COUNCIL OF THE DISTRICT OF COLUMBIA
Office of the Budget Director

Jennifer Budoff
Budget Director

TO:	**The Honorable Phil Mendelson** **Chairman, Council of the District of Columbia**
FROM:	**Jennifer Budoff** **Budget Director, Council of the District of Columbia**
DATE:	**April 29, 2022**
SUBJECT:	**Certification of the Report and Recommendations of the Committee on Health on the Fiscal Year 2023 Budget and Financial Plan for Agencies Under Its Purview**

This is to certify that the Office of the Budget Director has reviewed the Report and Recommendations of the Committee on Health on the Fiscal Year 2023 Budget and Financial Plan for Agencies Under Its Purview and found it to be balanced and compliant with Council Rule 703(b).

If you have any questions, please do not hesitate to call me at 724-5689.

Jennifer Budoff

COMMITTEE ON HEALTH

VINCENT C. GRAY, CHAIRPERSON
FISCAL YEAR 2023 COMMITTEE BUDGET REPORT

TO: Members of the Council of the District of Columbia

FROM: Councilmember Vincent C. Gray
Chairperson, Committee on Health

DATE: April 20, 2022

SUBJECT: Report and Recommendations of the Committee on Health on the Fiscal Year 2023 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 2023 ("FY 2023") 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 2023 Budget Support Act of 2022, as proposed by the Mayor.

TABLE OF CONTENTS

I. SUMMARY 1

A. Executive Summary 3
B. Fiscal Year 2021 Agency Operating Budget Summary 5
C. Fiscal Year 2021 Agency Full-Time Equivalent 6
D. FY 2021 - 2026 Agency Capital Budget Summary 7
E. Transfers In from Other Committees 8
F. Transfers Out to Other Committees 9
G. Revenue Adjustment 10
H. Funding of Legislation 10

II. AGENCY FISCAL YEAR 2021 BUDGET RECOMMENDATIONS 11

A. Introduction 11
B. Department of Health (DC Health) (HC0). 14
C. Department of Behavioral Health (RM0). 25
D. Department of Health Care Finance (HT0). 38
E. Office of the Deputy Mayor for Health and Human Services (HG0). 47
F. Not-for-Profit Hospital Corporation and Subsidy (HW0) (HX0). 50
G. DC Health Benefit Exchange Authority (HI0). 53

III. TRANSFERS TO OTHER COMMITTEES 57

IV. BUDGET SUPPORT ACT RECOMMENDATIONS 57

A. Recommendations on Mayor's Proposed Subtitles 58
1. Subtitle V-A. Medicaid Home Community Based SEF 58
2. Subtitle V-C. Alliance Enrollment 59

B. Recommendations for New Subtitles 61
1. Subtitle X. Behavioral Health Awareness Fund 61
1. Subtitle X. First-Time Mothers Home Visting Program 62
2. Subtitle X. Materal Mental Health Task Force. 63

V. COMMITTEE ACTION AND VOTE 65

VI. ATTACHMENTS 68

I. SUMMARY

A. EXECUTIVE SUMMARY

The Fiscal Year 2023 proposed budget from the Executive Branch continued a series of investments in public health with the aim of advancing health equity for residents in the District of Columbia. Recognizing the need for more support for students

Supports Healthy Returns for School Children

- The Committee increases the investment in school nurses an additional $1,396,631 over four years on top of the $4,500,000 one-time funding of the Mayor's proposed budget increase for this program.

- Invests $2,400,000 in recurring funding in the School-Based Mental Health Program to increase the CBO grant amount for school-based mental health clinicians from $70,000 to $80,000.

Continued Investments in Birth to Three

- Provides $700,000 for funding for Healthy Futures to expand this program to an additional site with the ability to reach more families in need of services.

- Provides $300,000 to fund the expansion of the Healthy Steps Program for an additional site in wards 5, 7, or 8.

Improvement in Licensure Processing and Health Facility Inspections

- Provides an additional $932,131 for a total of 10 FTEs to support reviewing and processing professional licenses in the Department of Health.

- Provides an additional $116,220 to fund 1.0 FTE to inspect long term care and rehabilitation facilities to ensure compliance protocols and complaints are properly and timely addressed.

Continued investment in Mental Health and Wellness for Yong Girls and Mothers

- Provides an additional $150,000 in one-time funding to continue a home visiting program for first-time mothers who are eligible for Medicaid benefits.
- Provides $118,000 in one-time funding for a Maternal Mental Health Task Force
- Provides $75,000 to support a mental health services position for programs designed to promote healthy development in girls attending DCPS and public charter schools in grades 8-12

Invests in Food Security Programs

- Provides $150,000 in one-time funding and another $100,000 in recurring funds for Healthy Corners to support the increase cost of the program
- Provides $200,000 in recurring funds to increase the program costs for Food and Friends.
- Provides $129,066 in recurring funds to support program costs for Produce Plus

Continue Community Support for Reducing Opioid Overdoses

- Provides $250,000 in one-time funding to ensure continuity of services between federal grants aimed at reducing opioid overdoses for the LGBTQ+ community

Commitment to HIV/AIDS Prevention

- Provides $700,000 in one-time funding for HASTA grants for community organization grants for HIV/AIDS prevention

Creates Crisis Response Pilot

- $200,000 to support the creation of a pilot program within the Department of Behavioral Health's Crisis Services team to provide counseling support to survivors of natural and human-made disasters

B. FISCAL YEAR 2023 AGENCY OPERATING BUDGET SUMMARY

Agency Operating Budget by Program

Program	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
Department of Behavioral Health					
0000 - (no program selected)	$0	$0	$0	$0	$0
1000 - AGENCY MANAGEMENT	$24,042,213	$28,433,442	$26,859,759	$0	$26,859,759
100F - DBH FINANCIAL OPERATIONS	$1,996,650	$2,230,398	$2,477,958	$0	$2,477,958
1800 - BEHAVIORAL HEALTH AUTHORITY	$4,800,390	$5,816,784	$6,506,086	($125,076)	$6,381,010
3800 - ST. ELIZABETHS HOSPITAL	$109,605,106	$113,486,407	$104,389,969	($77,269)	$104,312,700
4800 - BEHAVIORAL HEALTH SERVICES AND SUPPORTS	($43)	$0	$0	$0	$0
4900 - ACCOUNTABILITY	$3,566,776	$3,626,509	$3,478,460	($128,782)	$3,349,678
5800 - CLINICAL SERVICES DIVISION	$39,119,829	$23,209,144	$14,198,202	($160,564)	$14,037,638
5900 - SYSTEM TRANSFORMATION	$5,970,198	$0	$0	$0	$0
6500 - ADULT/TRANSITIONAL YOUTH SERVICES	$0	$113,778,688	$138,979,928	($1,139,473)	$137,840,455
6600 - CHILD/ADOLESCENT/FAMILY SERVICES	$0	$59,830,654	$48,494,824	$2,463,107	$50,957,931
6700 - "POLICY, PLANNING, & EVALUATION ADMIN "	$0	$0	$0	$118,000	$118,000
6800 - ADDICTION PREVENTION AND RECOVERY ADMIN	$0	$0	$0	$0	$0
6900 - COMMUNITY SERVICES	$140,361,288	$0	$0	($108,556)	($108,556)
7000 - ACTIVE TREATMENT	$0	$0	$0	$0	$0
9220 - DEPARTMENT OF MENTAL HEALTH - P-CARD	$0	$0	$0	$0	$0
9960 - YR END CLOSE	($11,395)	$0	$0	$0	$0
9980 - PAYROLL DEFAULT PROGRAM	$0	$0	$0	$0	$0
DCRP - DISTRICT RECOVERY PLAN	$0	$0	$10,158,063	$0	$10,158,063
TOTAL GROSS FUNDS	**$329,451,014**	**$350,412,027**	**$355,543,250**	**$841,387**	**$356,384,637**
Department of Health					
0000 - (no program selected)	$0	$0	$0	$0	$0
1000 - AGENCY MANAGEMENT SUPPORT	$25,785,723	$29,305,082	$30,831,376	$0	$30,831,376
100F - AGENCY FINANCIAL OPERATIONS	$2,502,498	$3,256,271	$3,328,480	$0	$3,328,480
2000 - ADDICTION PREVENTION & RECOVERY ADMIN	$0	$0	$0	$0	$0
2500 - HLTH EMERG PREPAREDNESS AND RESP.ADMIN	$11,235,213	$9,219,112	$7,737,007	$0	$7,737,007
3000 - HIV/AIDS HEPATITIS STD AND TB ADMIN	$89,618,236	$99,354,397	$82,474,871	$700,000	$83,174,871
4500 - HEALTH REGULATION AND LICENSING ADMIN.	$0	$0	$0	($2,918,369)	($2,918,369)
4500 - HEALTH REGULATION AND LICENSING ADMIN.	$25,760,201	$24,414,487	$35,159,938	$1,048,351	$36,208,289
5000 - PRIMARY CARE AND PREVENTION ADMIN.	$607,969	$0	$0	$0	$0
7000 - OFFICE OF HEALTH EQUITY	$653,790	$818,952	$804,645	$0	$804,645
8500 - COMMUNITY HEALTH ADMINISTRATION	$85,382,272	$97,878,839	$92,035,725	$2,600,697	$94,636,422
9220 - DOH PCARD POOL	($452)	$0	$0	$0	$0
9960 - YR END CLOSE	($51,920)	$0	$0	$0	$0
9980 - PAYROLL DEFAULT PROGRAM	$0	$0	$0	$0	$0
TOTAL GROSS FUNDS	**$241,493,529**	**$264,247,141**	**$252,372,042**	**$1,430,679**	**$253,802,721**
Department of Health Care Finance					
1000 - AGENCY MANAGEMENT	$31,153,937	$38,707,784	$47,708,113	($100,000)	$47,608,113
100F - AGENCY FINANCIAL OPERATIONS	$5,175,513	$6,786,406	$6,136,935	$0	$6,136,935
2000 - HEALTHCARE DELIVERY MANAGEMENT	$22,780,810	$29,032,940	$27,674,432	$0	$27,674,432
200L - LONG TERM CARE PROGRAM	$20,009,751	$23,444,775	$27,791,330	$0	$27,791,330
3000 - HEALTHCARE POLICY AND PLANNING	$4,786,282	$6,196,055	$5,198,508	$0	$5,198,508
300A - DCAS PROGRAM MANAGEMENT ADMINISTRATION	$72,403,722	$82,925,589	$73,133,587	$0	$73,133,587
5000 - HEALTH CARE FINANCE	$3,541,139,694	$3,407,944,734	$3,449,704,808	$0	$3,449,704,808
6000 - HEALTH CARE OPERATIONS	$41,599,006	$54,248,979	$55,939,073	$0	$55,939,073
8000 - HEALTH CARE REFORM AND INNOVATION	$15,262,873	$7,743,284	$13,463,605	$0	$13,463,605
9960 - YR END CLOSE	$0	$0	$0	$0	$0
DCRP - DISTRICT RECOVERY PLAN	$0	$0	$2,480,000	$0	$2,480,000
TOTAL GROSS FUNDS	**$3,754,311,588**	**$3,657,030,545**	**$3,709,230,390**	**($100,000)**	**$3,709,130,390**
Health Benefit Exchange Authority					
1000 - AGENCY MANAGEMENT	$23,031,741	$5,810,791	$5,974,210	$0	$5,974,210
100F - AGENCY FINANCIAL OPERATIONS	$703,153	$772,838	$806,495	$0	$806,495
5000 - CONSUMER EDUCATION AND OUTREACH PROGRAM	$3,018,043	$2,995,799	$3,231,707	$0	$3,231,707
6000 - BUSINESS DEVELOPMENT PROGRAM	$0	$0	$0	$0	$0
7000 - MARKETPLACE INNOVATION POLICY AND OPS	$9,466,130	$11,728,422	$13,325,626	$0	$13,325,626
8000 - IT RELATED OPERATIONS	$13,020,454	$11,534,130	$12,346,018	$0	$12,346,018
TOTAL GROSS FUNDS	**$49,239,520**	**$32,841,979**	**$35,684,055**	**$0**	**$35,684,055**
Medicaid Reserve					
1000 - MEDICAID RESERVE	$0	$0	$0	$0	$0
TOTAL GROSS FUNDS	**$0**	**$0**	**$0**	**$0**	**$0**
Not-for-Profit Hospital Corporation					
1000 - NOT FOR PROFIT HOSPITAL CORPORATION	$0	$155,000,000	$155,000,000	$0	$155,000,000
TOTAL GROSS FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
Not-for-Profit Hospital Corporation Subsidy					
1000 - NOT FOR PROFIT HOSPITAL CORP. SUBSIDY	$40,000,000	$15,000,000	$15,000,000	$0	$15,000,000
TOTAL GROSS FUNDS	**$40,000,000**	**$15,000,000**	**$15,000,000**	**$0**	**$15,000,000**
Office of the Deputy Mayor for Health and Human Services					
1000 - AGENCY MANAGEMENT	$1,747,383	$2,343,728	$2,343,376	$0	$2,343,376
2000 - HUMAN SUPPORT SERVICES	$337,894	$162,120	$517,841	$0	$517,841
3000 - THRIVE BY FIVE COORDINATING COUNCIL	$634,137	$416,694	$0	$0	$0
9220 - OFFICE OF THE DEPUTY MAYOR FOR HSS-PCARD	$6,781	$0	$0	$0	$0
9980 - PAYROLL DEFAULT PROGRAM	$0	$0	$0	$0	$0
TOTAL GROSS FUNDS	**$2,726,195**	**$2,922,542**	**$2,861,218**	**$0**	**$2,861,218**
GRAND TOTAL	**$4,417,221,846**	**$4,477,454,233**	**$4,525,690,955**	**$2,172,066**	**$4,527,863,021**

