP are "human errors" and not errors with the system.

While the Committee is heartened by the progress that has been made within the last year, including bringing their SNAP timeliness rate up to almost 85 percent in FY25,[22] problems remain with the District's health and human benefits enrollment process. These challenges will only be exacerbated as the Mayor's proposed FY26 budget includes significant changes to eligibility for certain healthcare and public benefits programs including Alliance, Medicaid, and the local TANF program. Clearly, being effective stewards of the District's scarce public resources is the best way of ensuring that the most residents receive their benefits in a timely manner. That is why the Committee, in close collaboration with the Committee on Human Services, public benefit advocates, and legal service providers, developed this proposal to expand the mission of the Ombudsman to include all ESA-administered public benefits.

The newly renamed Health Care and Public Benefits Ombudsman will continue with all the work and processes that have made it so successful to date, with two additional staff members dedicated to resolving issues that residents face regarding their ESA-administered public benefits. Technically, the Ombudsman has already been doing this work. In 2024, they had filed six administrative hearing requests on behalf of beneficiaries regarding SNAP benefits,[23] and by April 3, 2025 they had assisted at least 17 residents in resolving SNAP-related issues.[24]

The number of Fair Hearing requests filed at the Office of Administrative Hearings is a good indicator of the limited scope but deep impact and District-wide cost savings and efficiencies that the new Health Care and Public Benefits Ombudsman may realize. Of the 2,773 hearing requests filed by residents against DHS, 28% of them are resolved before the hearing – and 56% of those that do get to a hearing are resolved in favor of the resident - frequently because DHS recognized

[20] *SNAP Payment Error Rates*, USDA.GOV. 2024, (Accessed 6/21/25). https://www.fns.usda.gov/snap/qc/per.
[21] *FY24 DC AWL Response May 2024*, *in* Performance Oversight Responses (shared with the Committee and available upon request).
[22] FY24 Performance Oversight Follow-up Responses of the Department of Human Services at #42 ("ESA Performance Oversight Follow-up Responses").
[23] FY24 Performance Oversight Responses of the Department of Health Care Finance at #17.
[24] The Ombudsman staff shared this data with staff of the Committee on Health and the Committee on Human Services on April 3, 2025.

a human or DCAS error in the processing of an application that led to an erroneous outcome that was only resolved because it was elevated to a hearing.[25]

Both the Committee on Health and the Committee on Human Services hear frequently from residents and their advocates who complain of erroneous public benefit application and recertification denials and delays, inaccurate language on or delayed delivery of benefit notices, and continued difficulties using District Direct. Both Committees also frequently hear, both anonymously and during public hearings, from staff that describe a benefits determination system that frequently fails to account for human inputs and delivers incorrect outputs, with little remediation. These experiences are incredibly frustrating for all and can be financially devastating for some.

The Committee provides $619,100 for an additional 2 FTEs to the newly expanded Health Care and Public Benefits Ombudsman to fully fund the BSA subtitle *Health Care and Public Benefits Ombudsman Program Amendment Act of 2025*. Especially in a time with abundant changes to both public benefits and health care, this expanded Office can support residents in understanding these changes.

b. Fiscal Year 2026 - 2031 Capital Budget Recommendations

The Mayor's proposed FY 2026 budget does not include new capital budget projects for DHCF.

3. COMMITTEE POLICY RECOMMENDATIONS

The Committee recommends the agency adopt the following policy changes:

1. *Coordination and Planning Regarding Potential Federal Funding Cuts*

   The Committee acknowledges that there are parallel policy conversations occurring. The Council is working expeditiously to pass the District's FY 2026 budget, while Congress is having discussions on their own budget reconciliation. Many of the policies being discussed on the Hill will have direct effects on the District's public and private health insurance programs. For example, implementing "community engagement requirements," also known as work requirements, would likely require investment from the District to implement, though at the FY 2026 Budget Oversight hearing, DHCF staff confirmed that the DC Access System (DCAS) has the capacity to accept these types of uploaded forms. However, work requirements are a known policy intended to keep people from accessing health insurance; in February the Center for Budget and Policy Priorities estimated that 159,000 adults in the District could be at risk of losing Medicaid under this new work requirements policy, though this estimate did not consider the Medicaid population shifting to the BHP.[26]

[25] FY24 Performance Oversight Follow-up Responses of the Department of Human Services at #42.
[26] CBPP, "Medicaid work Requirements Could Put 36 Million People at Risk of Losing Health Coverage" Feb. 5, 2025. (Accessed 6/18/25). https://www.cbpp.org/research/health/medicaid-work-requirements-could-put-36-million-people-at-risk-of-losing-health#:~:text=Many%20people%20with%20chronic%20illnesses,request%20and%20renew%20their%20exemptions.

Another policy debate happening at the federal level is introducing cost-sharing requirements for certain services for Medicaid beneficiaries. This is not something DHCF currently does and would require additional work on the District's part to be able to implement and could affect implementation of the BHP as well. The Committee encourages DHCF to continue tracking the potential federal implications and keep an open dialogue with the Council and Mayor about what changes could be coming.

2. *Prioritize Increases to Provider Reimbursement Rates for Clinical Areas with Low Reimbursement Rates*

The Committee recommends DHCF continue to monitor and assess provider payment rates moving forward, particularly for clinical areas where chronic low reimbursement rates prove to be a challenge for providers to stay in business and keep clinicians employed, like for Home Health Agencies and pharmacies. Specifically for pharmacies, the Committee also recommends that DHCF align FFS and MCO reimbursement rates, particularly for independent pharmacies, and especially for those in Wards 7 and 8 who are not being reimbursed at-cost for pharmaceutical drugs and are struggling to stay in business.

3. *Centralize the Provider Credentialing Process*

The Committee recommends DHCF ease provider administrative burdens by centralizing provider credentialing through DHCF, instead of the current approach where DHCF contracts with each MCO to facilitate their own credentialing process. The current process is long, inefficient, and adds additional hurdles for providers who wish to participate in the Medicaid program, which is already a limited group. Several states, including Maryland, have already implemented this centralized process.[27] The new centralized credentialing system should ensure:

1) Written notice to providers within 10 days of submission of incomplete applications and steps to remediation;
2) Notice within 30 days of submission presumptive intent to credential, allowing provisional billing to begin; and
3) Transferal of credentialing status if a provider change employer.

4. *Ensure Medicaid Beneficiaries Who Transfer to the BHP Have No Gaps in Coverage*

DHCF is transitioning 25,500 beneficiaries off Medicaid by no later than January 1, 2026. to the Basic Health Plan. The Committee urges DHCF to continue public dialogue and outreach both with stakeholders including the healthcare associations and beneficiaries to ensure a smooth transition. DHCF should publicize their Medicaid renewal schedule and alert beneficiaries with ample time to correct any mistakes. One area of concern that has been raised to the Committee is how beneficiaries whose redeterminations fall in November and December will qualify for BHP in January 2026. The Committee will be conducting close oversight over this transition process to ensure beneficiaries do not lose coverage.

[27] MSDC, "MSDC Joins Health Associations Asking for Centralized Medicaid Credentialing," Nov. 19, 2024. (Accessed 6/12/25).

5. *Ensure District Residents Don't Lose Access to Critical Behavioral Health Services*

   Through the BHP: The Committee is concerned about the immediate loss of access to behavioral health care, substance use treatment, and facility-based services such as residential treatment, nursing homes, and case management for adults who will transition to the BHP. These benefits are Medicaid-specific and likely will not be covered through the BHP. The Committee urges DHCF to ensure that individuals currently receiving intensive behavioral health treatment that will not be covered by the BHP or residing in care facilities are not displaced and continue to receive necessary case management services.

   Through Alliance: The Alliance program does not currently cover behavioral health services – Alliance beneficiaries who require mental and behavioral health services currently receive services through the Department of Behavioral Health (DBH). The Committee will continue to be in discussions with DHCF and DBH to ensure Alliance adults are able to maintain services until the program sunsets for adults in FY 2027 and encourages the District to create a transition plan so beneficiaries do not abruptly lose access to behavioral health services.

6. *Shift Payment Structures to Value-Based Care Arrangements*

   The District has made critical strides toward transforming its health care delivery system by shifting from traditional fee-for-service models towards value-based payment (VBP) arrangements. These models prioritize outcomes, equity, and efficiency—ensuring that providers are incentivized not by the volume of services rendered but by improvements in population health and patient experience. Two key developments in a shift towards value:

   (1) The Transforming Maternal Health (TMAH) Model: The District is participating in the CMS-led initiative, which is designed to support a comprehensive value-based approach to maternal health. It encourages enhanced care coordination, person-centered care delivery, and performance-based payments to improve maternal outcomes.

   The new Amerigroup/ Primary Care Association Contract: The DC Primary Care Association recently entered a value-based contract with Amerigroup DC, one of the District's managed care organizations. This agreement aims to align financial incentives with quality improvement, emphasizing chronic disease management, preventive care, and health equity for Medicaid beneficiaries.

The Committee on Health recommends DHCF continue to allocate targeted funding and programmatic support to accelerate the District's transition to value-based payment arrangements. Specifically, DHCF could encourage provider readiness for VBP contracts, especially among small and community-based practices. This includes technical assistance, data infrastructure, and staffing. DHCF could encourage further value-based partnerships between MCOs and provider networks to test and scale successful models. To track the adoption and performance of VBP models, DHCF could establish a VBP performance dashboard, tracking metrics including maternal health, primary care, behavioral health, and targeted chronic disease metrics.

7. Strengthen Managed Care Oversight

During the FY 2024 performance oversight hearing, Lisa Truitt, Director of the Health Care Delivery Management Administration, noted that DHCF's previous approach to MCO oversight had been to work with the MCOs and help them improve their quality metric outcomes. A collaborative approach can only be successful up to a point if key MCO metrics are not improving. FY 2024 performance oversight data showed that MCO outcomes on maternal health metrics, like "Early and Adequate Prenatal Care," 'Timeliness of Prenatal Care," and "Low Birth Weight," varied across the managed care plans. Metrics on timeliness for prior authorizations also varied widely. Paying for performance or imposing penalties to poor performance could help the plans in making improvements, while DHCF considers shifting the payment model away from FFS payments towards value based payments.[28]

The Committee recommends DHCF enhance its oversight functions to drive measurable improvements in clinical quality and patient experience for those who receive managed care. One key action DHCF could take is requiring quarterly reporting of quality metrics from the MCOs with public transparency dashboards that highlight performance across critical domains such as maternal health, behavioral health, and chronic disease. The Committee is committed to strengthening Managed Care Oversight and plans to hold a separate MCO oversight roundtable in 2025.

8. Leverage Opportunities to Support Non-Clinical Drivers of Health

To advance health equity and improve outcomes for Medicaid beneficiaries, DHCF should implement a comprehensive strategy leveraging Medicaid to address non-clinical drivers of health, or Social Determinants of Health (SDOH). This should include continued support and community engagement around the new 1115 waiver demonstration.[29] The 1115 waiver offers a critical opportunity to pilot and scale evidence-based interventions—such as housing support services, medically tailored meals, and peer support for justice-involved populations—within Medicaid's scope. DHCF should ensure that data sharing infrastructure is strengthened to integrate clinical and social care, establish clear performance metrics tied to SDOH outcomes, and provide sustainable funding pathways for CBOs participating in care delivery. This approach will not only improve health outcomes but also reduce long-term costs by addressing root causes of poor health.

DHCF could expand and coordinate community-based services that address housing instability, food insecurity, and behavioral health needs, particularly through value-based purchasing models and partnerships with community-based organizations. Transportation is another driver of health the Committee will be paying close attention to, as this is a benefit that was previously available to Medicaid beneficiaries that will not be available to those who transition to the BHP.

[28] NEJM, "What is Pay for Performance in Healthcare?" March 1, 2018. (Accessed 6/3/25). https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245#:~:text=Studies%20and%20actual%20cases%20have,to%20meet%20individual%20patient%20needs.

[29] Department of Health Care Finance, "Section 1115 Demonstration" (Accessed 6/13/25). https://dhcf.dc.gov/1115-waiver-initiative

The Committee introduced B26-0024, the *Social Determinants of Health Spending Act of 2025*, to allow both public and private insurers to include expenditures for certain social determinants of health, especially those tied to the new 1115 waiver, in the health plan's medical loss ratio, and plans to hold a hearing in the fall.[30] The Committee encourages DHCF to continue exploring all avenues to support non-clinical drivers of health, including building incentives into MCO contracts, and partnering with community-based organizations who provide these services.

9. Streamline Maternal Health Initiatives

To effectively strengthen maternal health outcomes across the District, DHCF should prioritize sustained investment and implementation of evidence-based solutions. As previously mentioned, DHCF is currently implementing the *Transforming Maternal Health (TMaH) model* and participates in the *Doula Learning and Action Collaborative*.

However, follow-through to support maternal health remains critical. Despite Council-funded mandates in prior fiscal years, DHCF has yet to implement two Council-funded bills – Law 23-0312, the Postpartum Coverage Act of 2019, which included remote monitoring for pregnant and postpartum women, and Law 25-0321, the Home Visiting Services Reimbursement Act of 2023, which was intended to cover home visiting programs for first-time mothers—two proven interventions that address gaps in early care and health equity.

The Committee recommends DHCF prioritize implementing these programs, particularly as these two areas are priorities in the TMaH model. At the FY 2026 Budget Oversight hearing, DHCF noted that they would be able to implement the digital remote patient monitoring tools no sooner than 2030. However, establishing the infrastructure and plans for implementation early, ensuring funding mechanisms, provider engagement, and tracking outcomes means the District will be able to better serve women and families. Following through here is essential to making meaningful progress in maternal health equity and to fulfilling the District's legislative and public health commitments.

[30] LIMS, "B26-0024 – Social Determinants of Health Spending Act of 2025" (Accessed 6/13/25). https://lims.dccouncil.gov/Legislation/B26-0024

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)

The Office of the Deputy Mayor for Health and Human Services operates through the following 2 programs:

Human Support Operations – supports the agency's mission to provide oversight and support for all citywide health and human services-related policies, activities, and initiatives under its jurisdiction, by:

- Developing and supporting policies and programs to improve the delivery of services by government agencies and contracted providers;
- Coordinating inter-agency activities and initiatives;
- Identifying opportunities for reducing redundancies, leveraging resources, creating economies of scale, and improving outcomes; and
- Ensuring compliance with local and federal mandates.

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

2. COMMITTEE BUDGET RECOMMENDATIONS

a. Fiscal Year 2026 Operating Budget Recommendations

MAYOR'S FISCAL YEAR 2023 – 2026 OPERATING BUDGET SUMMARY

Description	*FY 2023 Actual*	*FY 2024 Actual*	*FY 2025 Approved*	*FY2026 Proposed*	*% Change from FY 2025*
DC Health Benefit Exchange Authority					
Operating Budget	$2,044,911	$2,092,456	$2,451,199	$2,510,221	2.4
FTEs	11.8	13.4	12.8	13.8	7.8
Capital Budget	$0	$0	$0	$0	N/A
FTEs	0.0	0.0	0.0	0.0	N/A

The Mayor's proposed FY 2026 operating budget for DMHHS is $2,510,221, which represents a 2.4% increase in operating funds, compared with the approved FY 2025 budget. The funding supports 13.8 FTEs, an increase of 1 FTE from the FY 2025 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 2024 Performance Oversight pre-hearing questions, showing that the District spent a total of $3.2 million on encampment outreach and clearings in FY 2024, a decrease of $1.3M from FY 2023 levels.

DHS	**FY22**	**FY23**	**FY24**
Encampment-Specific Outreach Staff and Equipment	$1,252,500	$1,118,819.19	$908,462.32
Outreach Staff Equipment (one-time cost)	N/A	N/A	N/A
Client Related Costs	$86,000	1,844,034.93	$1,043,201.97
2 DHS FTEs (Housing Navigator and Encampment Liaison)	$212,000	$182,534.32	$176,101.10 (DMHHS Specific)
Outreach/Communications Campaign Supplies	$3,500	$1,751.52	$27,983.42 (DMHHS Specific)

DBH			
2 Multidisciplinary Teams (2 teams of 9 staff each)	$1,560,522	$634,787.53	$574,232.24
DPW			
Encampment-Specific Trash Route	$336,199	$300,400	N/A
Encampment-Specific Cleanup Team (7 staff)	$293,780	$239,770	N/A
Expanded Biohazard Contract	$180,000	$180,000	$100,000.00
DMHHS Coordinated Engagements			$337,781.00
Totals	$3,924,501.00	$4,502,097.49	$3,167,762.05

Despite the decrease in spending, the number of encampment full cleanup/closures significantly increased in FY 2024 to 36 locations, up from 13 in FY 2023. Similarly, NPS full cleanups/closures increased to 10 encampments in FY 2024, up from 3 closures in FY 2023. The Committee is concerned that the biggest reduction in spending is for "Client Related Costs" and that less resources were seemingly spent on connecting clients with services, even though many more people were affected by encampment clearings than in previous fiscal years.

The Committee is also concerned with DMHHS' policy decision to decrease the number of days notice provided to residents living in encampments that the encampments will be cleared from 14 days in FY 2024 to 7 days in FY 2025. Not only was this policy change done with little to no input from the public, but the Committee also cannot ascertain if the impetus for the change was in fact due to increase health and safety concerns. The shift in notice gives individuals significantly less time to identify a safe place to relocate and to move their possessions.

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 connecting residents of encampments with safe housing and other needed services, improving the shelter system to make shelters a safe and attractive option for residents experiencing homelessness, and providing clear, consistent, and sufficient notice to encampment residents when their encampments are scheduled for clearing.

Focusing Age-Friendly DC on the Needs of DC Seniors

DMHHS is the home of the Age-Friendly DC Initiative, a program started in 2012 when the District entered into the World Health Organization (WHO) Global Network of Age-Friendly Cities and Communities. Age-Friendly DC brings together agencies across the District to identify and work towards goals that will make the District a more welcoming place for District residents as they age. In the first 5-Year Progress Report published in 2017, Age-Friendly DC focused on

initiatives the District had implemented such as launching and continuing Safe at Home, DC's program modifies homes for aging in place, and opening Plaza West, with affordable residences for grand families, older adults raising children.

In the most recent 2024-2028 Strategic Plan for Age-Friendly DC, the Age-Friendly DC Task Force identified three core pillars for Age-Friendly's future work: built environment, changing attitudes, and lifelong health and security. This is reflected in Age-Friendly's most recent survey, which ***did not*** target the experience of seniors, but rather interviewed residents from all age levels. Although the Committee recognizes the importance of ensuring that residents of all ages are able to safely live and move around the District, it is concerned that this evolving approach to Age-Friendly is taking the focus off of seniors, who still face unique and substantial barriers to aging in place.

For example, the 2024 Age-Friendly Livability Survey Report surveyed 611 District residents on aging well in the community. However, about 25% of respondents were under 30 years old and 50% were under 60 years old. The results were not disaggregated by age, so it is impossible to tell how seniors responded to questions like "How easy is it for you to walk to places in your neighborhood?" or "How easy is it for you to access public transportation?" While between 70-80% of survey respondents responded "Somewhat easy" or "Very easy" to these questions, the Committee believes these results obscure what likely are much more significant mobility challenges for seniors. The Committee is also concerned that less than 300 residents over 60 years old were surveyed for this report, with no way to tell what Ward they live in—an unrepresentative sample size to get real insights on the senior experience.

The District of Columbia has been recognized as an Age-Friendly City by the World Health Organization. If we want to live up to that honor, we need to take improving the senior experience of aging in place in the District much more seriously. Given the current long-term care and housing affordability crisis faced by the District, we do not have the luxury of not using our resources in the most effective way possible.

To that end, the Committee recommends through the Budget Support Act subtitle *Long Term Care Strategic Coordinator Amendment Act of 2025* that DMHHS repurpose the vacant Age-Friendly DC Coordinator role into a Long-Term Care Strategic Coordinator role. This role would be responsible for the following activities:

- Coordinating the Age-Friendly DC program;
- Tracking the long-term care services provided by agencies under the purview of DMHHS (health agencies);
- Using data to develop a strategy to improve and increase the capacity of the long-term care services workforce to meet the District's needs;
- Identifying points of contact within each relevant agency outside of the health agencies, including the Deputy Mayor for Education and the Department for Aging and Community Living, to avoid duplication of work across agencies and to ensure each agency's work aligns with the broader mission of supporting the District's aging population and long-term care workforce; and
- Other duties relevant to support the long-term care workforce as may be identified and assigned by DMHHS.

b. Fiscal Year 2026 - 2031 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 systemic challenges, such as behavioral health and substance use, within the Health and Human Services cluster.

Deputy Mayor Turnage has repeatedly testified before the Committee on his style of leadership over the agencies in the Health and Human Services cluster, stating that while there is an expectation that he would bring key issues to the Office of the City Administrator that need interagency coordination, he relies on the agency directors to notify him whether issues require additional attention. This approach to leadership hinges on having strong, effective leadership at the helm of each of the agencies. When it is clear that an agency is not capable of effectively addressing a challenge affecting District residents, it is the role and responsibility of the Deputy Mayor's office to step in.

There are several critical challenges within the cluster where the Committee believes it is urgent for DMHHS to step in:

- **St. Elizabeth's Hospital**, the only publicly run behavioral health hospital in the District, is experiencing chronic underfunding, leading to a lack of investment in security, supplies, and workforce. The population of individuals at St. Elizabeth's has changed with over 90% being there by court-order, but it does not appear that St. Elizabeth's has made any adjustments to operations to meet this new reality. At the public hearing for the Department of Behavioral Health (DBH), the Committee heard from many nurses who have been assaulted at work due to insufficient security, staff training, and infrastructure. DBH leadership had told the Committee privately and in public that "this is the role these nurses signed up for" and have generally not expressed the type of concern or commitment to improvement required by this situation.
- **The Supplemental Nutrition Assistance Program (SNAP) Payment Error Rate (PER)** for the District is unacceptably high, at 20.25%. This means that for one in every five SNAP customers in the District, the Department of Human Services is calculating their benefit level incorrectly. District residents deserve better, which is why the Committee has held several joint hearings with the Committee on Housing over the last 2 years to push the Department of Human Services, which uses the DC Access System (DCAS) to process SNAP benefits, and the Department of Health Care Finance, which administers the software for the DC Access System, to improve this performance. In summer 2024, the District was fined $4.4M by the U.S. Department of Agriculture for our high PER. Now, that fine could quickly be overshadowed, as current federal legislation proposes requiring states with over a 10% PER to begin paying 25% of the cost of SNAP benefit allotments. For the District, that would mean an additional local contribution of around $79 million

per year. Yet, the Department of Human Services does not seem to have a plan to address this issue and significantly course correct.

- **School-Based Behavioral Health Program:** The DBH chapter of this report lays out in details the Committee's years-long attempt to have DBH take accountability for the failure of the School-Based Behavioral Health Program to provide critical behavioral health services to youth in need. Currently, 42% of our public schools do not have a clinician connected to them. In fact, $1.8 million went unspent at the 25 highest need designated schools because they were not paired with a clinician. DBH has reluctantly introduced a new pilot that would provide varying flexibilities (i.e., allowing charter schools to hire a clinician; allowing virtual visits). Yet they have not significantly moved the needle or been responsive to what organizations have said would actually help with recruitment and retention. Due to inaction by DBH and lack of intervention by DMHHS, the Committee is requiring a report from DBH on changes to the program by October 15, 2025; if this report is not satisfactory, the Committee will recommend transferring the entire program out of the agency this year and into DC Health.

In all of these situations and others, DMHHS should have stepped in earlier after hearing that there were concerns the agencies either could not or would not address on their own. Deferring to agency leadership where there are clear harms being done to District residents is an abdication of responsibility over the cluster. The Committee is respectfully asking DMHHS to "lean in."

2. Support the Interagency Council on Homelessness (ICH) in connection with the Department of Behavioral Health on the intersection of homelessness and behavioral health challenges.

The ICH's July 2024 draft Work Plan proposed restructuring the ICH to focus on Health Care, especially Behavioral Health. DMHHS testified at the FY 2024 Performance Oversight Hearing that this is due to the significant rates of behavioral health challenges experienced by unhoused residents. ICH wanted to be able to work more actively with DBH on harm reduction and meeting the needs of residents using opioids. The Committee encourages DMHHS to support ICH in these efforts and ensure that DBH is being responsive to ICH's insights and feedback on current DBH programs.

Health Benefit Exchange Authority (H10)

1. AGENCY MISSION AND OVERVIEW

The DC Health Benefit Exchange Authority (HBX) 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, 2025 the District of Columbia Health Benefit Exchange Authority is in its thirteenth year of operations and has concluded its twelfth 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 6 divisions:

Consumer Education and Outreach: Educates District residents, small business and non-profit owners, and small business and non-profit employees about health coverage options available through DC Health Link 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

Partnerships and Marketplace Operations (PMO): Performs functions required of all state-based marketplaces, including enrollment, plan management and certification of qualified health and dental plans. This division develops, operates, and manages DC Health Link's Small Business Health Options Program (SHOP) for small businesses and non-profits, and their employees to shop and enroll in health insurance. This division and Health Coverage Innovation (HCI) division share four activities (Contact Center Services, Plan Management, Data Analytics and Reporting, and Performance and Strategic Management).

- Activities:
    - PMO Contact Center Services
    - PMO Plan Management
    - PMO Data Analytics and Reporting
    - PMO Small Business Health Operations Program (SHOP)
    - PMO Performance and Strategic Management

Health Coverage and Innovation (HCI): Performs functions required of all state-based marketplaces, including eligibility determinations and enrollment help, including through a call center for qualified health and dental plans. This division develops operates and manages the efficient operation of DC Health Link’s online insurance marketplace where residents and their families can shop and enroll in health insurance. This division and the Partnerships and Marketplace Operations division share four activities (Contact Center Services, Plan Management, Data Analytics and Reporting, and Performance and Strategic Management).

- Activities:
    - HCI Contact Center Services
    - HCI Plan Management
    - HCI Data Analytics and Reporting
    - HCI Eligibility and Enrollment
    - HCI Performance and Strategic Management

IT Department: Provides development, operations, maintenance, and security for DC Health Link, the District's on-line health insurance marketplace.