C. FISCAL YEAR 2023 AGENCY FULL-TIME EQUIVALENTS

Agency Full-Time Equivalent Summary					
Fund Type	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
DC Health Benefit Exchange Subsidy					
LOCAL FUND	0.00	0.00	0.00	0.00	0.00
TOTAL FTE	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Department of Behavioral Health					
LOCAL FUND	1,130.30	1,229.84	1,235.16	(9.10)	1,226.06
DEDICATED TAXES	0.00	0.00	0.00	0.00	0.00
FEDERAL PAYMENTS	0.00	55.00	55.00	0.00	55.00
FEDERAL GRANT FUND	94.01	88.55	147.53	0.00	147.53
FEDERAL MEDICAID PAYMENTS	5.09	4.00	3.50	0.00	3.50
PRIVATE GRANT FUND	0.80	0.00	0.00	0.00	0.00
PRIVATE DONATIONS	0.00	0.00	0.00	0.00	0.00
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	13.59	16.25	16.50	0.00	16.50
OPERATING INTRA-DISTRICT FUNDS	66.21	61.01	0.00	0.00	0.00
TOTAL FTE	**1,310.00**	**1,454.65**	**1,457.69**	**(9.10)**	**1,448.59**
Department of Health					
LOCAL FUND	139.80	157.72	177.10	11.00	188.10
FEDERAL PAYMENTS	0.00	0.00	0.00	0.00	0.00
FEDERAL GRANT FUND	420.35	378.46	425.20	0.00	425.20
PRIVATE GRANT FUND	1.25	0.30	0.00	0.00	0.00
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	113.79	141.86	144.11	0.00	144.11
OPERATING INTRA-DISTRICT FUNDS	4.11	5.68	0.00	0.00	0.00
TOTAL FTE	**679.30**	**684.02**	**746.41**	**11.00**	**757.41**
Department of Health Care Finance					
LOCAL FUND	117.15	142.89	168.23	0.00	168.23
DEDICATED TAXES	4.68	6.05	6.60	0.00	6.60
FEDERAL PAYMENTS	0.00	0.00	0.00	0.00	0.00
FEDERAL GRANT FUND	0.00	0.00	2.00	0.00	2.00
FEDERAL MEDICAID PAYMENTS	149.80	181.98	179.23	0.00	179.23
PRIVATE GRANT FUND	0.00	0.00	0.00	0.00	0.00
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	12.98	16.45	16.15	0.00	16.15
OPERATING INTRA-DISTRICT FUNDS	1.20	3.66	0.00	0.00	0.00
TOTAL FTE	**285.81**	**351.03**	**372.21**	**0.00**	**372.21**
Health Benefit Exchange Authority					
FEDERAL PAYMENTS	0.00	0.00	0.00	0.00	0.00
PRIVATE DONATIONS	0.00	0.00	0.00	0.00	0.00
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	0.00	0.00	0.00	0.00	0.00
ENTERPRISE AND OTHER FUNDS	95.98	109.00	117.00	0.00	117.00
TOTAL FTE	**95.98**	**109.00**	**117.00**	**0.00**	**117.00**
Medicaid Reserve					
LOCAL FUND	0.00	0.00	0.00	0.00	0.00
FEDERAL MEDICAID PAYMENTS	0.00	0.00	0.00	0.00	0.00
TOTAL FTE	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Not-for-Profit Hospital Corporation					
ENTERPRISE AND OTHER FUNDS	0.00	0.00	0.00	0.00	0.00
TOTAL FTE	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Not-for-Profit Hospital Corporation Subsidy					
LOCAL FUND	0.00	0.00	0.00	0.00	0.00
TOTAL FTE	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Office of the Deputy Mayor for Health and Human Services					
LOCAL FUND	12.54	15.75	14.75	0.00	14.75
OPERATING INTRA-DISTRICT FUNDS	0.00	0.00	0.00	0.00	0.00
TOTAL FTE	**12.54**	**15.75**	**14.75**	**0.00**	**14.75**
GRAND TOTAL	**2,383.63**	**2,614.45**	**2,708.06**	**1.90**	**2,709.96**

D. FY 2023 - 2028 AGENCY CAPITAL BUDGET SUMMARY

The Committee approves the mayor's proposed capital budget for all agencies under its purview, and makes no changes. Please find a chart of the Fiscal Year 2023 capital improvements in Attachment B.

E. TRANSFERS IN FROM OTHER COMMITTEES

Sending Committee	*Amount*	*FTEs*	*Receiving agency*	*Amount*	*FTEs*	*Program*	*Purpose*	*Recurring or One-Time*
Committee on Government Operations and Facilities	$700,000	0	DC Health	$700,000	0	3000	Restore HASTA Grants to Community Organizations	One-Time
Committee on Government Operations and Facilities	$150,000	0	DC Health	$150,000	0	8500	Enhance funding for Healthy Corners	One-Time
Committee on Government Operations and Facilities	$250,000	0	Department of Behavioral Health	$250,000	0	6500	Ensure continuity of services to reduce opioid overdoses	One-Time
Committee on Transportation and the Environment	$100,000		DC Health	$100,000	0		Enhance funding for Healthy Corners	Recurring
Committee on Transportation and the Environment	$129,066	0	DC Health	$129,066	0		Enhance funding for Produce Plus	Recurring
Committee on Transportation and the Environment	$200,000	0	DC Health	$200,000	0		Enhance funding for Food and Friends	Recurring
Committee on Transportation and the Environment	$75,000	0	DC Health	$75,000	0		To fund a mental health services position with Crittenton for matching fund eligibility	Recuring
Committee on Transportation and the Environment	$100,000	0	DC Health	$100,000	0		To fund a diaper bank program	Recurring
Committee on Judiciary and Public Safety	$118,000	1	Department of Behavioral Health	$118,000	1		Maternal Mental Health Task Force	One-Time
Committee on Judiciary and Public Safety	$200,000	0	Department of Behavioral Health	$200,000	0	6000	To support the creation of a pilot program within DBH's Crisis Services team to provide counseling support to survivors of natural and human-made disasters	One-Time
Total	$2,022,066	1.0		$2,022,066	1.0			

F. TRANSFERS OUT TO OTHER COMMITTEES

Receiving Committee	*Amount*	*FTEs*	*Receiving agency*	*Amount*	*FTEs*	*Program*	*Purpose*	*Recurring or One-Time*
Total								

G. REVENUE ADJUSTMENT (N/A)

The Committee has not made any recommendations for revenue adjustment for Fiscal Year 2023.