- Activities:
    - Operations Maintenance and Development
    - IT Security
    - Electronic Data Interchange
    - IT Performance and Strategic Management

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 2026 Operating Budget Recommendations

MAYOR'S FISCAL YEAR 2023 – 2026 OPERATING BUDGET SUMMARY

Description	*FY 2023 Actual*	*FY 2024 Actual*	*FY 2025 Approved*	*FY2026 Proposed*	*% Change from FY 2025*
DC Health Benefit Exchange Authority					
Operating Budget	$47,557,909	$39,977,544	$41,752,784	$41,634,470	-0.3
FTEs	110.7	118.5	128.0	129.0	0.8
Capital Budget	$0	$0	$0	$0	N/A
FTEs	0.0	0.0	0.0	0.0	N/A

The Mayor's FY 2026 proposed operating budget for the DC Health Benefit Exchange Authority (HBX) is $41,634,470, which represents a 0.3% decrease in operating funds compared with the approved FY 2025 budget. Most of HBX's budget is funded through an assessment fee on health insurers in the District, which will remain flat at 0.080% in FY 2026. The proposed budget includes a small increase in salary, fringe benefits, and other personnel services costs across multiple divisions, and adds 1.0 FTE. The small decrease in the budget is due to projected contractual costs and obligations.

The most significant change in the FY 2026 proposed budget for HBX is its new authority to create a Basic Health Program for District residents no longer eligible for Medicaid. This chapter details that policy proposal, as well as provides updates up the Health Care 4 Child Care Program and fertility benefits. This chapter also includes policy recommendations for the agency.

Basic Health Program

The FY 2026 proposed Budget Support Act gives HBX the authority to implement a Basic Health Program (BHP) for District residents in response to the Department of Health Care Finance (DHCF) limiting eligibility for DC Medicaid coverage.

Most of the 25,500 residents who will likely lose Medicaid coverage under DHCF's proposed eligibility changes will not be able to afford to purchase a commercial plan offered in the HBX health insurance marketplaces. In order to provide an affordable health insurance option for those residents, HBX plans to create a BHP, a tool created by the federal Centers for Medicare and Medicaid Services (CMS) used by several other states to increase health care coverage

affordability.[31] A BHP allows the state to shift the cost of providing health insurance from traditional Medicaid, where the state pays a percentage of the cost, almost completely to the federal government, while at the same time limiting costs to participants.

As proposed, to be eligible for the BHP in DC an individual must earn between 138 percent and 200 percent FPL; be under 65 years old; and be ineligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-provided coverage. BHP coverage is also available to lawfully present immigrants who are not eligible for Medicaid because of Medicaid's five-year waiting period for new immigrants. DHCF estimates around 25,500 childless adults and parents/caretakers will transition from Medicaid coverage to BHP coverage, and HBX estimates that approximately 300 residents currently enrolled in a marketplace plan could be eligible to switch to a BHP.

HBX has already convened two stakeholder working groups, one for the HBX Advisory Council and one for insurance carriers, to provide input on the development of the BHP. HBX has invited any health maintenance organization (HMO) to participate as a carrier for the BHP, including the District's existing Medicaid managed care organizations (MCO). The goal is to have as seamless a transition as possible for enrollees.

At the time this report is being published, there are still many aspects of the BHP design that have yet to be decided. The HBX Advisory Council working group will assist HBX on making decisions regarding the BHP design, including setting premiums and cost-sharing based on HBX's actuary analysis - which statutorily can be no more than the amounts that enrollees would otherwise have paid in the marketplace. Costs for District enrollees are projected to be lower since the BHP is likely to be modeled on Medicaid, which in the District does not currently have cost sharing. HBX Executive Director Mila Kofman has indicated to the Committee that initial modeling will likely result in no premiums, and hopefully no cost-sharing for beneficiaries, to match Medicaid coverage. However, if changes to Medicaid like requiring cost-sharing were to be made on a federal level, adjustments to the BHP may also need to be made. The Insurance Carrier Working group is a closed group and will advise HBX on technical decisions including contracting language.

HBX must submit a BHP Blueprint form to CMS, which will detail the program design choices, operations, IT, management, and compliance with federal rules. HBX publicized the District's Blueprint on June 16, 2025 for a 30-day public comment period before they will finalize and submit to CMS.[32] Director Kofman also indicated that the benefits available to enrollees of the BHP would mirror the District's Essential Health Benefits. Enrollees can expect to have coverage for primary care, specialty care, hospital services including imaging, skilled nursing facilities, laboratory services, durable medical equipment, and some mental and behavioral health services. The BHP will likely not cover some benefits that are currently covered by DC Medicaid, including dental, vision, some behavioral health and substance-use disorder treatments including psychiatric

[31] Centers for Medicare and Medicaid Services, "Basic Health Program" (Accessed 6/13/15). https://www.medicaid.gov/basic-health-program

[32] HBX, "Basic Health Plan Program Blueprint – Draft" June 16, 2025 (Accessed 6/20/25). https://hbx.dc.gov/sites/default/files/dc/sites/hbx/page_content/attachments/DC%20BHP%20Blueprint%20Draft%20-%206.16.25.pdf

residential treatments, and assertive community treatments, and non-emergency medical transportation.[33] Beneficiaries losing access to these benefits which they have come to rely on is of particular concern to the Committee.

Pregnancy is another example of a benefit not covered by BHP. Federal regulations require pregnant individuals who qualify for Medicaid to use Medicaid coverage for their pregnancy– and in the District that means those who earn up to 319% FPL.[34] Therefore, an individual earning between 138%-200% FPL who was transitioned to the BHP and became pregnant would be transitioned back to Medicaid coverage for the duration of the pregnancy plus 12-months postpartum. After the 12-months postpartum coverage through Medicaid ended, that individual's coverage would revert back to the BHP. This type of scenario will require close communication and data sharing between HBX, the insurance plans participating in BHP, and DHCF.

HBX has informed the Committee that they are working with their actuary to determine true costs of benefits, to see if the District can afford no premiums or cost-sharing for enrollees. The current estimates are based on a number of assumptions, including that the enhanced premium tax credits will expire at the end of calendar year 2025. HBX will detail their assumptions and calculations in the BHP Blueprint. This process may require additional back-and-forth once CMS has reviewed the Blueprint.[35] The Committee expects final estimates on costs and benefits to be available once the Blueprint has been submitted to CMS. The proposed FY 2026 budget anticipates that if approved, the transition to the BHP would occur in January 2026.

HBX estimates that dental coverage for BHP enrollees is $17 per member per month (PMPM) and Medicaid-equivalent behavioral health services is $85 PMPM. Although the Committee was not able to identify these funds, the Committee does believe these services are vital, and encourages the Committee of the Whole to consider funding the approximately $5.2 million needed for dental coverage and the $26.01 million for Medicaid-equivalent behavioral health services for BHP beneficiaries.

HealthCare4ChildCare

The Committee is pleased that the FY 2026 proposed budget funds the Pay Equity Fund, including maintaining $12 million for the HealthCare4ChildCare (HC4CC) program within HBX. However, the Committee is concerned that this funding was shifted to one-time funding and that the rest of the financial plan does not include funding for the Pay Equity Fund or HC4CC. To be clear, the Council fully funded both programs throughout the financial plan during the budget process in 2024. 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

[33] Health Benefit Exchange, "Draft Benefit Comparison Chart," (accessed 6/12/25). https://hbx.dc.gov/sites/default/files/dc/sites/hbx/page_content/attachments/DRAFT%20Benefit%20Comparison%206-06-25_0.pdf
[34] DHCF, "Pregnant Individual," (Accessed 6/13/25). https://dhcf.dc.gov/service/pregnant-individual#:~:text=Are%20Pregnant%20or%20have%20been,Meet%20income%20requirements
[35] Health Benefit Exchange Authority, "BHP Advisory Council Meeting #2 – Monday June 9, 2025," (Accessed 6/13/25). https://hbx.dc.gov/sites/default/files/dc/sites/hbx/page_content/attachments/BHP%20Advisory%20Council_6.9.25%20minutes.pdf

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.

HC4CC pays for the bulk of employer premiums; for every one dollar HC4CC spends on group coverage, employers contribute 35 cents. The premiums are guaranteed for 12 months once an employee or employer enrolls in the program. 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. The cost of administering HC4CC is absorbed by HBX. Since January 2023, HC4CC has helped 2,414 people and 231 facilities. As of January 2025, 220 businesses in the District are enrolled in HC4CC, representing 79% of eligible District early childhood businesses, a 24% increase from 2024. In total, 1,967 people are currently enrolled in HC4CC including 1,607 employees and 360 dependents.

In FY 2023 and FY 2024, HBX received $18 million to operate the HC4CC program. In the FY 2025 budget, HC4CC was reduced from $18 million to $12 million. This reduction meant that all previous enrollees maintained their coverage, but that HBX had to institute a waitlist for new applicants. And as of June 2025, there is one facility on the waitlist. In post-hearing responses, HBX estimated they had sufficient funding to clear the waitlist by July 2025.

The Committee commends Director Mila Kofman and the staff at HBX for their continued collaboration with OSSE and community partners 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 recurring funding for the Pay Equity Fund for the rest of the financial plan, including the $12 million per year necessary to maintain the current level of coverage.**

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.[36] Diagnosis and medical treatment of infertility for Medicaid patients went into effect January 2024, and private insurers in the District are required to cover the services mentioned above in their 2025 plans.

The Committee worked closely with HBX and DISB to determine the costs for HBX to implement this legislation, and fully funded the law in the FY 2025 budget at a funding level of $420,000 over the financial plan.

[36] *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

Whether due to pent up demand, or unanticipated demand, this benefit has proven to be extremely popular for HBX beneficiaries. Initial HBX data shows that in Q1 of FY 2025, HBX has already made $853,360 in payments on claims. This includes payments from enrollees on the individual and the small business health options (SHOP) side. Meaning, people who are self-enrolled in an insurance plan and those who enroll through employers, including Congressional staffers, are using this benefit. HBX is still processing over $1 million in incurred but not yet paid claims for Q1 of FY 2025. In 2024, the Centers for Medicare and Medicaid Services (CMS) approved the District's request to add coverage of infertility treatments as an Essential Health Benefit, and therefore the District is required to pay the costs of this benefit only until the end of calendar year 2025.[37] Based on usage and claims data thus far, HBX's actuaries estimate $6,000,000 in costs to cover these services by the end of calendar year 2025.

The Committee is pleased that so many individuals have been able to take advantage of this new benefit to grow their families. Although the Committee recognizes the unforeseen spending pressure, it believes that it is the Executive's responsibility to address these costs, as the law is no longer subject to appropriations. **Therefore, the Committee recommends that either DHCF or the Office of the Deputy Mayor for Health and Human Services supports HBX in addressing this one-time spending pressure.**

b. Fiscal Year 2024 - 2029 Capital Budget Recommendations

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

3. COMMITTEE POLICY RECOMMENDATIONS

1. *Safeguard sufficient and affordable health care coverage for new Basic Health Program enrollees.*

The Committee recognizes the challenge it is to stand up an entire new health insurance program in a short amount of time and commends Director Kofman and her team at HBX, as well as the team at the Department of Health Care Finance**.** HBX has already begun educating key stakeholders on the Basic Health Program and working with groups to ensure all perspectives are included prior to launching the program. The Committee has also been in dialogue with District partners around potential areas of concern with the BHP, like a lack of coverage for non-emergency transportation, dental, vision, and certain key behavioral health/substance use and community treatments.

The Committee recommends a concerted effort to make the benefits as comprehensive as possible, including dental, behavioral health, and to ensure no premiums or cost sharing for the new enrollees. The Committee also recommends continued dialogue with DHCF and the DC Department of Human Services, which administers Medicaid enrollment through the DC Access System, to ensure a smooth transition of beneficiaries, and other stakeholders to make sure the BHP is meeting District residents' needs, well beyond the launch of the program in January.

[37] CMS, "Information on Essential Health Benefits Benchmark Plans," (Accessed 6/13/25). https://www.cms.gov/marketplace/resources/data/essential-health-benefits

2. *Clearly and Concisely Communicate Health Insurance Changes to Beneficiaries.*

As detailed in the first policy recommendation above, the Committee acknowledges the challenges to stand up this new health insurance program and acknowledges the work HBX is doing to develop the program. Equally important is the necessity for clear and concise communication to the Medicaid beneficiaries whose insurance coverage will be changing. The District's intent is to seamlessly transition coverage behind the scenes for beneficiaries, so as many as possible can maintain care through their current MCO, but the extent of participation and contractual agreements for MCOs is still being discussed. Beneficiaries deserve to have all information available to them, including what benefits will be covered, what the changes from their previous Medicaid coverage are, and make an informed decision that works the best for themselves and their families.

3. *Continue to monitor the stability of District health insurance rates and educate federal leaders about the importance of affordable health insurance.*

The Committee is proud of the near universal insurance coverage in the District: nearly 97% of DC residents have health insurance and the District is the #2 most insured state in the country. However, federal discussions could put maintaining this position in jeopardy. The Committee is concerned about the implications of the potential sunset of the Enhanced Premium Tax Credits (PTCs), passed through Congress as part of the American Rescue Plan Act of 2020, to ensure that Americans had access to affordable health care. The PTCs will be sunset on December 31, 2025, without any further extensions from Congress. This means for calendar year 2026, beneficiaries' premiums will be more expensive than in the past 5 years and some may make the hard decision to choose other basic necessities over health insurance. The Committee appreciates the work HBX has been doing to educate Congress about the importance of maintain affordable health insurance and encourages continued health education and advocacy.

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

1. AGENCY MISSION AND OVERVIEW

The Not-For-Profit Hospital Corporation (NFPHC) Subsidy provided a direct payment to the Not-For-Profit Hospital Corporation, an independent instrumentality of the District of Columbia created by legislation adopted by the Council. The Corporation was established to hold the land, improvements, and equipment of United Medical Center (UMC), the District's only public hospital, which ceased operations on April 15, 2025.

NFPHC was governed by a Fiscal Management Board that served as a control board beginning in May 2021. The Board consisted of nine members—seven voting and two non-voting. Voting members included:

- The Chief Financial Officer of the District of Columbia (or designee), who served as Chair;
- The Deputy Mayor for Health and Human Services (or designee);
- The Director of the Child and Family Services Agency (or designee);
- One citizen member from Ward 7 or Ward 8, appointed by the Mayor, with experience in public health or health care delivery;
- One citizen member, appointed by the Mayor, with experience as a former City Administrator of the District;
- An individual with hospital management or finance expertise, appointed by the Mayor; and
- One representative from each of the two largest unions at UMC, selected by the unions.

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

The Not-For-Profit Hospital Corporation Subsidy agency will be eliminated in Fiscal Year 2026. All agency funding, functions, and responsibilities will cease at the end of Fiscal Year 2025, following the closure of UMC.

COMMITTEE COMMENTS

The Committee on Health closely monitored the final months of UMC's operations in the first half of FY 2025 leading up to the closure on April 15, 2025. The Committee held a public roundtable in December 2024 focused on the closing and the transition of patients to Cedar Hill Regional Medical Center. The Committee also sent multiple written follow-up questions to leadership, and met with UMC and Cedar Hill to get clarity on closure timelines, staffing issues, and patient handoffs.

The Committee monitored how UMC handled service reductions, especially around department closures like OB/GYN, primary care, and the Wound Care Center. The first service reductions began on August 31, 2024. The Committee also pushed for transparency around the hospital's closure plan, which we received in November 2024.The Committee requested updates on patient notifications of department closures, and how the hospital was connecting patients to other providers for chronic conditions.

While there were delays in getting full information, particularly around planning and vendor transitions, the Committee appreciates that the hospital closure went relatively smoothly. UMC and Cedar Hill worked together to minimize service gaps, and the Committee commends both teams for prioritizing patient safety and continuity of care during this major transition.

A New Beginning with Cedar Hill

The closure of UMC on April 15, 2025, marked the end of the District's only public hospital, but it also signaled the transition to a new chapter in health care for the east end of the District with the opening of Cedar Hill Regional Medical Center. Located on the St. Elizabeths East campus, Cedar Hill is a state-of-the-art, full-service acute care hospital operated by Universal Health Services (UHS) through a public-private partnership with the District. UHS partners with GW Medical Faculty Associates, George Washington University, and Children's National Hospital for the hospital operations. The facility includes an emergency department, labor and delivery services, intensive care, and surgical capabilities, offering many of the core services previously housed at UMC while modernizing infrastructure and care delivery for residents east of the Anacostia River.[38]

For Ward 8 residents, Cedar Hill represents a major investment in health equity. The community has long faced disproportionate barriers to care, including fewer providers, longer wait times, and high rates of chronic disease.[39] Cedar Hill closes critical access gaps by offering services closer to home, reducing the need for residents to travel across the city for hospital-level care.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. FISCAL YEAR 2026 OPERATING BUDGET RECOMMENDATIONS

The Mayor's FY 2026 proposed subsidy for the Not-For-Profit Hospital Corporation is $0 due to the hospital closing in FY 2025.

b. FISCAL YEAR 2026 - 2031 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

The Committee does not have any policy recommendations for this agency.

[38] Government of the District of Columbia. (2023). *FY2024 Proposed Budget and Financial Plan: Volume 1 Executive Summary*. Retrieved from https://cfo.dc.gov/page/annual-operating-budget-and-capital-plan
[39] District of Columbia Department of Health. (2021). *Health Equity Report: District of Columbia 2021*. Retrieved from https://dchealth.dc.gov/publication/dc-health-equity-summit-2021-summary-report

Budget Support Act Recommendations

Recommendations on Mayor's Proposed Subtitles

The Committee provides comments on the following subtitles that were referred to the Committee on Health in the "Fiscal Year 2026 Budget Support Act of 2025":

- Title V, Subtitle A. State Health Planning and Development Agency
- Title V, Subtitle C. Environmental Health Functions
- Title V, Subtitle E. Health Care Alliance
- Title V, Subtitle H. Health Occupation Criminal Background Checks
- Title V, Subtitle I. Basic Health Programs
- Title V, Subtitle J. Direct Care Professional Payment Rates
- Title V, Subtitle L. Healthy DC and Health Care Expansion Fund

The Committee also provides comments on the following subtitle with implications on the Committee's jurisdiction:

- Title VII, Subtitle H. Non-Lapsing Account Repeals Amendment Act of 2025

The legislative language is included in Attachment F.

TITLE IV, SUBTITLE A. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

Purpose, Effect, and Impact on Existing Law
The State Health Planning and Development Agency (SHPDA) within DC Health develops the Health Systems Plan, which serves as a guide for the development of healthcare services in the District. The SHPDA also operates and enforces the Certificate of Need program.

The subtitle clarifies that SHPDA operates under the direct control of DC Health. Dr. Bennett testified at the public hearing that the funding for data collection for health systems and health facilities planning had been separated, which is not the best practice. SHPDA and the Community Health Needs Assessment were asking for duplicative data, and this subtitle instead enables the agency to better integrate the SHPDA staff with other programs within the agency.

The subtitle also changes the State Health Planning and Development Fund (Fund) from non-lapsing to lapsing and directs any money remaining available in the Fund at the end of a fiscal year to be transferred to the unassigned fund balance of the General Fund. The subtitle specifies the allowable expenses from the Fund, including paying salaries and expenses necessary to carry out the function of the SHPDA, paying salaries and other expenses for other health assessment, planning, and evaluation functions at DC Health, and then having the unused balance revert to the unassigned fund balance of the General Fund at the end of the fiscal year. In its post-hearing responses, DC Health provided the following chart to show the end-of-year fund balance in the SHPDA Fund in the previous three fiscal years. Please note that SHPDA revenue is loaded into two separate funds, which fluctuate depending on the number and scope of SHPDA applications each year.

Fund Detail	Fund Detail Title	Description	FY22 Fund Balance	FY23 Fund Balance	FY24 Fund Balance
1060050	SHPDA Fees	Fees for a certificate of need when a person proposes to develop a new institutional health service or invest in capital assets.	$2,074,955.51	$1,162,624.34	$623.34
1060166	SHPDA Admission Fees	Fees paid by non-federal hospitals for each in-patient admissions. Paid in lieu of CON application fee.	$82,960.76	$4,154.66	$319,952.30
		Total:	**$2,157,916.27**	**$1,166,779.00**	**$320,575.64**

Committee Recommendation and Reasoning

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

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Health Services Planning Program Re-establishment Act of 1996 to specify that the State Health Planning and Development Agency falls under the direction and control of the Director of the Department of Health. Changes the State Health Planning and Development Fund ("Fund") to a lapsing special fund. Specifies that the Fund shall be used primarily for the salaries of employees and other necessary expenses of carrying out the duties of the SHPDA, with any excess money used to pay the salaries and other expenses necessary in carrying out other health assessment, planning, and evaluation functions of DC Health. Requires that any excess balance in the Fund at the end of each fiscal year revert to the unassigned fund balance of the General Fund of the District of Columbia.

Fiscal Impact

The Office of Revenue Analysis reports that there is no fiscal impact associated with this subtitle. Changing the Fund to lapsing does not have an impact because all estimated revenue is either budgeted in the Fund or already specified to be recognized as local revenue, according to ORA.

TITLE V, SUBTITLE C. ENVIRONMENTAL HEALTH FUNCTIONS

Purpose, Effect, and Impact on Existing Law

The subtitle gives DC Health the authority to regulate medical waste, low-level radioactive waste, and environmental health hazards in residential settings, including indoor air and pest management. The subtitle also makes conforming changes to clarify the Department of Energy and Environment's (DOEE) authority concerning environmental health functions.

The subtitle establishes an Environmental Health Administration within DC Health by transferring a portion of the existing DOEE Healthy Housing Branch and dormant Medical Waste Management Program to DC Health. All functions, authority, programs, positions, personnel, property, records, and unexpended balances of appropriations, allocations, and other funds related to these programs will be transferred to DC Health. Additionally, all rules, orders, obligations, determinations, grants, contracts, licenses, and agreements for these programs will become the responsibility of DC Health.

The Healthy Housing Branch at DOEE, which includes implementation of the Childhood Lead Poisoning Screening and Reporting Act of 2002 and Healthy Homes programs, will move to DC Health. The Healthy Housing Branch reduces and investigates childhood lead poisoning exposure and identifies home environmental health and safety hazards to minimize injury, safety concerns, and respiratory health hazards. The program also works to reduce childhood asthma and respiratory illnesses, reduce blood lead levels in children, and provides educational materials to physicians on the District's lead screening and reporting law.

Committee Recommendation and Reasoning

The Committee Print makes several changes to the subtitle as introduced. The Committee Print clarifies that DC Health will take over implementation and enforcement of the Childhood Lead Poisoning Screening and Reporting Act of 2002, effective October 1, 2002 (D.C. Law 14-190; D.C. Official Code § 7-871.01 et seq.). It also standardizes the definitions of "elevated blood lead level" and "Lead-poisoned child" to align with the Lead-Hazard Prevention and Elimination Act of 2008.

It clarifies that DOEE is responsible not just for lead-based paint hazards, but for all "lead hazard prevention and elimination" except for the childhood lead poisoning screening and reporting that will now be under DC Health.

The Committee on Transportation & the Environment also added several provisions to the Committee Print that the Committee on Health accepts. These are as follows:

DOEE Rulemaking

The District Department of the Environment Establishment Act of 2005, effective February 15, 2006 (D.C. Law 16-51; 52 DCR 10812), established the District Department of the Environment, which was later renamed the Department of Energy and Environment ("DOEE").

The original language of the Act required that the Mayor promulgate rules to implement provisions of the Act within 180 days of its effective date. The Act further specified that proposed rules must be submitted to the Council for a 45-day period of review and were to be deemed disapproved if the Council did not approve or disapprove the proposed rules by resolution – that is, active approval. The rationale for requiring active approval was to ensure that the Council could review the initial set of rules and regulations promulgated by the newly established agency.

In 2021, the Council passed the Green Food Purchasing Amendment Act of 2021, effective July 29, 2021 (D.C. Law 24-16; 68 DCR 6015) ("GFPAA"). The GFPAA amended D.C. Official Code § 8-151.10 to provide rulemaking authority for purposes of implementing provisions of the GFPAA. However, due to a drafting error, the GFPAA unintentionally subjected all new rules and regulations promulgated by DOEE to the 45-day active approval period that had been reserved for rules and regulations promulgated during DOEE's establishment. The resulting uncertainty regarding the Executive's rulemaking authority pursuant to the Act impaired the agency's ability to promulgate rules and regulations necessary for implementing the District's environmental laws in a timely manner.

To clarify DOEE's ability to promulgate rules and regulations without being subjected to a 45-day active approval process, the Council passed the Department of Energy and Environment Rulemaking Clarification Emergency Amendment Act of 2024, effective November 22, 2024 (D.C. Act 25-629; 71 DCR 14456). The Council also passed the Department of Energy and Environment Rulemaking Clarification Temporary Amendment Act of 2024 (D.C. Act 25-639; 71 DCR 14478). This subtitle will make changes from the emergency and temporary legislation permanent.

DOEE Definitions

In 2024, DOEE approached the Committee on Transportation and the Environment to discuss issues with the statutory definitions of three key terms that DOEE relies on when fulfilling its statutory duties and administering agency programs. To prevent the misinterpretation or misapplication of those terms, the Council passed the Department of Energy and Environment Definitions Clarification Emergency Amendment Act of 2024, effective November 22, 2024 (D.C. Act 25-636; 71 DCR 14470) and the Department of Energy and Environment Definitions Clarification Temporary Amendment Act of 2024 (D.C. Act 25-665; 71 DCR 16302). Specifically, the emergency and temporary legislation amended the definitions of "subscriber organization," "lead-based paint," and "producer" to reflect their initial intent or current practice. This subtitle would make those changes permanent. Below is a subscription of each definition and how it was amended.