H FUNDING OF LEGISLATION

Bill #, Law #, Subtitle #	*Status*	*Agency*	*Program/Activity*	*Amount*	*FTEs*
Subtitle X. First-Time Mothers Home Vising Program	BSA	DC Health	8500/8506	$150,000	0.0
Subtitle X. Maternal Mental Health Task Force	BSA	DBH	6700/6702	$118,000	1.0

II. AGENCY FISCAL YEAR 2023 BUDGET RECOMMENDATIONS

A. INTRODUCTION

The Committee on Health is responsible for matters concerning health and environmental health, the regulation of health occupations and professions, and health-care inspectors. The Committee reviews and approves the budget for six District agencies, as well as a handful of boards and commissions. The Committee works closely with these agencies, District residents, and community advocates to craft careful and deliberate policies for public health services and programs. The Committee is chaired by Councilmember Vincent C. Gray; the other members are Councilmembers Mary M. Cheh, Brianne K. Nadeau, Charles Allen, and Christina Henderson.

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

- Advisory Committee on Acupuncture
- Advisory Committee on Anesthesiologist Assistants
- Advisory Committee on Clinical Laboratory Practitioners
- Advisory Committee on Naturopathic Medicine
- Advisory Committee on Physician Assistants
- Advisory Committee on Polysomnography
- Advisory Committee on Surgical Assistants
- Board of Allied Health
- Board of Audiology and Speech-Language Pathology
- Board of Behavioral Health
- Board of Chiropractic
- Board of Dentistry
- Board of Dietetics and Nutrition
- Board of Long-Term Care Administration
- Board of Marriage and Family Therapy
- Board of Massage Therapy
- Board of Medicine
- Board of Nursing
- Board of Occupational Therapy
- Board of Optometry
- Board of Pharmacy
- Board of Physical Therapy
- Board of Podiatry
- Board of Professional Counseling
- Board of Psychology
- Board of Respiratory Care
- Board of Social Work
- Board of Veterinary Medicine

- Commission on Health Disparities
- Commission on Health Equity
- Commission on HIV/AIDS
- Committee on Metabolic Disorders
- 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
- Health Information Exchange Policy Board
- Health Literacy Council
- Mental Health Planning Council
- Metropolitan Washington Regional Ryan White Planning Council
- Not-For-Profit Hospital Corporation
- Statewide Health Coordinating Council

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

Performance Oversight Hearings	
January 24, 2022	• DC Health Benefit Exchange Authority • Department of Behavioral Health
February 23, 2022	• Department of Health
February 28, 2022	• Office of the Deputy Mayor for Health & Human Services • Department of Health Care Finance • Not-for-Profit Hospital Corporation

Budget Oversight Hearings	
March 21, 2022	• DC Health Benefit Exchange Authority • Department of Behavioral Health
March 28, 2022	• Office of the Deputy Mayor for Health & Human Services • Department of Health Care Finance • Not-for-Profit Hospital Corporation
April 4, 2022	• Department of Health

The Committee received important comments from members of the public during these hearings. Copies of witness testimony are included in this report as Attachment C. A video recording of the hearings can be obtained through the Office of Cable Television or at *oct.dc.gov*. The Committee continues to welcome public input on the agencies and activities within its purview.

B. DEPARTMENT OF HEALTH (DC HEALTH)

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 agency 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 8 divisions:

Health Emergency Preparedness and Response Administration (HEPRA) – provides regulatory oversight of Emergency Medical Services and ensures that DC Health and its partners are prepared to respond to citywide medical and public health emergencies, such as those resulting from terrorist attacks, large accidents, or natural events or weather-related emergencies, for example.

This division contains the following 5 activities:

- **Public Health Emergency Preparedness** – provides the District's response to the emergency medical needs of its visitors and residents. It's responsibilities cover a wide range of activities, including the development and training of emergency response plans, coordination of medical response with federal regional and local partners across the healthcare system and volunteers through the Medical Reserve Corps. HEPRA also works with community and community organizations to withstand and bounce back from natural and man-made disasters. Resilient communities leverage community connections, relationships, and resources to ensure optimal health and security for individuals and families in both routine and emergency situations;

- **Public Health Emergency Operations and Program Support** – supports government and private partners with the development of their health and safety plans, emergency operation plans, and training exercises. The program also provides a public health command and control element that coordinates all DC Health assets and operations during incidents, special events, and national special security events. Under this program is Pharmaceutical Procurement and Distribution, which acquires and distributes over $58 million of life-saving medications for the DC Health programs that will allow as many District residents as possible access to medications. It also provides clinical support, formulary management, and quality assurance monitoring to address the needs of all DC Health programs that utilize or distribute pharmaceuticals. The program also maintains the Strategic National Stockpile (SNS) of drugs for the Washington, DC region in the event

of a declared national emergency;

- **Epidemiology Disease Surveillance and Investigation** – HEPRA works with community and community organizations to withstand and bounce back from natural and man-made disasters. Resilient communities leverage community connections, relationships, and resources to ensure optimal health and security for individuals and families in both routine and emergency situations; see also the Center for Policy, Planning, and Evaluation (CPPE), which provides surveillance, investigation, and control of reportable diseases, disease outbreaks, and other public health threats within the District of Columbia (excluding sexually transmitted diseases (STDs), hepatitis, HIV/AIDS, and tuberculosis (TB));

- **Emergency Medical Services Regulation** – provides oversight and regulation of Emergency Medical Services (EMS), including certification and regulation of District of Columbia EMS providers, ambulance agencies, and EMS educational institutions. The program monitors training standards and certifies instructional programs and instructors. In addition, it provides inspection and certification of all ambulances operated in the District whether they are governmental, private, or volunteer; and

- **Office of the Senior Deputy Director** – provides overall direction, policy development, and supervision for the four subordinate activities.

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

This division contains the following 10 activities:

- **HIV/AIDS Support Services** – provides overall management, planning, direction and support for the HIV/AIDS, STD, TB and adult hepatitis surveillance, prevention, treatment, care, and control programs. It also provides HIV/AIDS information to individuals and community organizations, coordinates HAHSTA participation in public events, prepares written and other resources for public distribution, and manages special projects;

- **HIV/AIDS Policy and Planning** – provides community capacity to respond to the HIV/AIDS and STD epidemics more effectively through the Effi Barry program, which provides training and technical assistance to small, ward-based community organizations, a social marketing program aiming to promote health behavior to reduce risk of disease, and a free condom distribution program. It writes reports and creates other written

materials for public distribution; and it provides HIV/AIDS, STD, TB, and hepatitis information to government agencies, community organizations, media, and individuals. It also coordinates participation in public events;

- **HIV Health and Support Services** – provides a comprehensive range of primary medical care and supportive services for persons living with HIV and AIDS;

- **HIV/AIDS Data and Research** – provides a comprehensive picture of the HIV/AIDS epidemic in the District of Columbia for purposes of ensuring that the needs of people infected with HIV, or at risk of infection, are met. It collaborates with healthcare providers and laboratories to collect and maintain comprehensive HIV/AIDS data in a confidential and secure manner; analyzes, interprets, and distributes epidemiologic information for use in developing public policy, planning, and evaluating prevention intervention and health care services; and supports funding requests;

- **Prevention and Intervention Services** – provides comprehensive HIV prevention programs and services through community organizations to the residents of the District of Columbia. Prevention programs include health education, HIV testing and counseling services, science-based prevention programs, and other support services, including condom distribution. In addition, the program monitors organizations to ensure that quality prevention services are being delivered through program evaluation and quality assurance activities as well as through the provision of capacity building, training, and technical assistance to sub-grantees;

- **AIDS Drug Assistance Program (ADAP)** – provides assistance with deductibles, co-payments, and health insurance/Medicare Part D premiums. DC ADAP also provides an entry point for other District health programs available to people living with HIV/AIDS;

- **Grants and Contracts Management** – provides fiscal and administrative monitoring of District and federally appropriated funds in the form of over 100 grants and sub-grants to more than 50 providers. Fiscal monitoring includes ensuring that grant funds are expended in accordance with federal and local grant regulations, conducting site visits, providing technical assistance to grantees and sub-grantees, and providing continued analysis of grant spending to program counterparts;

- **Sexually Transmitted Disease (STD) Control** – provides assistance to prevent and control sexually transmitted diseases in the District of Columbia through the provision of clinical services, partnerships with local community providers, and promotion of healthy sexual behavior. The program also conducts surveillance for statistical purposes to track diseases and partner notification;

- **Tuberculosis Control** – provides direct care services to District residents, including clinical follow-up for active and/or suspected tuberculosis cases, directly observed therapy, preventive therapy, chest x-rays, contact investigations, and case management; and

- **HIV/AIDS Housing and Supportive Services** – provides housing support, emergency shelter, and other related services to help persons living with HIV and AIDS and their families achieve independent living.

Health Regulation and Licensing Administration (HRLA) – is comprised of the Office of Health Professional Licensing Boards, the Office of Health Care Facilities, the Office of Food, Drug, Radiation and Community Hygiene, and HRLA Support services.