Definition of "Subscriber Organization"

The Retail Electric Competition and Consumer Protection Act of 1999, effective May 9, 2000 (D.C. Law 13-107; 47 DCR 1091), defined the term "Subscriber organization" as "any for-profit or nonprofit entity permitted by District of Columbia law that owns or operates one or more community renewable energy facilities for the benefit of the subscribers."[40] A primary function of subscriber organizations is to assign energy credits to subscribers who participate in community renewable energy facilities ("CREFs"). Subscription management is an administratively burdensome activity, and solar developers generally prefer to assign the responsibility for subscription management to another entity.

In practice, the Department of Energy and Environment ("DOEE") has been functioning as a subscriber organization for low- to moderate-income District residents, who are subscribers to CREFs through DOEE's Solar for All program. Uncertainty regarding whether the definition of "subscriber organization" covered a government entity could have adversely impacted DOEE's authority perform these administrative functions, and may have inhibited other government entities from performing these functions for future CREFs. The emergency and temporary legislation amended the law to make clear that a government entity can serve as a subscriber organization, which resolved any uncertainty regarding DOEE's ability to act in that capacity. This subtitle makes that change permanent.

Definition of "Lead-Based Paint"

The Residential Housing Environmental Safety Amendment Act of 2020, effective March 16, 2021 (D.C. Law 23-188; 68 DCR 1227), amended the Lead-Hazard Prevention and Elimination Act of 2008, effective March 31, 2009 (D.C. Law 17-381; 56 DCR 1596), to lower the amount of lead needed in paint or other surface coatings to qualify as a "lead-based paint" from one milligram per square centimeter (1.0mg/cm2) to 0.7 milligrams per square centimeter (0.7mg/cm2).[41] However, the parenthetical within the amended definition erroneously uses microgram symbol ("μ") instead of the correct abbreviation for milligram ("mg"). The emergency and temporary legislation amended the law to use the correct abbreviation, and this subtitle would make that change permanent.

Definition of "Producer"
The Zero Waste Omnibus Amendment Act of 2020, effective March 16, 2021 (D.C. Law 23-211; 68 DCR 68), amended the Sustainable Solid Waste Management Amendment Act of 2014, effective February 26, 2015 (D.C. Law 20-154; 61 DCR 9971) to define "producer."[42] Due to a drafting error, the definition used the phrase "A person who manufacturers *[sic]* a . . ." when it should instead read "A person who manufactures a . . ." The emergency and temporary legislation eliminated the typographical error, and this subtitle would make that change permanent.

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

[40] *See* D.C. Official Code § 34–1501(27A).
[41] *See* D.C. Official Code § 8–231.01(20).
[42] *See* § 8-771.01(11)(A).

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Department of Health Functions Clarification Act of 2001 to authorize DC Health to regulate medical waste, low-level radioactive waste, and including indoor air and pest management. Requires DC Health to implement the lead poison prevention program to reduce lead exposure in children, pursuant to the Childhood Lead Poisoning Screening and Reporting Act of 2002.

Sec. xxx3 Amends the District Department of Environment Establishment Act of 2005 with clarifying amendments to the Department of Energy and the Environments establishment and responsibilities. Transfers all functions, authority, programs, positions, personnel, property, records, and unexpended balances of appropriations, allocations, and other funds available or made available to DOEE for childhood lead poisoning prevention program or medical waste management to DC Health.

Sec. xxx4 Amends the Childhood Lead Poisoning Screening and Reporting Act of 2002 by amending the definitions of "elevated blood lead level" and "lead-poisoned child" to align with the Lead-Hazard Prevention and Elimination Act of 2008. Authorizes the Mayor to issue rules to provide support to health care providers in delivering appropriate care for the treatment of lead poisoning in children.

Sec. xxx5 Amends the Retail Electric Competition and Consumer Protection Act of 1999 to make clear that a government entity can serve as a subscriber organization.

Sec. xxx6 Amends the Lead-Hazard Prevention and Elimination Act of 2008 to clarify that the elevated blood level standard should be measured in milligrams ("mg"), not micrograms ("µ").

Sec. xxx7 Amends the Sustainable Solid Waste Management Amendment Act of 2014 to correct a typographical error.

Sec. xxx8 Applicability.

Fiscal Impact

The Mayor's 2026 budget and financial plan transfers $1.32 million in fiscal year 2026 and $5.47 million in local funds over the financial plan from DOEE to DC Health to implement the subtitle, and the Committee maintains this funding in the Committee report. The positions that will transfer to DC Health include an Environmental Protection Specialist Supervisor, five Public Health Analysts, an Environmental Protection Specialist, an Epidemiologist, a Public Health Specialist, and a Program Analyst.

The Office of Revenue Analysis reports there are no additional costs related to the Committee's changes.

Subtitle (V)(C) - Environment Health Clarification Amendment Act of 2025 Total DOEE Transfer to DC Health ($ thousands)					
	FY 2026	**FY 2027**	**FY 2028**	**FY 2029**	**Total**
Salary	$1,180	$1,205	$1,229	$1,253	$4,867
Fringe	$141	$147	$153	$160	$601
Total Transfer	$1,320	$1,352	$1,382	$1,413	$5,468

TITLE V, SUBTITLE E. HEALTH CARE ALLIANCE

Purpose, Effect, and Impact on Existing Law

This proposed subtitle makes significant changes to both the Alliance and the Immigrant Children's program (ICP) that will drastically reduce the number of District residents with health insurance. The Mayor introduced this subtitle in response to major spending pressures within the District's healthcare budget, including a projected $27 million increase for the Alliance Program. Specifically, the subtitle proposes:

- Repealing the ICP and adding all ICP beneficiaries to the Alliance program;
- Limiting the services the Alliance program would provide to adult enrollees in FY 2026, including no longer providing coverage for durable medical equipment;
- Codifying the requirement that all Alliance enrollees meet non-financial eligibility factors that include (1) being a District resident and (2) providing a social security number if assigned and available, and creating a timeline for enrollees to meet financial eligibility factors;
- Requiring that beginning March 1, 2026, all applicants for the Alliance Program complete a face-to-face interview to recertify eligibility every 6 months;
- Establishing new requirements to prove residency for the Alliance Program;
- Creating a moratorium for new Alliance enrollees age 21 and over to join the program starting August 1, 2025; and
- Phasing individuals over the age of 21 out of coverage through the Alliance Program beginning October 1, 2027. Those under age 21 who enroll in coverage will be terminated from coverage upon turning 21.

Committee Recommendation and Reasoning

Although the Committee understands the spending pressures faced by the agency, it has serious concerns about the proposed changes to Alliance. Since its inception in 2001, the District has committed to providing health coverage for residents and their families, regardless of immigration status. Reducing benefits and ending adult coverage after FY 2026 could leave many without access to regular health care. This population, often in low-wage, gig-based jobs, may be forced

to forgo primary and preventive care and rely solely on urgent care and emergency departments for health care, which will strain the entire healthcare system. While DHCF has indicated that children's coverage will remain largely unchanged, the Committee is concerned about the chilling effect these policy proposals will have on both adults and children on their ability and willingness to seek coverage and health care. The changes the Committee has made in the Committee Print are intended to reduce as much harm for as many people as possible in a tight fiscal year.

The Committee Print makes several changes to the subtitle as introduced, including:

- Clarifies that the benefits and services limited are specific to the Alliance Program;
- Increases the moratorium age for new Alliance enrollees from 21 to 26 for FY 2026;
- Restores durable medical equipment (DME), such as inhalers, glucose monitors, blood pressure cuffs and more, as a covered benefit for adults and youth;
- Requires the Mayor to go through the Administrative Procedure Act and submit any new rules for Council review;
- Allows proof of enrollment in a District of Columbia public school to count as proof of residency;
- Removes the requirement for in-person recertification for adults;
- Removes the requirement for in-person recertification for youth; and
- Removes the requirement for recertification every 6 months for youth under 19.

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. 5041 Short title.

Sec. 5042 Amends section 2202 of the Medical Assistance Expansion Program Act of 1999 by removing the Mayor's directive to establish the Alliance program. Amends this act by repealing the Immigrant Children's Program.

Sec. 5043 Amends the Health Care Privatization Amendment Act of 2001 by limiting the services provided by the Alliance program for those 21 and older to primary care services, inpatient and outpatient acute-care hospital services, emergency medical transportation services, durable medical equipment and prescription drugs. Amends the services provided by the Alliance program for those under 21 to primary care, dental, durable medical equipment and behavioral health services as may be designated by the Mayor, and specifically excludes home health services, nursing facility services, and services provided by an inpatient psychiatric hospital. Exempts new contract entered into by the Mayor from the requirements of the Procurement Practices Reform Act of 2010. Adds a new subsection to allow the Mayor to limit how many beneficiaries can be enrolled in the program. Repeals the subsection detailing DC Alliance recertification and reporting requirements for the Alliance program.

Sec. 5044 Amends Chapter 33 of Title 22-A of the District of Columbia Municipal Regulations to require all Alliance beneficiaries enrolled or applying for the program meet certain financial and non-financial eligibility requirements including income requirements and acceptable forms of proof of residency. Phases out eligibility for enrollees 21 and older after October 1, 2027. Creates requirement that each applicant aged 19 and older must recertify eligibility every 6 months starting March 1, 2026. Creates moratorium for new enrollees over the age of 26 after August 1, 2025.

Fiscal Impact

The Office of Revenue Analysis estimates the financial impact of the Committee print is $3,723,219 for FY 2026, and $12,112,538 over the financial plan. See below for a breakdown of those costs for each policy change.

Alliance subtitle costs	**FY 2026**	**FY 2027**	**FY 2028**	**FY 2029**	**Total**
Increase moratorium age for new Alliance beneficiaries from 21 to 26	$1,801,051	$4,437,712	$8,724,471	$8,907,685	$23,870,920
Not require in-person certification for adults	$0	$0	$0	$0	$0
No in-person recertification for youth under 19 (no face-to-face)	$197,678	$776,966	$1,019,335	$1,130,969	$3,124,949
Not require recertification every 6 months for youth under 19	$0	$760,435	$997,647	$1,106,906	$2,864,988
Include DME for all adults	$1,379,202	$1,270,151	$0	$0	$2,649,353
Include DME for youth *(Includes assumption for no face-to-face recert and no 6-month recert)*	$345,287	$395,117	$441,709	$490,083	$1,672,196
Allow for public school enrollment to count as proof of residency	$0	$0	$0	$0	$0
Total:	**$3,723,218**	**$7,640,381**	**$11,183,162**	**$11,635,643**	**$34,182,406**

TITLE V, SUBTITLE H. HEALTH OCCUPATION CRIMINAL BACKGROUND CHECKS

Purpose, Effect, and Impact on Existing Law

As introduced in the Mayor's FY 2026 proposed budget, this subtitle amends the District of Columbia Health Occupations Revision Act of 1985 to strike the language requiring the Department of Health or a private agency determined by the Department of Health to obtain

criminal background checks and replace it with language requiring that criminal background checks are forwarded to the Mayor in addition to the appropriate health licensing board.

Committee Recommendation and Reasoning

The Committee recommends the inclusion of this subtitle in the Budget Support Act to improve the efficiency and effectiveness of the health professional licensure process in the District. During the Budget Oversight Hearing, Department of Health Director Dr. Ayanna Bennett emphasized the importance of this subtitle. She explained that allowing the Metropolitan Police Department (MPD) to participate in the FBI's continuous monitoring service—known as the Record of Arrest and Prosecution Back (Rap Back) program—would improve the health professional licensure application process.

Specifically, Rap Back would extend the validity of background checks to five years, eliminating the need for health professionals to complete new checks with each application or renewal. It would also help automate portions of the licensure process, allowing the Department of Health to process applications more quickly and reduce administrative burdens.

The Committee notes that this subtitle should only be included in the BSA if the associated subtitle, Subtitle (III)(E), *District of Columbia Rap Back Program Act of 2025*, which requires MPD to participate in the FBI's Rap Back program, is also included. If Subtitle (III)(E) is included, the Committee recommends including the subtitle in the BSA with technical drafting changes.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the District of Columbia Health Occupations Revision Act of 1985 to strike language requiring the Department of Health or a private agency determined by the Department of Health to obtain criminal background checks; and to require that criminal background checks be forwarded to the Mayor or the appropriate health licensing board.

Fiscal Impact

The OCFO reports that the Mayor's proposed budget allocates revenue collected in the Health Occupation Fund to cover the cost of implementing new background check procedures, and that there is therefore no fiscal impact associated with the Mayor's proposed subtitle.

TITLE V, SUBTITLE I. BASIC HEALTH PROGRAMS

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Health Benefit Exchange Authority Establishment Act of 2011 to give the Health Benefit Exchange (HBX) the authority to establish and operate a new basic health program (BHP).

The BHP is a tool created by the federal Centers for Medicare and Medicaid Services (CMS) used by several other states to increase health care coverage affordability. A BHP allows the state to shift the cost of providing health insurance from traditional Medicaid, where the state pays a percentage of the cost, almost completely to the federal government, while at the same time limiting costs to participants. Please see the HBX Chapter of this report for more details on the planned development and implementation of the BHP in the District.

Committee Recommendation and Reasoning

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

Section-by-Section Analysis

Sec. 5031 Short title.

Sec. 5032 Amends the Health Benefit Exchange Authority Establishment Act of 2011 to give HBX the authority the establish and operate a basic health program.

Fiscal Impact

The Office of Revenue Analysis reports that there is no fiscal impact associated with this subtitle.

TITLE V, SUBTITLE J. 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 repealing the section that dictates the ongoing requirement that Mayor determine the enhanced wages for Direct Support Professionals (DSP) to be, on average, 117.6% of either the District minimum wage or living wage, whichever is higher. This subtitle also repeals the Mayor's annual reporting requirement for the upcoming year's DSP wages. The Mayor's proposed subtitle sets the requirement that direct care service providers are paid 117.6% of the higher of the "then-current" District living wage or minimum wage for FY 2026 only.

The Committee print makes a technical change and amends the Living Wage Act to match the wage-determination language to the language set forth in this subtitle. The Mayor's subtitle as introduced strikes the language that allow direct care service providers to pay lower than the 117.6% as long as they set a tiered compensation schedule that meets certain requirements, so the Committee print adds that requirement back in for determining the FY 2026 rates.

Committee Recommendation and Reasoning

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

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Direct Support Professional Payment Rate Act of 2020 by repealing the reoccurring requirement for Direct Care Service providers to receive enhanced payment at on average 117.6% of the minimum wage or living wage, whichever is higher, to a one-time payment enhancement for FY 2026. Adds exemption that it is not a violation for providers to pay less than the 117.6% if they create a tiered compensation schedule that meets certain requirements.

Fiscal Impact

The Mayor's proposed 2026 budget includes $6.51 million for the enhanced DSP wages. DHCF will make a one-time supplemental payment to fund the wage enhancement for all of fiscal year 2026 using the District living wage as calculated on July 1, 2025. Freezing wages in fiscal year 2026 and discontinuing the enhanced wages beginning in fiscal year 2027 is anticipated to generate savings of $3.9 million ($1.2 million local; $2.7 million federal) in fiscal year 2026 and $270.2 million ($81.1 million local; $189.1 million federal) over the financial plan.

No longer requiring direct care service providers to pay enhanced wages to direct care service professionals beginning in fiscal year 2027 will result in savings of $87.0 million in fiscal year 2027 ($26.1 million local; $60.9 million federal) and $266.2 million ($79.9 million local; $186.4 million federal) over the financial plan.

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

TITLE V, SUBTITLE L. HEALTHY DC AND HEALTH CARE EXPANSION FUND

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Hospital and Medical Services Corporation Regulatory Act of 1996 by reversing the required transfer of $5,567,566 from the Healthy DC Fund to Local funds in Fiscal Years 2025-2028 only for FY 2025, but maintains the requirement transfer for Fiscal Years 2026-2028.

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 moved from the Healthy DC Fund to the General Fund will be repurposed back to the Healthy DC Fund just for FY 2025. The Committee cannot take additional funding from the Healthy DC Fund to use for any Committee-related budget purposes in FY 2025 or FY 2026

because there are restrictions on fund use balances for the remainder of FY 2025 and because the entire fund balance has been allocated for FY 2026.

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

Section-by-Section Analysis

Sec. 5071 Short title.

Sec. 5072 This section amends DC Code 31-3514.02 to revoke the transfer of $5.57 million to the General Fund for FY 2025 only.

Fiscal Impact

The FY 2025 budget includes a transfer of $5,567,566 in dedicated taxes back to the Healthy DC Fund from Local funds. The Committee did not make any changes to the subtitle.

TITLE VII, SUBTITLE H. NON-LAPSING ACCOUNT REPEALS AMENDMENT ACT OF 2025

Purpose, Effect, and Impact on Existing Law

The Mayor's proposed subtitle changes District law establishing 74 special local funds, special purpose revenue funds and dedicated tax funds to make then lapsing, rather than non-lapsing. All funds would become lapsing in fiscal year 2025 except for the Drug-, Firearm- or Prostitution-Related Nuisance Abatement Fund which would become lapsing in fiscal year 2026.

This subtitle includes several funds within the Committee's jurisdiction, including:

- Adverse Health Benefit Decision Grievance Fund (1060132) (DHCF)
- Board of Pharmacy Fund (1060133) (DC Health)
- Communicable and Chronic Disease Prevention and Treatment Fund (1060188) (DC Health)
- Health Occupations Regulation Fund (1060151) (DC Health)
- Healthy DC and Health Care Expansion Fund (1011007) (DHCF)
- Medicaid Collections- 3rd Party Liability (1060128) (DHCF)

Committee Recommendation and Reasoning

The Committee looked into the Funds affected by this subtitle and has concerns about several of the Funds being transitions to nonlapsing. The following includes comments and recommendations on whether each fund should become lapsing.

Board of Pharmacy Fund (1060133) (DC Health)

The Board of Pharmacy Fund, pursuant to D.C. Code § 7–733.02, holds all revenue from licensing facilities, licensing detailers, and notices of infractions issued by the Pharmaceutical Control

Division. This Fund is used to support the staff of that Division. Dr. Bennett testified that this fund can be unpredictable because its partly funded by infractions and the opening of new facilities. However, she said they would monitor whether the transition to a lapsing fund becomes problematic for the agency and address any challenges with the Mayor.

The Committee, therefore, does not oppose changing this Fund to become lapsing.

Communicable and Chronic Disease Prevention and Treatment Fund (1060188) (DC Health)

Changing the Communicable and Chronic Disease Prevention and Treatment (CCDPT) Fund from lapsing to nonlapsing would likely violate federal regulations and threaten the funding source for this Fund. Although the CCDPT Fund can statutorily hold revenue from several sources related to the prevention and treatment of communicable and chronic diseases, including third-party payors, sliding-fee scale collections, and other collections,[43] DC Health only uses the Fund to hold the federal Ryan White 340b rebates for the AIDs Drug Assistance Program (ADAP).

Ryan White 340b rebate funds must be prioritized to fund the ADAP program. In the event there are additional funds, they may be used elsewhere within the agency, but are bound by the same rules and regulations that govern Ryan White grant funds. They are ineligible to be swept as they must be reinvested into the HIV program. This is laid out in U.S. Health Resources and Services Administration regulations, "[R]ebates collected on ADAP medication purchases be applied to the RWHAP Part B Program with a priority, but not a requirement, that the rebates be placed back into ADAP. These rebates must be used for the statutorily permitted purposes under the RWHAP Part B Program, which are limited to core medical services including ADAP, support services, clinical quality management, and administrative expenses (including planning and evaluation) as part of a comprehensive system of care for low-income individuals living with HIV."[44]

The Committee, therefore, strongly recommends striking this Fund from the Mayor's subtitle. To support this change, the Committee has restored the FY 2026-2029 sweeps from the Fund ($3,4400/year).

Health Occupations Regulation Fund (1060151) (DC Health)

Pursuant to D.C. Code § 7–733, the Health Occupations Regulations Fund holds all licensing fees, civil fines, and interest relating to the practice of health occupations in the District of Columbia. This revenue is used to fund DC Health staff that manage the District Health Professional Licensing Boards and who process the applications, as well as related IT and administrative costs.

Although this Fund has traditionally fluctuated dramatically over the course of the fiscal year, since all license holders in each profession would have to renew by the same date, DC Health has recently transitioned to having license holders renew on their birthday months. This should create

[43] D.C. Code § 7–736.02.
[44] U.S. Health Resources and Services Administration, PCN 15-04, General Guidance and Expectations (Revised 01/11/2019), https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-04-pharmaceutical-rebates.pdf (last visited June 18, 2025).

a more steady and predictable source of revenue for the Fund, although DC Health did testify that there could end up being some large end-of-year balances on a year where several large classes of license holders at recertifying and there are a lot of August and September birthdays.

The Committee believes that there is too much uncertainty this year, while the agency is transitioning to the new license renewal calendar, to also transition this Fund to lapsing. Further, the Committee believes that if there continue to be regular balances in this fund at the end of the fiscal year, DC Health should consider lowering the application fees for licensed health professionals, rather than the funds going towards the general fund.

Therefore, the Committee recommends striking this Fund from the Mayor's subtitle.

Recommendations for New Subtitles

The Committee recommends the following new subtitles of the "Fiscal Year 2026 Budget Support Act of 2025":

- Department of Health Licensure Pathways Program
- Grocery Access Pilot Program
- School-Based Behavioral Health Program Strengthening
- Substance Use and Behavioral Health Services Targeted Outreach Grant
- Opioid Abatement Directed Funding and Opioid Abatement Advisory Commission Structure
- Long Term Care Strategic Coordinator
- Health Care and Public Benefits Ombudsman Program
- Subject to Appropriations Repeals

The legislative language is included in Attachment G.

TITLE V, SUBTITLE X DEPARTMENT OF HEALTH LICENSURE PATHWAYS PROGRAM.

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Department of Health Functions Clarification Act of 2001 by adding a new section establishing a Health Licensure Pathways program within the Department of Health. The program would assist internationally trained health professionals and provide Guidance on the licensure application process, information on examinations, educational requirements, and training requirements, assistance with accessing resources for language support and exam preparation, and any other services the Department of Health deems necessary.

Committee Recommendation and Reasoning

The Committee on Health's subtitle, as introduced, supports internationally trained health professionals in navigating the often complex process of obtaining licensure in the District.

The program would provide guidance on the licensure application process, including information about required examinations, educational and training prerequisites, and available pathways to

meet those requirements. It would also assist applicants in accessing resources for language support and exam preparation. Additionally, the Department of Health would have the flexibility to offer other services deemed necessary to help internationally trained professionals overcome barriers to licensure.

The Committee finds that this subtitle is an important step toward strengthening the District's health workforce by recognizing and supporting the talents of internationally trained professionals.

The Committee recommends inclusion of this subtitle in the Budget Support Act.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Department of Health Functions Clarification Act of 2001 by adding a section establishing a Health Licensure Pathways program; requires the Health Licensure Pathways program to provide internationally trained health professionals with guidance on the licensure application process, information on examinations, educational requirements, and training requirements, assistance with accessing resources for language support and exam preparation, and any other services the Department of Health deems necessary.

Fiscal Impact

The Office of Revenue Analysis reports that there is a fiscal impact associated with the Committee's subtitle:

- Salary and fringe: Program Coordinator (Union Position, Grade 12, Step 5 – Salary: $104,168): This person would be responsible for administering the program
- Supplies (IT): $4,000 in one-time costs for IT equipment for the Program Coordinator

The Committee has provided full funding for this subtitle in the Committee budget report.

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 continue a grocery access grant pilot program that the Committee created in the FY 2025 budget 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. This subtitle would extend the pilot to operate for a second year in FY 2026.

Committee Reasoning

By offering membership to a grocery delivery service at no cost for two years 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.

In the FY 2026 pre-hearing responses and at the Budget Oversight Hearing, DC Health testified that it had taken longer than usual to finalize the grant agreement for this program, so the pilot will start July 1, 2025. The grantee, Martha's Table, will contract with Instacart to distribute 1,000 Instacart+ Membership Codes to 1,000 residents. DC Health has also supplemented the program with federal funds so that Martha's Table will also provide $75/month in Instacart food funds to 200 residents for six months. DC Health testified that it would be helpful to continue the pilot for 2 years in order to understand the effectiveness of the intervention.

The Committee recommends inclusion of this subtitle in the Budget Support Act.

Section-by-Section Analysis

Section xxx1 Short title.

Section xxx2 Amends the Department of Health Functions Clarification Act of 2001 to continue the grocery access grant pilot program for a second year.

Fiscal Impact

The Office of Revenue Analysis reports that the cost of this subtitle is $120,000 in one-time funds. The Committee has provided full funding for this subtitle in the Committee budget report.

TITLE V, SUBTITLE X. SCHOOL-BASED BEHAVIORAL HEALTH PROGRAM STRENGTHENING

Purpose, Effect, and Impact on Existing Law

The School-Based Behavioral Health Program Strengthening Act of 2025 requires DBH in FY 2026 to award grants to CBOs in an amount no less than $120,000 per school; places limits on how DBH may restrict the use of grant funds; and requires the agency to collect salary information for all CBO clinicians funded through the program. In addition, the subtitle mandates that DBH submit a comprehensive improvement plan to the Council and the Mayor by October 15, 2025, outlining the agency's strategy to strengthen and transform the SBBH Program.
The subtitle requires DBH to submit an improvement plan that includes the following:

1. **A strategic vision for the SBBH program**, outlining how DBH will strengthen and transform the program to meet the behavioral health needs of students using a public health framework.