This division contains the following 3 activities:

- **Office of Health Professional License Administration** – the Office of Health Professional Licensing Boards administers the licensure of almost 70,000 health professionals in the District of Columbia supporting 19 health professional boards. The Office also executes the investigation of consumer incidents or complaints against health professionals and recommends enforcement, if necessary, to bring licensees into compliance with District and federal law. The health professional boards advise the Department of Health in matters pertaining to the development of rules and regulations for health professionals and provide additional services, including licensure verification and licensure examinations;

- **Office of Food, Drug, Radiation and Community Hygiene Regulation** – provides varied inspection and regulatory services. The Food Safety and Hygiene Inspection Services regulates smoking bans in establishments and food services that are provided in boarding homes, commission merchants, dairies, delicatessens, bakeries, candy and ice cream manufacturers, grocery stores, retail markets, restaurants, wholesale markets, mobile vendors, and hotels. The Division of Community Hygiene provides abatement notices, inspection of premises, code enforcement, premises baited, catch basin larvicide, community education and outreach, investigation of bite cases, issuance of dog and cat licenses, vaccinations, animal adoptions, spay and neutering, dead animal pick-up, and dangerous dog control services in the District. The Division of Radiation seeks to eliminate radiation overexposure of persons from naturally occurring and man-made radiation by the inspection of dental x-ray tubes and medical x-rays and the regulation of health physicists, suppliers, and radioactive-material users in the District of Columbia; and

- **Office of Health Care Facilities Regulation** − includes the Health and Intermediate Care Facility Divisions which administers all District and federal laws and regulations governing the licensure, certification and regulation of all health care facilities in the District of Columbia. In this role, HRLA staff inspects health care facilities and providers who participate in the Medicare and Medicaid programs, responds to consumer and self-reported facility incidents and/or complaints, and conducts investigations, if indicated. When necessary, HRLA takes enforcement actions to compel facilities, providers, and suppliers to come into compliance with District and federal law.

Office of Health Equity (OHE) – works to address the root cause of health disparities, beyond health care, and health behaviors by supporting projects, policies and research that will enable every resident to achieve their optimal level of health. The Office achieves its mission by informing, educating, and empowering people about health issues and facilitating multi-sector partnerships to identify and solve community health problems related to the social determinants of health. As the newest division of DC Health, this Office is charged with providing leadership to the evidence-based paradigm and practice change effort that is essential to promoting and achieving health equity. This work includes practitioners not only

within DC Health, but across District government, as well as with other public, private, and non-profit entities, including community residents.

This division contains the following 3 activities:

- **Multi Sector Collaboration** – provides informed, data-driven and evidence-based leadership in convening and sustaining effective multi-sector collaborative partnerships essential to promote and achieve health equity, uses a "health in all policies" (HIAP) approach to improving community health; and serves as liaison and technical advisor to all DC Health Administrations regarding health equity, as well as to external District government agencies and private partners;

- **Community Based Participatory Research and Policy Evaluation** – applies data-driven and evidence-based research methods, tools and practices, including Geographic Information Systems (GIS) and other innovative methodologies, to measure social determinant and population health outcomes, including current and projected opportunities for health, disparate outcomes, and inequities by socioeconomic and demographic subpopulation and geographic location. This core function includes support for design, development and implementation of Health Equity Programs and their evaluation, including community-based participatory research, and publication of reports that inform the policy-making process as well as building the evidence base; and

- **Health Equity Practice and Program Implementation** – develops and delivers selected programs and initiatives with demonstrable strategic health-equity 'nexus' and operationalization potential, so as to contribute to and inform the essential paradigm shift in policy and practice to improve population health and promote more equitable opportunities for health, especially amongst vulnerable populations.

Center for Policy, Planning, and Evaluation (CPPE) – is responsible for developing an integrated public health information system to support health policy decisions, state health planning activities, performance analysis, and direction setting for department programs; health policy, health planning and development; health research and analysis; vital records; disease surveillance and outbreak investigation; and planning, directing, coordinating, administering, and supervising a comprehensive Epidemiology and Health Risk Assessment program, which involves federal, state, county, and municipal functions.

This division contains the following 4 activities:

- **Epidemiology Disease Surveillance and Investigation** – provides surveillance, investigation, and control of reportable diseases, disease outbreaks, and other public health threats within the District of Columbia (excluding sexually transmitted diseases (STDs), hepatitis, HIV/AIDS, and tuberculosis (TB));

- **Research, Evaluation, and Measurement** – plans and coordinates epidemiologic studies and outbreak investigations, defines the health status of residents, and assists with tracking of health events. This includes the planning, development, and coordination of appropriate methodologies to collect and process data as well as monitoring and evaluation of health and social issues. This division responds to internal and external inquiries about various health events and provides reports on health risk behaviors to both internal and external entities;

- **State Center for Health Statistics** – collects, processes, analyzes, and disseminates birth and death record information and other vital statistics data and information. It is responsible for the statistical analyses of the data generated from birth, death, and other vital records information. In addition, it develops comprehensive statistical and epidemiologic reports on District residents' health status; and

- **State Health Planning and Development** – develops the District's State Health Plan and Annual Implementation, and reviews and approves Certificate of Need applications that allow health care providers to establish new services, make certain capital expenditures, or take other actions as specified in the law. The activity is also responsible for monitoring free care requirements of hospitals and other health care providers.

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

This division contains the following 6 activities:

- **Cancer and Chronic Disease Prevention –** develops, implements and evaluates programs and policy aimed at preventing and controlling the leading causes of death in the District. The Bureau implements cancer control and prevention initiatives aimed at reducing the high rates of cancer-related mortality among District residents. Its programs target treatable or preventable cancers, such as breast, cervical, lung, and colorectal, through primary and secondary prevention. The Bureau also works to reduce the impact of chronic conditions such as cardiovascular disease, hypertension, and diabetes mellitus, by developing innovative management approaches and building community partnerships. It supports clinical quality improvement initiatives, which include developing decision support tools and participating in the design of clinical delivery systems, and it provides expert technical assistance to clinical and community settings around best practices for chronic disease prevention and management. The Bureau implements social marketing campaigns to change social norms and introduces long-lasting protective interventions, like cancer screening and tobacco cessation and treatment programs. The Bureau also helps strengthen the infrastructure for chronic disease care and promotes population-based policy strategies to reduce the common risk factors for chronic disease, including tobacco use, poor nutrition, and physical inactivity;

- **Health Care Access Bureau –** supports population-based programs to improve access to quality primary care services for residents. The Bureau works to support and promote medical and dental homes so that all residents can access comprehensive preventive medical and dental services. The Bureau administers the State Oral Health Program, the Immunization program including its Vaccines for Children program and the immunization registry, and health care workforce development programs. By administering the District's Health Professional Shortage Areas and Medically Underserved Area programs, the Bureau is a key component of the District's health planning infrastructure. The Bureau

also supports innovations in primary care service delivery and quality, diffusion of primary care access to underserved communities, and linkages to primary care services regardless of resident's ability to pay. The Bureau also ensures that underserved populations maintain access and linkages to healthcare services and the services provided by other CHA bureaus;

- **Family Health Bureau –** works to improve perinatal, early childhood, and child and adolescent health outcomes so that every child in the District of Columbia is healthy and able to thrive in school and beyond. The Bureau supports the development of a coordinated, culturally competent, family-centered health care delivery system; promotes community and clinical linkages for women, parents, children and adolescents; and works to align and integrate services to connect District families with resources they need. It also provides expert technical assistance and builds the capacity of clinical and community-based organizations to deliver evidence-based practices and innovative programs in perinatal, early childhood, child, and adolescent health directly in communities. In addition, the Bureau facilitates school-based health services and coordinates with education partners to implement policies and programs that support healthy school environments that support the whole child;

- **Support Services –** provides overall oversight of all of CHA's programs and operations. Provides strategic direction for the administration and represents the agency within District government and to community stakeholders. Sets priorities for administration activities and leads policy development, planning, and operational management. It also includes program support services, whose purpose is to ensure efficient and effective daily operations across the administration through the development, implementation, execution, and review of all administrative functions and policies, including administration-specific human resources, information technology, facilities, and customer service activities; a grant and budget monitoring unit, whose purpose is to uniformly address all of the administration's fiscal duties, including responsibility for the development of, oversight over the execution of, and reporting of the fiscal year budget; provision of support for all local and grant-funded Administration programs; procurement, monitoring, and evaluation for all non-personnel activities, such as contracts, memoranda of understanding, and sub-grants; implementation of comprehensive strategic fiscal plans to include allocation of personnel costs across all administration funding sources; and a program evaluation unit, whose purpose is to collaborate with program and fiscal staff to ensure effective and efficient performance of sub grantees. Program analysts will review and provide ongoing feedback on performance metrics and process and outcome measures to program staff and sub grantees, provide technical assistance around evaluation and measurement, and advise on performance improvement activities. They will work closely with grant monitors as well as program staff to ensure positive impact of funded initiatives. A Deputy Director of Programs and Policy (DDPP) unit leads the activities of CHA that address the determinants of health in the District of Columbia. The DDPP oversees implementation of evidence-based programs and policies to prevent illness and injury, promote healthy behaviors and healthy environments across the lifespan, improve access to medical and dental homes, and foster clinical quality improvement and innovation. The DDPP ensures that CHA programs follow best practices and are aligned with the core public health functions and essential services. The DDPP serves as the Title V Maternal and Child Health Block Grant Director and oversees the four programmatic bureaus within CHA: the Cancer and Chronic Disease Prevention

Bureau, the Nutrition and Physical Fitness Bureau, the Health Care Access Bureau, and the Family Health Bureau;

- **Perinatal and Infant Health –** provides comprehensive services to improve perinatal outcomes for high-risk pregnant and parenting women, the health and development of their infants into early childhood, and health outcomes for children with special healthcare needs by facilitating access to coordinated primary and specialty health care and other services in partnership with their families and community organizations. The overarching goal is to reduce infant mortality and perinatal health disparities in the District of Columbia primarily through a home visiting approach; and

- **Nutrition and Physical Fitness –** promotes health and reduces obesity among District residents by encouraging behavior change through direct nutrition and physical activity education and by facilitating policy, systems, and environmental changes that make healthy choices the easy choice in every community. The Bureau administers programs that supply food or funds for food such as the Supplemental Nutrition Assistance Program, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Produce Plus Program, pop-up community markets, and other programs to impact socioeconomic factors that influence access to healthy foods. The Bureau also provides food, health and nutrition assessments and intervention, as well as education and counseling aimed at improving dietary habits and overall nutrition. Nutritional support is coupled with programs to promote physical activity and to decrease obesity.