2. **Findings from the recent environmental scan** and an explanation of how those findings will inform clinician assignments, resource allocation, and the use of risk-based models.
3. **An evaluation of DBH's pilot initiatives**, including lessons learned and how those findings will shape future program design.
4. **A review and proposed revision of the SBBH funding model**, including strategies to improve Medicaid billing, adjust clinician subsidy levels, address financial sustainability for community-based providers, and address barriers to billing.
5. **A workforce development and supervision strategy**, addressing recruitment and retention, supervision for graduate-level staff, licensure issues, and professional development for both DBH and CBO clinicians.
6. **A framework for integration between behavioral health clinicians and school nurses**, developed in consultation with the DC Health, to support coordinated care in school settings.
7. **A review and potential update of clinician performance metrics, curriculum standards, and quality assurance protocols**, with a focus on accountability and improved service delivery outcomes.
8. **An assessment of the feasibility of a shared or interoperable electronic health record (EHR) system** for DBH and CBO clinicians to improve care coordination and data tracking.
9. **A summary of clinician feedback**, including perspectives from DBH-employed and CBO-employed staff on program strengths, challenges, and opportunities for improvement.
10. **A proposal to revise the structure and function of the SBBH Coordinating Council**, including its membership, responsibilities, and role in supporting program accountability and transparency.
11. **A timeline and implementation plan**, including major milestones, responsible entities, and any necessary legislative or budgetary changes to support the transformation of the program.

Committee Reasoning

This subtitle reflects the Committee's response to longstanding oversight findings, direct feedback from stakeholders, and persistent implementation challenges related to the SBBH Program. Over multiple years of program growth, the Committee has identified ongoing concerns with program monitoring, grant administration, staffing coordination, and the ability to respond effectively to school-level needs. Despite significant investments and expansion, the program has not consistently delivered the level of oversight, integration, or responsiveness required to meet the behavioral health needs of District students.

The Committee considered transferring the SBBH Program from the DBH to DC Health, beginning July 1, 2026, in response to ongoing oversight findings, stakeholder input, and persistent implementation challenges.

In response, DBH Director Dr. Barbara Bazron submitted a letter on June 19, 2025, describing the proposed transition as premature and requesting time for the agency to implement a new vision. Her letter outlined DBH's planned reforms, including engaging a national expert, revising the funding model, using school-level data to guide clinician placement, integrating services with

school nurses, improving billing and supervision, and reevaluating pilot initiatives and the Coordinating Council.

The Committee has agreed to pause the transition and instead this subtitle requires DBH to submit a comprehensive improvement plan to the Council and the Mayor by October 15, 2025. The Committee will continue regular oversight and expects DBH to follow through on its stated commitments. Should DBH fail to submit the plan or begin timely implementation, the Committee will revisit the transition proposal for the 2026–2027 school year.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Department of Mental Health Establishment Amendment Act of 2001 to award grants to community-based organizations for the operation of the SBBH Program at a rate of no less than $120,000 per clinician; places limits on how DBH may restrict the use of grant funds; and requires the agency to collect salary information for all CBO clinicians funded through the program. This section also mandates that DBH submit a comprehensive improvement plan to the Council by October 15, 2025, outlining the agency's strategy to strengthen and transform the SBBH Program.

Fiscal Impact

The Office of Revenue Analysis reports that there is no fiscal impact associated with this subtitle.

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

Purpose, Effect, and Impact on Existing Law

The purpose of this subtitle is to require DBH to continue to provide, for a third year, grant funding by October 31, 2025 to provide direct support, relationship development, and resource brokering to individuals in need of substance use and behavioral health services at six sites with high drug activity and substance use in Wards 1, 5, 6, 7 and 8.

The subtitle provides $800,000 from the Opioid Abatement Fund to support outreach services at four priority locations:

5. The vicinity of the 600 block of T Street, NW;
6. The vicinity of the of the 1300-1700 blocks of North Capitol Street, NW, and the 1600-1700 blocks of Lincoln, Road, NE.;
7. The 3800–4000 blocks of Minnesota Avenue, NE; and
8. The 1300–1800 blocks of Marion Barry Avenue, SE.

The Committee is please to accept a transfer of $200,000 from the Committee on Transportation and the Environment to DBH for a fifth site in Ward 6. These funds will be

used by DBH to award a grant to an organization that will provide targeted outreach and support services in the vicinity of the King Greenleaf Recreation Center, located at 201 N Street, SW.

For a third year, the Committee is also pleased to accept a transfer of $750,000 in recurring funds from the Committee on Public Works and Operations to DBH. 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.

Committee Reasoning

Since 2018, the District has lost 2,660 residents to fatal opioid overdoses. However, for the first time in several years, the number of fatal overdoses has declined significantly. According to the LIVE.LONG.DC dashboard, preliminary data show an encouraging reduction in opioid-related fatalities from March 2024 through early 2025. Specifically, the District reported approximately 344 fatal opioid overdoses in 2024, representing a nearly 33 percent decrease from the 516 deaths reported in 2023. Encouragingly, this trend has continued into 2025, and the Committee awaits updated data from the Office of the Chief Medical Examiner (OCME). Non-fatal overdoses also declined in 2024, with 4,798 reported, which was a 6.3 percent decrease from 2023.[45] While modest, this reduction reinforces the ongoing need for strategies for prevention and intervention.

Despite the overall decline, opioid overdoses continue to disproportionately affect older Black men, particularly those living in Wards 5, 7, and 8. Between February 2024 and January 2025, Black men accounted for 71 percent of all fatal overdoses. Nearly 60 percent of those who died were aged 50 or older.

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 third year of the pilot. The goal is to pilot the effectiveness of an influx of direct support, relationship development, and resource brokering for individuals in need of substance use 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 3 years, the Office of Ward 1 Councilmember Brianne Nadeau has been coordinating with the Mayor's Office of Neighborhood Engagement, local Advisory Neighborhood Commissions, businesses,

[45] DC Overdose Dashboard

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 use and behavioral health issues faced by these individuals.

2. **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.
3. **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.
4. **The vicinity of the 3800-4000 blocks of Minnesota Avenue, N.E.:** There is serious drug use in the 3800-4000 blocks of Minnesota Ave., N.E. 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.
5. **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. Advisory Neighborhood Commission 8A has received concerns from community residents regarding drug use in the area, as well as concerns regarding a nearby methadone clinic.

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:

- 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.

Each of these areas 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. The deployed targeted outreach team improve access to treatment, provide harm reduction services, and address the root causes of drug use in the area. The Committee believes it is important to continue this intervention for a third year.

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 $1,750,000 to a 501(c)(3) organization to provide direct support, relationship development, and resource brokering to individuals in need of

substance use and behavioral health services in the (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. 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 2026 to the same organizations that were awarded grants in FY 2025.

Fiscal Impact

The Office of Revenue Analysis estimates that the Financial Impact of this subtitle is $1,750,000 in one-time funding, which is equal to the cost of the grants. The Committee has provided full funding for this subtitle in the Committee budget report.

TITLE V, SUBTITLE X. OPIOID ABATEMENT DIRECTED FUNDING & OPIOID ABATEMENT ADVISORY COMMISSION STRUCTURE

Purpose, Effect, and Impact on Existing Law

The purpose of this subtitle is to strengthen the District's opioid response infrastructure by (1) directing specific uses of opioid settlement funds in FY 2026 to critical behavioral health and public health initiatives, and (2) restructuring the Opioid Abatement Advisory Commission to improve its effectiveness. The subtitle also establishes new governance expectations for Commission leadership and engagement practices, and provides targeted support for urgent mental health services within the District's justice system.

This subtitle amends several sections of existing law to implement the directed uses of opioid settlement funds and to restructure the governance of the District's opioid response. It amends the Opioid Abatement Fund Establishment Act of 2022 to authorize the use of $2,107,000 in FY 2026 for targeted outreach, peer educator stipends, drug testing infrastructure at the Office of the Chief Medical Examiner, and operational support for a courthouse-based mental health urgent care clinic.

It also amends the Opioid Litigation Proceeds Amendment Act of 2022 to restructure the Opioid Abatement Advisory Commission. The amendments expand Commission membership, add qualifications for leadership, authorize the election of co-chairs, permit the formation of subcommittees, and codify regular consultation with District agencies responsible for health, safety, and social services.

Lastly, it amends the Department of Behavioral Health Establishment Act of 2013 to provide clear legal authority for DBH to contract with a nonprofit provider to operate a mental health urgent care clinic within the D.C. Superior Court. This clinic is intended to serve individuals engaged with the legal system and address urgent behavioral health needs.

Committee Reasoning

The Committee recommends this subtitle to strengthen the operations and impact of the Opioid Abatement Advisory Commission, refine the District's opioid abatement strategy, and safeguard core behavioral health services at risk due to recent budget reductions.

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 2026 budget includes $16,000,000 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[46]. 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").

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.

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 use, promoting behavioral health services, and enhancing community well-being. The initiatives include:

- **$400,000** for advanced toxicology work at the Office of the Chief Medical Examiner, enabling real-time detection of emerging opioids and other lethal adulterants. Without this capacity, agencies would lack the data needed to tailor prevention and treatment strategies.
- **$800,000** for Substance Abuse and Behavioral Health Targeted Outreach Grants in high-need corridors of Wards 1, 5, 7 and 8 , where outdoor drug use endangers residents and strains neighborhood safety. Outreach teams will provide harm-reduction supplies, build trust, and connect individuals to treatment and housing.
- **$907,000** to DBH to contract with a non-governmental organization to fund the operation of the 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 as identified in the Mental Health Court Urgent Care Clinic Amendment Act of 2024. The UCC provides a vital entry point to treatment for court-involved individuals, many of whom have unmet mental health and substance use needs. Through same-day assessments and immediate referrals to detox, inpatient, and outpatient care, the UCC helps connect individuals to substance use disorder treatment services and reduce further justice system involvement.

[46] Opioid Litigation Proceeds Amendment Act of 2022." D.C. Law 24-315.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Opioid Abatement Fund Establishment Act of 2022 to direct funds toward targeted behavioral health and substance use outreach in Wards 1, 5, 7 and 8; testing of illicit drug use and development of novel opioid detection methods at the Office of the Chief Medical Examiner's Forensic Toxicology Lab and Data Fusion Center; and restoration of funding for the Mental Health Urgent Care Clinic.

Sec. xxx3 Amends the Opioid Litigation Proceeds Act of 2022 to implement governance reforms, including reducing the size of the Opioid Abatement Advisory Commission and clarifying membership categories.

Sec. xxx4 Amends the Department of Behavioral Health Establishment Act of 2013 to require DBH to 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.

Fiscal Impact

The Office of Revenue Analysis estimates that the Financial Impact of this subtitle is $2,107,000 in recurring funds, which is equal to the cost of the contract. The Committee has provided full funding for this subtitle in the Committee budget report.

TITLE V, SUBTITLE X. LONG TERM CARE STRATEGIC COORDINATOR

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Study of Long-Term Care Facilities and Long-Term Care Services Act of 2018 by adding a new section that establishes within the office of the Deputy Mayor for Health and Human Services (DMHHS) a new position, a Long-Term Care Strategic Coordinator role. This role would be responsible for the following activities:

- Coordinating the Age-Friendly DC program;
- Tracking the long-term care services provided by agencies under the purview of DMHHS (health agencies)
- Using data to develop a strategy to improve and increase the capacity of the long-term care services workforce to meet the District's needs;
- Identifying points of contact within each relevant agency outside of the health agencies, including the Deputy Mayor for Education and the Department for Aging and Community Living, to avoid duplication of work across agencies and to ensure each agency's work aligns with the broader mission of supporting the District's aging population and long-term care workforce; and
- Other duties relevant to support the long-term care workforce as may be identified and assigned by DMHHS.

The Committee would repurpose the currently vacant role of the Age-Friendly Coordinator within DMHHS for this role.

Committee Reasoning

In 2022, the Mayor convened a Healthcare Workforce Task Force, which released a report highlighting the need to rebuild, strengthen, and grow the District's healthcare workforce. The report made specific recommendations address supply-and-demand challenges in the healthcare workforce. A well-supported long-term care workforce is integral in the system of caretaking for the elderly. While the Task Force helped identify priorities, the Executive has not taken coordinated strategic actions since the report's release. Although various agencies, both within and outside the health cluster, are working on related efforts, there is no designated leader to drive a comprehensive approach to supporting the long-term care workforce and seniors in the District.

The Committee held a roundtable in March 2025, Strategies to Support the District of Columbia's Long-Term Care Workforce, to hear from the public and the Executive regarding previously existing challenges District residents and workers face in the District's task to support the health and wellbeing of our aging population and long-term care workforce. At the roundtable, stakeholders consistently emphasized the need for a whole-of-government approach and a coordinated strategy including educational institutions, training providers, consumers, family members, advocated, long-term care providers, and government agencies. This collaboration will be critical to create and implement a sustainable plan to address the workforce shortage and support the District's aging population.

The Committee believes this Long-Term Care Strategic Coordinator role, housed within DMHHS would be well-positioned to address interagency silos, convene the necessary government stakeholders, and serve as a liaison within the government and to non-government partners.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Study of Long-Term Care Facilities and Long-Term Care Services Act of 2018 by adding a new section to establish a new Long Term Care Strategic Coordinator Role.

Fiscal Impact

The Office of Revenue Analysis estimates there is no additional financial impact for this role as it is repurposing a currently vacant position and is not growing the size of the office.