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.

MAYOR'S FISCAL YEAR 2020-2023 OPERATING BUDGET SUMMARY

Description	*FY 2021 Actual*	*FY 2022 Approved*	*FY 2023 Proposed*	*% Change from FY22*
The Department of Health				
Operating Budget	$301,076,987	$282,292,322	$283,100,519	0.3
FTEs	679.3	684.0	746.4	9.1
Capital Budget	$0	$862,500	$4,750,000	450.7
FTEs	$0	$0	$0	N/A

COMMITTEE COMMENTS AND ANALYSIS

School Nurses Program: The District provides school nurses to public and public charter schools with eligible accommodations for a health suite. The Committee has taken a keen interest in ensuring that every school has a full-time school nurse on site. The Committee advanced the Public-School Health Services Amendment Act of 2018, to provide each public and public charter school with a full-time registered nurse or licensed practical nurse. Due to the nationwide nursing shortage affecting the availability of nurses in the District, Maryland, and Virginia, it has proven difficult to find enough nurses to fill the positions. The nursing shortage has been stressed further by the demands of the COVID-19 pandemic.

Children's National Hospital ("Children's Hospital"), which has been awarded a three-year grant for providing school nurses, noted the difficulty previously in recruiting school nurses. However, recently Children's Hospital shared that hiring conditions have improved as surges in COVID has decreased and more nurses are interested in the working conditions of school nursing. Currently school nurses are available in all DC public schools at least part-time.

In August 2021, District students returned to full-time, in-person learning. While some parents were relieved to have their children back in the classroom, there were even more parents of those who had returned that expressed concerns about the health and safety of the return to school policy. One of their more vocal concerns was that most nurses were in person at schools part-time during the COVID-19 pandemic. Parents noted some confusion in the return to school policy because the school nurse was no longer testing the children on-site for COVID and almost any sickness that a child presented was viewed as a possible symptom of COVID, which protocols required the child be isolated for testing by a third party, not evaluated by the school nurse.

Dr. Andrea Boudreaux, the Executive Director of Children's School Services at Children's Hospital testified that they have been able to increase the presence of school nurses at schools through telehealth visits. However, Dr. Boudreaux noted that if parents and schools wanted a school nurse to be physically present full-time that it would require additional funding on top of the $4.5M one-time increase that DC Health has put toward this program. The Committee is supportive of having a school nurse in every eligible public and public charter school and will provide additional funding toward the goal of ensuring full time coverage.

Following a tour of every school nurse site, Dr. Boudreau noted that school nurses needed to have Narcan on site to assist students who are suffering for opioid use and Glucagon for students who are trying to manage their diabetes. The Committee is interested in learning more about emergency assistance drugs that schools and school nurses may need to have to support students in urgent need.

Healthy Steps: The Committee has been focused on advancing all aspects of the "Birth to Three for All DC" legislation. In previous years, the Committee has added funding to the Healthy Steps Program with the goal of adding an additional site every year. Dr. LaQuandra Nesbitt, Director of DC Health, indicated that the Department intends to add two additional Healthy Steps sites by the end of FY22. Numerous advocates testified to the benefits of the program and have requested that the program expand to another site in FY23. Some advocates have placed emphasis that they would like a site to open in ward 5 as to date, all of the Healthy Steps sites which by law could open in either wards 5, 7 or 8 are opening in Wards 7 and 8 exclusively. The Committee encourages DC Health to look for opportunities for a Healthy Steps site to open in Ward 5 where it is possible to be placed in an area of high need and supports the efforts DC Health has made with implementing this program to date.

New Animal Shelter: DC Health intends to open a new animal shelter to replace the current shelter site on New York Ave NE. To date, animal services are predominantly completed in an annexed site due to poor conditions of the shelter. The Committee is thrilled that the Mayor has allocated $4.5M to this new site which was slated to be at 6500 Blair Rd NE. A follow up with DC Health has revealed that the location and therefore the opening date slated for the new shelter are still to be determined. The Committee whole heartly supports the work of the Human Rescue Alliance, which is the contractor for District animal care and control, which offers its services for domestic animals and wildlife. The Committee applauds their effort to reach out to the community to do mobile animal visits to offer services annually for those who cannot travel to their clinic on New York Ave NE and their work to protect District residents and visitors from potentially dangerous wildlife.[1] The Committee will take careful note of the planning for a new shelter to open in the District with the hope that it is located in a place easily accessible for animal owners in the East End.

2. COMMITTEE BUDGET RECOMMENDATIONS

Fiscal Year 2023 Capital Budget Recommendations

The Committee approves the proposed capital budget for DC Health.

3. COMMITTEE POLICY RECOMMENDATIONS

The Committee on Health makes the following policy recommendations regarding the work of DC Health:

[1] Recently, DC Animal Control made national news with its capture of a fox on Capital Hill that had been attacking pedestrians. Upon reports of the animal's unusual behavior, DC Animal Control worked quickly to capture the fox which was later determined to be rabid. The Committee commends DC Animal Control and for their efforts to keep residents and visitors safe. https://www.washingtonpost.com/dc-md-va/2022/04/06/capitol-fox-euthanized-kits-found/

1. The Department should continue its efforts to increase scheduled vaccinations for children before the rush to return to school. This should also include COVID-19 vaccinations at schools for eligible children and interested families.

2. The District should make great efforts to have the new animal shelter in a site that is accessible for all District residents, particularly those in the East End and continue efforts to increase mobile clinics to increase vaccinations and wellness checks for residents with pets in Wards 5,7, and 8. Because so much of the new animal shelter is unknown, the Committee would encourage that $2.35M currently reserved for consultation services at the new animal shelter actually go to animal services, regardless if it is connected to the services being offered at the new animal shelter.

3. Recently the District opened COVID-19 centers in the East End to facilitate people access to free masks, free testing kits and portals to register the kits for testing with in-person assistance. The Committee recommends these efforts continue to help residents who may need technical assistance to complete testing registration.

4. The Committee appreciates the efforts DC Health has made to implement the Healthy Steps Program and encourages the Department to continue efforts to open additional sites to meet the community demand, particularly in Ward 5.

C. DEPARTMENT OF BEHAVIORAL HEALTH

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. The agency 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, and (4) enhance provider monitoring to ensure high quality service.

The Department of Behavioral Health operates through the following 10 divisions:

Behavioral Health Authority – 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:

- **Office of the Director/Chief Executive Officer** – leads management and oversight of the public behavioral health system; directs the design, development, communication, and delivery of behavioral health services and supports; and identifies approaches to enhance access to services that support recovery and resilience;

- **Consumer and Family Affairs** – promotes and protects the rights of individuals with behavioral health disorders; encourages and facilitates consumer and client and family leadership of treatment and recovery plans; and ensures consumer and client voice in the development of the behavioral health system. The Administration also promotes consumer and client leadership, manages the peer certification training, and provides expertise on the consumer and client perspective and is made up of the following teams: Peer Support, Consumer Engagement, Consumer Rights, Quality Improvement, and Saint Elizabeths;

- **Office of Ombudsman** – identifies and helps consumers and clients resolve problems, complaints and grievances through existing processes; educates on available services and helps to maximize outreach; refers individuals when appropriate to other District agencies for assistance; and comments on behalf of residents on District behavioral health policy, regulations, and legislation;

- **Legal Services –** provides legal advice to the Director on all aspects of DBH's operations and activities; drafts, research and/or reviews legislation, regulations, and policies affecting DBH's mission and programs; and formulates strategic advice on DBH program development and compliance and oversight activities; and

- **Legislative and Public Affairs –** manages legislative initiatives and acts as the liaison to the District Council. Also, coordinates the agency's public education, internal and

external communications, and public engagement and outreach initiatives; facilitates responses to constituent complaints and service requests; and provides information and support for special projects.

Saint Elizabeths Hospital (SEH) – 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 14 activities:

- **Office of the Chief Executive** – provides overall executive management and leadership for all services and departments of Saint Elizabeths;

- **Office of Clinical and Medical Services** – SEH – provides the clinical, operational, strategic, and cultural leadership necessary to deliver care that is high-value (in terms of cost, quality and patient experience) to support their recovery and reintegration into the community;

- **Engineering and Maintenance – SEH –** provides maintenance and repairs to ensure a functional, safe, and secure facility to maximize the benefits of the therapeutic environment;

- **Fiscal and Support Services – SEH** – provides for the formulation, execution, and management of the hospital's budget, billing and revenue operations; approves and finances all requests for procurements; and oversees the overall financial integrity of the Hospital to ensure the appropriate collection, allocation, utilization, and control of resources;

- **Quality and Data Management** – provides quality improvement utilizing performance improvement techniques; uses data and research to guide clinical practices; provides oversight of reporting functions; and manages the reporting functions from the electronic medical record;

- **Housekeeping – SEH –** maintains a clean and sanitized environment to enhance the therapeutic environment and level of clinical performance;

- **Materials Management – SEH** – receives and delivers materials, supplies, and postal and laundry services; maintains an inventory of goods; replenishes stock; and performs electronic receiving for all goods and services;

- **Nursing Services – SEH –** provides active treatment and comprehensive, high quality 24-hour nursing care through a recovery-based therapeutic program; establishes the training curriculum for all levels of hospital staff; and ensures compliance with training programs for clinical and clinical support staff to maintain the health and safety of patients and staff;

- **Nutritional Services – SEH –** provides optimum nutrition and food services, medical nutrition therapy, and nutrition education services in a safe and sanitary environment;

- **Security and Safety – SEH** – provides a safe and secure facility for patients, visitors, and staff to support a therapeutic environment;

- **Transportation and Grounds – SEH –** manages the resources, administrative functions, contracts, and personnel; and provides transportation and maintenance services, including solid and medical waste disposal, and snow and ice removal;

- **Office of the Chief of Staff – SEH** – primarily responsible for the organization, ongoing management and oversight of key hospital administrative functions; regularly interacts and coordinates with medical staff and executive leadership; and serves as liaison with external partners including the Department of Corrections, DC Superior Court, and the District of Columbia Hospital Association;

- **Office of the Chief Operating Officer – SEH** – provides the operational, strategic, and cultural leadership necessary to plan, direct, and manage major administrative functions. This ensures the provision of high quality services while also meeting the needs of individuals in care and external stakeholders. The Chief Operating Officer regularly interacts and coordinates with finance, information systems, human resources, performance improvement, and risk management; and

- **Office of the Chief Clinical Officer – SEH** – provides clinical leadership and interdisciplinary treatment teams; and ensures the provision of social work services, treatment programs, rehabilitation services, utilization review, and volunteer services.

Accountability Division – oversees provider certification, mental health community residence facility licensure, program integrity, quality improvement, major investigations, incident management, claims audits, and compliance monitoring. Issues annual Medicaid and local repayment demand letters, annual quality reviews, and annual provider scorecards.

This division contains the following 5 activities:

- **Office of Accountability –** leads the Accountability Division by providing oversight and management of all of the agency's certification, licensure, incident management, and program integrity activities;

- **Incident Management and Investigations** – conducts major investigations of sentinel events and major unusual incidents, presents a disposition of the matter, and develops the final investigate report submitted to the agency Director, General Counsel, and other appropriate parties to ensure the needs and treatment goals of individuals in care are identified and addressed.

- **Licensure** – reviews and processes applications for licensure for Mental Health Community Residence Facilities (MHCRF), monitors MHCRF operators' compliance with agency regulations and policies, and generates and enforces statements of deficiencies and corrective action plans when necessary;

- **Certification** – reviews and processes applications for certification and recertification for behavioral health providers, monitors provider compliance with agency certification regulations and policies, and generates and enforces statements of deficiencies and

corrective action plans when necessary; and

- **Program Integrity** – provides oversight of certified providers through audits and reviews to ensure that they meet or exceed service delivery and documentation standards for mental health rehabilitation and substance use disorder services, and that they comply with agency policies and procedures and applicable District and federal laws and regulations.

Clinical Services Division – 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 7 activities:

- **Office of the Chief Clinical Officer** – supervises and sets clinical care standards for provision of the full range of substance use, mental health and gambling addiction services throughout the agency and public behavioral health system for children, youth, and adults; oversees community hospitals that treat agency consumers on an involuntary basis; serves as the petitioner in guardianship cases.

- **Behavioral Health Services** – directs and manages mental health services at two agency-operated locations;

- **Behavioral Health Services – Pharmacy** – provides psychiatric medications for residents enrolled in the public behavioral health system who are uninsured and unable to pay for medications;

- **Comprehensive Psychiatric Emergency Program (CPEP) –** provides emergency stabilization services for adults 18 years of age and older experiencing a mental health crisis, including immediate and extended observation care to individuals who present in crisis, as well as services in the community; and participates in the District's cold weather alert response. Individuals may be of voluntary or involuntary status;

- **Homeless Outreach/Mobile Crisis (CPEP) –** Homeless Outreach connects homeless individuals and families with behavioral health sciences and assists in the District's encampment protocol. Mobile Crisis provides crisis intervention and stabilization services to residents and visitors who are experiencing psychiatric crisis in the community or at home; services include linkage to DBH psychoeducation, treatment compliance support, and grief and loss services to individuals after a traumatic event;

- **Forensics –** provides and oversees continuum of behavioral health and other services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community; and

- **Assessment and Referral Center (ARC)** – a walk-in Clinic, comprised of multi-disciplinary team of medical and behavioral health professionals, which provides assessment and referral service for those seeking treatment for Substance Use Disorders (SUD). The ARC also provides COVID rapid testing at the point of care for those seeking SUD treatment.

Adult/Transitional Youth Services Administration – 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 16 activities:

- **Adult/Transitional Youth Services Administration –** develops, implements, and monitors a comprehensive array of prevention, community-based behavioral health services, and substance abuse services to support resiliency, recovery and overall well-being for District residents who have mental health and substance use disorders;

- **Behavioral Health Services MH/SUD –** oversees development, implementation, and monitoring of a comprehensive array of community-based mental health and substance use disorders services including evidenced-based and promising practices, implemented within the behavioral health provider network to address the needs of adults, youth, and their families.

- **Government Operated Services 35 K Street Adult Clinic –** provides clinical assessment and treatment of persons who are 18 years of age and older who present with mental health concerns, and provides urgent same-day evaluations for persons in crisis that do not arise to the level of needing an emergency room visit;

- **Provider Relations** – provides oversight, technical assistance and training to enhance the success and effectiveness of DBH's certified behavioral health provider network, monitors provider performance, ensures delivery of quality service, on-boards new providers and manages provider closures;

- **Co-Located Services** – oversees the co-location of DBH clinicians at various District government agencies and community-based sites to conduct behavioral health screenings, assessments, consultations, and to make referrals to the provider network;

- **Residential Support and Continuity of Services –** determines individuals' housing needs and level of support; provides referrals to landlords; assures properties are inspected and approved; monitors service provision according to individualized clinical treatment plans; assures coordination and resolves problems among landlords, tenants, and providers; and conducts regular reviews to transition individuals to more independent, least restrictive community-based settings of their choice when appropriate;

- **Housing Support Services –** develops housing options and administers associated policies and procedures governing eligibility, access to housing, and issues vouchers for eligible individuals with behavioral health diagnoses; monitors providers' compliance with contracts and provides technical assistance to providers on the development of corrective action plans; and develops and monitors grant agreements pertaining to housing development and the funding of housing vouchers;

- **Community Response Team** – operates a 24 hour, 7 days a week multi-disciplinary community-based team which offers services to individuals and communities experiencing psychiatric emergencies, trauma, grief, mental health issues, or substance use disorders;

- **State Opioid Response Program** – leads the District's State Opioid Response which focuses on reducing opioid-related deaths by increasing access to medication-assisted treatment (MAT), reducing unmet treatment needs through the provision of prevention, treatment, and recovery support services (RSS) to individuals with opioid use disorder (OUD). Expanded services and supports are also provided to individuals with stimulant use disorders (STUD);

- **Assessment and Referral Center** –provides a walk-in Clinic, comprised of multi-disciplinary team of medical and behavioral health professionals, which offers assessment and referral service for those seeking treatment for Substance Use Disorders (SUD). The ARC also provides COVID rapid testing at the point of care for those seeking SUD treatment;

- **Access Helpline** – operates the 24 hour / 7 days a week, Mental Health Crisis Hotline which fields calls from the National Suicide Prevention Lifeline, provides on the spot crisis counseling, enrollment and authorizations to care, as well as dispatching Crisis and Outreach teams to individuals in the community as needed;

- **Specialty Services** – develops, implements, and ensures sustainability of specialized and evidence-based behavioral health programs for adults, adolescents, transition-aged youth, children, and their families;

- **Substance Use Disorder Treatment Services –** monitors service provision according to individualized clinical treatment plans; assures coordination and resolves problems among landlords, tenants, and providers; and conducts regular reviews to transition individuals to more independent;

- **Mental Health Rehabilitation Services (MHRS) Local Only** – provides local funding for the payment of claims to providers for District residents who receive mental health rehabilitation services who are not eligible for Medicaid;

- **Behavioral Health Rehab - Local Match** – offers Medicaid match for paid claims submitted by providers for District residents who are Medicaid-eligible and receive mental health and substance use disorder services that are funded by Medicaid; and

- **Gambling Addiction Treatment and Research** – provides support services for the prevention, treatment, and research of gambling addictions.

Child/Adolescent/Family Services – 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 10 activities:

- **Child/Adolescent/Family Services Administration –** 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;

- **Behavioral Health Services MH/SUD –** oversees development, implementation, and monitoring of a comprehensive array of community-based mental health and substance use disorders services including evidenced-based and promising practices, implemented within the behavioral health provider network to address the needs of adults, children, youth, and their families. This program leads the oversight and management of the agency's integrated community-based, prevention, early intervention, and specialty behavioral health programs;

- **SUD Prevention and Treatment –** ensures comprehensive prevention systems by developing policies, programs, and services to prevent the onset of illegal drug use, prescription drug misuse and abuse, alcohol misuse, and abuse, and underage alcohol and tobacco use. It also, oversees the provision of substance use treatment for children and adolescents and transition-aged youth by ASTEP providers;

- **School Based Behavioral Health Services –** provides school-based, primary prevention services to students and school staff, early intervention and treatment services to students and parents, and consultation to individual teachers and school administrators;

- **Crisis Services** – offers through a contract crisis intervention and stabilization services to residents and visitors who are experiencing psychiatric crisis in the community or at home; services include linkage to DBH, psycho education, treatment compliance support, and grief and loss services to individuals after a traumatic event;

- **Court Assessment** – provides the Superior Court of the District of Columbia with court-ordered, high-quality, comprehensive, and culturally competent mental health consultation, and psychological and psychiatric evaluations, for children and related adults with involvement in child welfare, juvenile justice, and family court;

- **Early Childhood Services –** provides in home and center-based early childhood mental health supports and child and family-centered consultation to child development center staff and families to build their skills and capacity to promote social/emotional development and to prevent, identify, and respond to mental health issues among children in their care;

- **Specialty Services** – provides centralized coordination and monitoring of placement, continued stay, and post-discharge of children and youth in psychiatric residential treatment facilities (PRTF). Oversees the coordination of the PRTF medical necessity review process. Supports Juvenile Court by providing JBDP and HOPE Court Juvenile Behavioral Diversion Program and Hope Court that conduct mental health and substance use disorder screening, assessments, and referrals for youth, and families involved with the courts ensuring they have easy access to a full continuum of quality behavioral health services and supports. DC MAP-Through contract support the provision of screening and psychiatric consultation in pediatric practices. Co-Located Services: Oversees the co-location of DBH clinician at CFSA to facilitate early behavioral health screenings, assessments, and consultations with CFSA social work staff and to make service referrals to the behavioral health provider network

- **Government Operated Services-Howard Road** – provides early childhood treatment services through the Parent Infant Early Childhood Enhancement Program (PIECE) program for children ages 0-7. Provides same day Urgent Care Psychiatric Evaluations for youth ages 0-18 years of age; and

- **Evidence Based Practice (EBP)** – provides oversight of the design, development, implementation, and evaluation of a comprehensive continuum of evidence-based practices offered to children and youth with mental health and substance-related issues which includes 7 Evidence-Based Practices. In addition, the division provides oversight and support of Community Based Intervention (CBI) services for youth in crisis up to age 21. The Division also assists in the implementation and monitoring of children's assessment tools, Child and Adolescent Functional Assessment Scale and Preschool Early Childhood Functional Assessment Scale.