TITLE V, SUBTITLE X. HEALTH CARE AND PUBLIC BENEFITS OMBUDSMAN PROGRAM

Purpose, Effect, and Impact on Existing Law

The subtitle amends the Health Care Ombudsman Program Establishment Act of 2024 to expand the scope of the Health Care Ombudsman and Bill of Rights (OHCBOR) Program by allowing them to counsel and assist individuals applying for, currently receiving, or adversely impacted by a public benefits determination, in addition to matters pertaining to health care coverage. The public benefits specifically refer to those administered by the Economic Services Agency within the Department of Human Services. The subtitle also moves the newly expanded Health Care and Public Benefits Ombudsman Program officially under the Department of Health Care Finance. Finally, the subtitle requires the Ombudsman include in its annual report to the Council, the Department of Human Services, Department of Health Care Finance, and the Deputy Mayor for Health and Human Services challenges they experience with the DC Access System for oversight purposes.

Committee Reasoning

The Committee on Health worked closely with the Committee on Human Services to develop this subtitle. The Health Care Ombudsman and Bill of Rights (OHCOBR) office at DHCF is a high-performing office; in FY 2024, the office filed a total of 202 administrative hearing requires on behalf of beneficiaries and the office was able to determine that 167 (83%) were resolved successfully in favor of the beneficiary. OHCOBR was able to resolve numerous complaints without needing to submit formal complains. Notably, in FY 2024 performance oversight responses, OHCOBR data showed that 6 of the 202 administrative hearing requests were related to the Supplemental Nutrition Assistance Program (SNAP) – a public benefit, not a health care insurance related issue. By April 2025 the office had helped at least 17 residents in responding to SNAP-related issues. Committee staff met with OHCOBR staff in early 2025 and they shared their mission is to help anyone who calls their office to the best of their ability despite not being formally tasked with responding to resident issues related to public benefits.

This subtitle expands the scope and size of OHCOBR to formally give the office authority to assist District residents with matters pertaining to their public benefits. In the upcoming fiscal year where eligibility requirements for the District's Medicaid and Alliance program and access to public benefits may be tightened, it is crucial to have an office working on behalf of DC residents who may need assistance navigating the systems as they change.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Health Care Ombudsman Program Establishment Act of 2004 to rename the Health Care Ombudsman the Health Care and Public Benefits Ombudsman ("Ombudsman"); expand the scope of the office to include counsel and assistance for individuals applying for, or receiving public benefits, or those adversely impacted by a public benefits determination, and help District residents access public benefits options; move the Ombudsman to DMHHS and delegate authority to operate the program to DHCF; require the Ombudsman to include in its annual report to DHS, DHCF, DMHHS and the Council the activities, performance, and fiscal accounts of the program including any issues with the DC

Access system; require DHS to display information about the Ombudsman program on their website.

Fiscal Impact

The Office of Revenue Analysis estimates this position will require 2 FTEs which will cost $619,100 over the financial plan. The Committee has provided full funding for this subtitle in the Committee budget report.

TITLE V, SUBTITLE X. SUBJECT TO APPROPRIATIONS 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 Periods 25 and 26:

- Certificate of Need Improvement Amendment Act of 2025, effective June 10, 2025 (D.C. Law 26-7; 72 DCR 4878);
- Child Behavioral Health Services Dashboard Amendment Act of 2024, effective March 7, 2025 (D.C. Law 25-279; 72 DCR 3090);
- Farmers Market Support Amendment Act of 2025, approved on 2nd reading on June 17, 2025 (Enrolled Bill 26-109); and
- Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024, effective March 21, 2025 (D.C. Law 25-0304; 72 DCR 003666)**.**

Committee Reasoning

The Committee is pleased to fund several critical pieces of legislation considered and approved by the Committee during these Council Periods.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Repeals section 4 of D.C. Law 26-7, the Certificate of Need Improvement Amendment Act of 2025, effective June 10, 2025.

Sec. xxx3 Repeals section 3 of D.C. Law 25-279, the Child Behavioral Health Services Dashboard Amendment Act of 2024, effective March 7, 2025.

Sec. xxx4 Repeals Section 5 of the Farmers Market Support Amendment Act of 2025, approved on 2nd reading on June 17, 2025 (Enrolled version of Bill 26-109).

Fiscal Impact

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

1. Certificate of Need Improvement Amendment Act of 2025, effective June 10, 2025 (D.C. Law 26-7; 72 DCR 4878)
    a. The Committee requested an updated Financial Impact Statement from ORA during the FY 2026 budget formulation process. The update FIS is included below and the funds are allocated as follows:
        i. $205,000.00 in FY26 recurring local funds for Program 700402 Development Of The State Health Plan And Annual Implementation - FY26, Cost Center 70587 State Health Planning And Development Agency (SHPDA), Account 7132001 Contractual Services - Other to fund CON Application Fee Reduced Revenue for B26-25, Certificate of Need Improvement Amendment Act of 2025.
        ii. $214,000.00 in FY26 recurring local funds for Program 700402 Development Of The State Health Plan And Annual Implementation - FY26, Cost Center 70587 State Health Planning And Development Agency (SHPDA), Account 7011001 Continuing Full Time to fund Salary for B26-25, Certificate of Need Improvement Amendment Act of 2025 for one Grade 12, Step 6 Management Analyst.
        iii. $47,000.00 in FY26 recurring local funds for Program 700402 Development Of The State Health Plan And Annual Implementation - FY26, Cost Center 70587 State Health Planning And Development Agency (SHPDA), Account 7014008 Misc Fringe Benefits to fund Fringe for B26-25, Certificate of Need Improvement Amendment Act of 2025 for one Grade 12, Step 6 Management Analyst.
        iv. $84,000.00 in FY26 one time and $36,000.00 in FY26 recurring local funds for Program 700402 Development Of The State Health Plan And Annual Implementation - FY26, Cost Center 70587 State Health Planning And Development Agency (SHPDA), Account 7131035 It Hardware Maintenance to fund IT Cost and Maintenance for B26-25, Certificate of Need Improvement Amendment Act of 2025.

The following FIS is based on FY 2025-FY 2028, but the Office of Revenue Analysis confirmed that these costs would be the same for FY 2026- FY 2029.

Bill 26-25 - Certificate of Need Improvement Amendment Act of 2025 Total Cost ($ in thousands)					
	FY 2025	FY 2026	FY 2027	FY 2028	Total
CON Application Fee Reduced Revenue	$205	$205	$205	$205	$820
Salary[a]	$214	$218	$222	$227	$881
Fringe[b]	$47	$49	$51	$53	$201
IT Cost and Maintenance[c]	$120	$36	$36	$36	$228
Total	$586	$508	$515	$521	$2,130

2. Child Behavioral Health Services Dashboard Amendment Act of 2024, effective March 7, 2025 (D.C. Law 25-279; 72 DCR 3090)

a. The Committee requested an updated Financial Impact Statement from ORA during the FY 2026 budget formulation process. The update FIS is included below and the funds are allocated as follows:
    i. $90,805.00 in FY26 recurring local funds for Program 700026 Family Health, Cost Center 70058 Family Health Bureau, Account 7011001 Continuing Full Time to fund Salary for B25-0759 - Child Behavioral Health Services Dashboard Amendment Act of 2025 for one Grade 12, Step 5 Data Analyst.
    ii. $20,794.00 in FY26 recurring local funds for Program 700026 Family Health, Cost Center 70058 Family Health Bureau, Account 7014008 Misc Fringe Benefits to fund Fringe for B25-0759 Child Behavioral Health Services Dashboard Amendment Act of 2025 for one Grade 12, Step 5 Data Analyst.

	FY26	FY27	FY28	FY29	Total
Salary	$90,805	$92,712	$94,566	$96,457	$374,541
Fringe	$20,794	$21,741	$22,697	$23,694	$88,926
Total	$111,599	$114,452	$117,263	$120,152	$463,466

3. Farmers Market Support Amendment Act of 2025, approved on 2nd reading on June 17, 2025 (Enrolled version of Bill 26-109)
    a. The Committee requested an updated Financial Impact Statement from ORA during the FY 2026 budget formulation process. The update FIS is included below. The Committee was able to identify funding to cover all costs except for the Farmers Market Grant Program. The funds are allocated as follows:
        i. $117,029.00 in FY26 recurring local funds for Program 700028 Nutrition And Physical Fitness, Cost Center 70057 Nutrition And Physical Fitness Bureau, Account 7011001 Continuing Full Time to fund Salary for B26-0109 - Farmers Market Support Amendment Act of 2025 for one Grade 13, Step 4 Public Health Analyst.
        ii. $26,800.00 in FY26 recurring local funds for Program 700028 Nutrition And Physical Fitness, Cost Center 70057 Nutrition And Physical Fitness Bureau, Account 7014008 Misc Fringe Benefits to fund Fringe for B26-0109 - Farmers Market Support Amendment Act of 2025 for one Grade 13, Step 4 Public Health Analyst.
        iii. $250,000.00 in FY26 recurring local funds for Program 700028 Nutrition And Physical Fitness, Cost Center 70057 Nutrition And Physical Fitness Bureau, Account 7141007 Grants & Gratuities to fund Grants for B26-0109 - Farmers Market Support Amendment Act of 2025.
        iv. $50,000.00 in FY26 recurring local funds for Program 700028 Nutrition And Physical Fitness, Cost Center 70057 Nutrition And Physical Fitness Bureau, Account 7131033 Marketing to fund Marketing for B26-0109 - Farmers Market Support Amendment Act of 2025.
        v. $50,000.00 in FY26 recurring local funds for Program 700028 Nutrition And Physical Fitness, Cost Center 70057 Nutrition And Physical Fitness Bureau, Account 7111002 Office Supplies to fund Program Supplies for B26-0109 - Farmers Market Support Amendment Act of 2025.

DC Health	FY2026	FY2027	FY2028	FY2029	Total
Salary	$117,029	$119,487	$121,876	$124,314	$482,706
Fringe	$26,800	$28,019	$29,251	$30,537	$114,607
Grants	$250,000	$250,000	$250,000	$250,000	$1,000,000
Marketing	$50,000	$50,000	$50,000	$50,000	$200,000
Program Supplies	$50,000	$50,000	$50,000	$50,000	$200,000
Total	$493,829	$497,506	$501,127	$504,851	$1,997,313

DLCP	FY2026	FY2027	FY2028	FY2029	Total
IT Update	$225,000	$250,000	$0	$0	$475,000

4. B25-0692 - Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024, effective March 21, 2025 (D.C. Law 25-0304; 72 DCR 003666)
    a. The Committee requested an updated Financial Impact Statement from ORA during the FY 2026 budget formulation process. The update FIS is included below. The Committee was able to identify funding to cover all costs except for the Farmers Market Grant Program. The funds are allocated as follows:
        a. $126,000.00 in FY26 recurring for Program 700281 Community Response Team, Cost Center 70412 Community Response Office, Account 7011001 Continuing Full Time to fund B25-0692 - Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024 - Salary for one Grade 14, Step 5 FTE.
        b. $34,000.00 in FY26 recurring for Program 700281 Community Response Team, Cost Center 70412 Community Response Office, Account 7014008 Misc Fringe Benefits to fund B25-0692 - Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024 – Fringe for one Grade 14, Step 5 FTE.
        c. $340,000.00 in FY26 one time for Program 700281 Community Response Team, Cost Center 70412 Community Response Office, Account 7132001 Contractual Services - Other to fund B25-0692 - Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024 - Training Development - One Time.
        d. $40,000.00 in FY26 recurring for Program 700281 Community Response Team, Cost Center 70412 Community Response Office, Account 7132001 Contractual Services - Other to fund B25-0692 - Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024 - Training Development - ongoing.
        e. $125,000.00 in FY26 recurring for Program 700281 Community Response Team, Cost Center 70412 Community Response Office, Account 7131009 Prof Service Fees & Contr to fund B25-0692 - Enhancing Mental Health

Crisis Support and Hospitalization Amendment Act of 2024 - Awareness Campaign.

	FY 2026	FY 2027	FY 2028	FY 2029	Total
Salary	$124,091	$126,697	$129,231	$131,815	$511,834
Fringe	$33,629	$35,159	$36,705	$38,319	$143,811
IT Contract	$380,000	$40,000	$40,000	$40,000	$500,000
Awareness Campaign	$125,000	$127,500	$130,050	$132,651	$515,201
Total	$662,720	$329,356	$335,986	$342,785	$1,670,846

Committee Action and Vote

On Monday, June 23, 2025, at 3:00PM, 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 2026 budget for the agencies under its jurisdiction, the provisions of the FY 2026 Budget Support Act of 2025 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 2026 Local Budget Act recommendations, the Committee's Fiscal Year 2026 Budget Support Act of 2025 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, Health Policy Advisor Rebecca Cooper, Legislative Assistants Ashley Strange and Nneka Onyekwuluje, and Legislative Aide 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 May 30, 2025 (public witnesses) and June 2, 2025 (government witness), Fiscal Year 2026 Budget Oversight Hearing for the Department of Behavioral Health

Attachment I: Witness List and Testimony Submitted for the June 5, 2025 (public witnesses) and June 9, 2025 (government witness), Fiscal Year 2026 Budget Oversight Hearing on the DC Health Benefit Exchange Authority, Office of the Deputy Mayor for Health and Human Services, and the Department of Health Care Finance

Attachment J: Witness List and Testimony Submitted for the June 6, 2025 (public witnesses) and June 16, 2025 (government witness), Fiscal Year 2026 Budget Oversight Hearing for the Department of Health