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 4 activities:

- **Data and Performance Measurement –** The Evidence-Based Services Division provides oversight of the design, development, implementation, and evaluation of a comprehensive continuum of evidence-based practices offered to children and youth with mental health and substance-related issues which includes 7 Evidence-Based Practices. In addition, the division provides oversight and support of Community Based Intervention (CBI) services for youth in crisis up to age 21. The Division also assists in the implementation and monitoring of children's assessment tools, Child and Adolescent Functional Assessment Scale and Preschool Early Childhood Functional Assessment Scale;

- **Strategic Planning and Policy –** develops programmatic regulations, policies and procedures to support the agency's mission and direction from executive leadership; supports the development and implementation of the agencies strategic goals and priorities;

- **Training Institute –** enhances the knowledge and competencies of the DBH provider network, and internal and external customers, through performance-based and data-driven learning environments and activities; and

- **Behavioral Health Block Grant Program –** leads development, implementation, and annual reporting on the Mental Health Block Grant and the Substance Abuse Block Grant; manages the agency's process for identifying and responding to federal grant opportunities; and provides ongoing support to the Behavioral Health Planning Council.

District Recovery Plan – leads the District Recovery Plan initiatives, which include COVID-19 Public Health Emergency Direct Response Costs; Economic Recovery for Residents and Businesses; Build and Preserve Affordable Housing; Learning Acceleration; Reduction of Healthcare Disparities; Gun Violence Prevention; Youth Safety; and Alternative 911 Response. These initiatives are funded by District Recovery Plan Funds, which include the following sources: the American Rescue Plan Act and the Coronavirus Aid, Relief, and Economic Security Act.

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.

MAYOR'S FISCAL YEAR 2020-2023 OPERATING BUDGET SUMMARY

Description	*FY 2021 Actual*	*FY 2022 Approved*	*FY 2023 Proposed*	*% Change from FY22*
The Department of Behavioral Health				
Operating Budget	$329,451,014	$553,232	$369,419,870	3.7
FTEs	1,310.0	1,454.6	1, 457.7	.2
Capital Budget	$553,232	$4,420,383	$12,700,000	187.3
FTEs	0.0	0.0	0.0	N/A

COMMITTEE COMMENTS AND ANALYSIS

Substance/Opioid Abuse: According to DBH Director Barbara Bazron, there were 426 opioid deaths in 2021, representing a 3.5% increase in opioid deaths in the District from 2020, despite a pledge from the Mayor's Live. Long. DC. Plan to cut deaths in half. The agency testified at its budget oversight hearing that individuals often turned to alcohol, opioids, and other drugs to help them cope with the COVID-19 pandemic. For people already facing mental illness, opioid addiction or other substance use disorders, Director Bazron testified that pandemic related disruptions in treatment regimes, social networks, and daily routines challenge their recovery.

The Committee was pleased to see an investment of $41 million in substance abuse treatment services, which includes $28 million in federal dollars by way of the State Opioid Response (SOR) grant. In addition, the proposed budget includes $250,000 to fund prevention of opioid use disorders in the LGBTQ community. The Committee recognizes the ongoing challenges of reaching these various populations, and hopes that with continued investments in treatment, combined with the implementation of focused legislation and the policy recommendations set forth in this report, the District can begin to see the reversal of opioid related deaths.

As the responsibility of Naloxone distribution has now transitioned from the Department of Health to the Department of Behavioral Health, the Committee would like to be kept updated on exactly how the life-saving drug is being made available, information on testing and administration, and coordinating efforts on the part of DBH.

School Based Behavioral Health Program: The pandemic has exasperated the mental trauma that many District children were already facing; this is especially true for many children in low-income families who, on top of the isolation of a global pandemic, also

must grapple with the effects of economic uncertainty and unstable housing caused by the pandemic, food insecurity, more violent crime in their neighborhoods, and the effects COVID-19. The need for mental health professionals to be available for our public and public charter students is vital to truly heal the trauma experienced by our younger residents and give them a chance to succeed.

The Committee was pleased to see a proposed investment of $33.6 million in the School-Based Behavioral Health (SBBH) program, which includes an 8 FTE and $3.7 million increase to expand support for students' mental health through wrap-around services, as well as a strengthening of the workforce pipeline towards a career in school-based clinicians to ensure demand for clinicians can be met. Currently, community-based organizations (or CBOs) are in 158, or 63% of public schools, and the added investment allows for the addition of clinicians in 25 schools with the most significant needs.

Though the agency reports that the program is on track to being able to provide behavioral health services in all 251 projected schools, the Committee believes the program is still underfunded and in desperate need of long-term stabilization. The grant funding the program originally created in 2016 was based on projections that drastically underestimated its needs and did not take into account inflation and a future viral pandemic. The current funding provides $70,344 per year for each school, which has been insufficient to cover the costs of the program. For the last two years, the District has used one-time funding supplements to stabilize the community-based organization grant program and address the financial strain of the pandemic on providers. These supplements should be made permanent, and the community-based organization grant amount should also cover the inflationary cost increases over the next three years, while a cost study is conducted. Each of the 251 schools in the program will require roughly $80,000, which is $9,656 more per school than is currently in the Mayor's proposed budget. To cover this budget shortfall, the Committee reallocated resources to add $2.42 million in recurring funding to the program for FY23. By providing this additional recurring funding, the District can build a workforce pipeline, expand information sharing and family engagement efforts, and provide for the most effective school-based behavioral health program for District children and their families.

The Committee was also pleased to learn that DBH has plans to conduct a rate study to determine if current funding is sufficient to support the program. It is the Committee's recommendation that the agency conducts this study in consultation with the members of the Coordinating Council on School-Based Behavioral Health, including the Deputy Mayor of Education, the Office of the Superintendent of State Education, DC Public Schools, the Public Charter School Board, and other District agencies or organizations, and ensures that it identifies and evaluates the costs associated with fully implementing the school-based behavioral health program and its components. The study would, in effect, determine current and future CBO operating costs, including clinician salaries and benefits, supervision costs, and overhead costs, among others, and engage all stakeholders.

Healthy Futures: The Healthy Futures Program, administered by the Department of Behavioral Health, offers child and family-centered consultation services to care providers

and family members that build their skills and capacity to promote social emotional development in young children. Most sites that participate in the program are traditional child development centers and serve children ages 0 to 5; however, other sites, such as home-based providers, pre-kindergarten incentive, and the District's Quality Improvement Network, participate as well. Working in tandem with the Birth-to-Three Act, which was introduced by Chairperson Gray in 2018, the Healthy Futures program greatly benefits childhood educators. Schools often report significant improvements in teacher-child interactions and significant reductions in negative behaviors towards staff. The Committee was pleased to see an investment of $480,412 and 2.0 FTEs to support the expansion of the program, but still views the program as being underfunded. Therefore, the Committee reallocated $700,000 from the Mayor's proposed budget to the program in order to expand and continue administering these critical early childhood services.

Integration of Managed Care: The Committee was pleased to see that work is underway with the Department of Healthcare Finance to integrate behavioral health services into the Medicaid managed care program, effective October 1, 2023. According to DBH's Director, DBH and the Department of Health Care Finance are engaging in planning and readiness activities with providers to ensure the smooth transition of behavioral health services to managed care. They are surveying providers to identify their needs and providing multiple technical assistance opportunities and grants to support IT development. In addition, the agency is conducting a rate study to determine the appropriate payment for behavioral health services. It is the agency's hope that bringing these services into the managed care program supports better care coordination and alleviates the need for residents to navigate multiple systems, leading to healthier people living longer lives.

The Committee would also like to highlight the following investment made in the FY23 proposed budget that will help further DBH in meeting its mission of providing community based, culturally competent behavioral health services that support prevention, resiliency, and recovery:

- $36.5 million for mental health services
- $28.4 million to maintain supported housing for 1,700 residents
- $8.9 million to support behavioral health transformation services and increased utilization by Medicaid eligible residents
- $10.9 million for mental health services for uninsured residents
- $18.3 million for crisis services
- $104.4 million to support Saint Elizabeths Hospital
- $7.3 million in grants for victims of sexual assault and other victim services, including crisis intervention, advocacy, and trauma-informed mental health services
- $40.7 million in ARPA funds to support broad gun violence prevention initiatives within the District, ranging from public works employment for at-risk individuals to grants to expand mental health services for victims of gun violence
- $6 million to support violence prevention and diversion among at-risk, non-incarcerated youth

- $2.5 million for the Sobering and Stabilization Center
- $213,000 to support health promotion and public engagement

2. COMMITTEE BUDGET RECOMMENDATIONS

Fiscal Year 2023 Capital Budget Recommendations

The Committee approves the capital budget as proposed by the Mayor.

3. COMMITTEE POLICY RECOMMENDATIONS

1. Continue to equip all police officers and EMS workers with naloxone in high overdose areas of city, particularly in Wards 7 and 8

2. Continue expanding mental health crisis intervention and pre-arrest diversion initiatives as part of the District's comprehensive approach to police reform, and help steer individuals with acute and chronic behavioral health issues away from the criminal legal system

3. Develop an evidence-based and cost-effective program to help individuals diagnosed with Hoarding Disorder (HD)

4. Develop a comprehensive report on gambling addictions in the District, including prevention and treatment. The Committee would like to be kept informed on how DBH is spending the $200,000 it receives in Dedicated Taxes to support its Gambling Addiction Treatment program.

5. The Committee was pleased to learn that DBH has plans to conduct a rate study to determine if current funding is sufficient to support the School Based Behavioral Health program. DBH should conduct this study in consultation with the members of the Coordinating Council on School-Based Behavioral Health, including the Deputy Mayor of Education, the Office of the Superintendent of State Education, DC Public Schools, the Public Charter School Board, and other District agencies or organizations, and ensure that it identifies and evaluates the costs associated with fully implementing the school-based behavioral health program and its components. This study should determine current and future CBO operating costs, including clinician salaries and benefits, supervision costs, and overhead costs, among others, and engage all stakeholders.

6. Provide the Committee on Health with an up-to-date report on opioid-related deaths thus far in 2022.

7. Work with the District Medical Examiner's Office to develop a semi-annual report on opioid related deaths in the District and report these statistics to the Council every 6 months.

8. Develop and provide the Committee on Health with a new model discharge plan for Community Residential Facilities, which would ensure that all parties, including providers and ACT teams, are providing consistent and appropriate support to CRF residents throughout their discharge process.

9. Create a student loan repayment assistance program for current and prospective clinicians. Much like the District's Health Professional Loan Repayment Program (HPLRP), administered by the DC Department of Health, this program would provide loan repayment to eligible health professionals practicing full-time at certified sites in health professional shortage and medically underserved areas in the District. These licensed and credentialed mental health providers would include clinical social workers, clinical psychologists, and professional counselors.

10. Continue to develop strategies that help to increase the number of licensed mental health professionals in the workforce, i.e. expediting the review and approval process for professional licensing board applications.

11. Continue to develop multi-year affiliation agreements with local universities to host graduate-level interns.

12. Hire an analyst who collects priority mental health data from DC Public and Public Charter Schools and Department of Behavioral Health, and report to Council on a quarterly basis. Priority data should include Student mental health or ACE (Adverse Childhood Experience) assessment results, the number of students and parents requesting support, the number of mental health staff on the ground in each school, and the content and availability of web-based information at the school and system level, among other information

13. Increase the number of Community Response Teams to enhance engagement of residents with behavioral health needs, connect them to care, and address crisis.

14. The Mayor's budget includes $2.2 million to continue operating the Sobering and Stabilization Center expected to open this summer. The Committee requests a comprehensive report on the function and types of services that will be available at the center, and continue to update the Committee on its opening.

D. DEPARTMENT OF HEALTH CARE FINANCE

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. The agency provides health care services to low-income children, adults, the elderly, and persons with disabilities. More than 280,000 District of Columbia residents (approximately 40 percent of all residents) receive health care services through DHCF's Medicaid and Alliance programs.

The Department of Health Care Finance operates through the following 10 divisions:

Health Care Delivery Management (HCDM) – ensures that quality services and practices pervade all activities that affect the delivery of health care to beneficiaries served by the District's Medicaid, Children's Health Insurance Program (CHIP), and Alliance programs. HCDM accomplishes this through informed benefit design; use of prospective, concurrent, and retrospective utilization management; ongoing program evaluation; and the application of continuous quality measurement and improvement practices in furnishing preventive, acute, and chronic/long-term care services to children and adults through DHCF's managed care contractors and institutional and ambulatory fee-for-service providers.

This division contains the following 5 activities:

- **Managed Care Management** – provides oversight, evaluation, and enforcement of contracts with organizations managing the care and service delivery of Medicaid and Alliance beneficiaries, along with providing oversight and enrollment of eligible beneficiaries;

- **Preventive and Acute Care (Children's Health Services)** – develops, implements, and monitors policies, benefits and practices for children's health care services, including HealthCheck/EPSDT, CHIP, and the Immigrant Children's Program;

- **Division of 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;

- **Division of Clinicians, Pharmacy and Acute Provider Services** – develops, implements, and oversees the programming for primary and specialty providers,

hospitals, and other acute and preventive care services; and manages the non-emergency transportation contract; and

- **Health Care Delivery Management Support Services** – provides administrative support functions to the Health Care Delivery Management division.

Long-Term Care Administration (LTCA) – 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, the 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; and

- **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.

Health Care Policy and Planning – maintains the Medicaid and CHIP state plans that govern eligibility, scope of benefits, and reimbursement policies for the District's Medicaid and CHIP programs; develops policy for the Health Care Alliance program and other publicly funded health care programs that are administered or monitored by DHCF based on sound analysis of local and national health care and reimbursement policies and strategies; and ensures coordination and consistency among health care and reimbursement policies developed by the various divisions within DHCF. The division also designs and conducts research and evaluations of health care programs.

This division contains the following 4 activities:

- **Policy Unit Management (Regulation and Policy Management)** – maintains the Medicaid State Plan, which governs the eligibility, scope of benefits, and reimbursement policies of the Medicaid and CHIP programs; creates State Plan Amendments, waivers, and regulations that form the foundation of Medicaid policy and programs administered or monitored by DHCF; and ensures the coordination and consistency of health care and reimbursement policies developed

by various divisions within DHCF;

- **Data Analysis (Division of Analytics and Policy Research)** – gathers information, analyzes data, and evaluates all activities related to multiple District-wide components of Medicaid, CHIP, the Alliance, and future healthcare delivery systems, including data collection systems; and designs and conducts research and evaluation of health care programs, studying their impacts on beneficiaries, providers, plans, and other partners and customers, designing and assessing potential improvements, and developing new measurement tools;

- **Member Management (Eligibility Policy)** – 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; 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; and

- **Health Care Policy and Planning Support (Health Care Policy and Research Support)** – provides administrative support functions to the Health Care Policy and Planning Administration.

DCAS Project Management Administration – has responsibility to design, develop, implement and manage the DC Access System (DCAS), which is an integrated eligibility system for all health and human services for the District. In addition, this administration is responsible for supporting the functionality and funding for all components of DCAS and their seamless interface with the Health Benefits Exchange and Department of Human Services program components.

This division contains the following 4 activities:

- **Program Management** – manages all operational and functional activities related to the DCAS project;

- **Project Management** – manages all project management and functional activities related to the DCAS project;

- **Organizational Change** – manages all historical, current, and forecasted project initiatives associated with Organization Change Management; and

- **Information Technology** – manages the operational tasks and maintenance for the DCAS project.

Health Care Finance – provides provider payments for the following provider types: Medicaid providers, public providers, and Health Care Alliance providers.

This division contains the following 3 activities:

- **Medicaid Provider Payment** – provides payment to Medicaid providers;

- **Medicaid Public Provider Payment** – provides payment to Medicaid public providers; and

- **Alliance Provider Payment** – provides payment to Alliance providers.

Health Care Operations – ensures the division of programs that pertain to the payment of claims and manages the fiscal agent contract, the administrative contracts, systems, and provider enrollment and requirements. The office provides contract management of the Pharmacy Benefits Manager, the Quality Improvement Organization contract, and the Medicaid Management Information System (MMIS) Fiscal Intermediary contract as well as additional administrative contracts.

This division contains the following 3 activities:

- **Medicaid Information Systems (Claims Management)** – oversees MMIS operations; systems requests; member services, including member out-of-pocket reimbursements; Consolidated Omnibus Budget Reconciliation Act (COBRA) payments; third-party liability processing; and processing of financial transactions. The division also manages all internal and external data requests and data involving agency audits (local and federal), as well as MMIS training for all DHCF employees and system security;

- **Division of Public and Private Provider Services** – manages the Administrative Services Organization contract, provider enrollment and recruitment, and internal and external provider services and inquiries. 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; and

- **Health Care Operations Support (Health Care Operations Support Services)** – provides administrative support functions to the Health Care Operations division.

Health Care Reform and Innovation (HCRIA) – 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 2 activities:

- **Affordable Care Reform and Grants Development** – develops and executes strategies for payment and delivery system reform in the District, including developing, implementing, and monitoring health reform activities as well as developing demonstration projects and grants to support various value–based purchasing and practice transformation strategies; and

- **Health Care Reform and Innovative Support Services** – is responsible for advancing the use of information technology among health care providers in the District. 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.

District Recovery Plan – provides the District Recovery Plan initiatives, which include COVID-19 Public Health Emergency Direct Response Costs; Economic Recovery for Residents and Businesses; Build and Preserve Affordable Housing; Learning Acceleration; Reduction of Healthcare Disparities; Gun Violence Prevention; Youth Safety; and Alternative 911 Response. These initiatives are funded by District Recovery Plan Funds, which include the following sources: the American Rescue Plan Act and the Coronavirus Aid, Relief, and Economic Security Act.

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.

MAYOR'S FISCAL YEAR 2020-2023 OPERATING BUDGET SUMMARY

Description	*FY 2021 Actual*	*FY 2022 Approved*	*FY 2023 Proposed*	*% Change from FY22*
The Department of Health Care Finance				
Operating Budget	$3,754,311,588	$3,657,030,545	$3,709,230,390	1.4
FTEs	285.8	351.0	372.2	6.0
Capital Budget	$82,654,247	$125,221,539	$127,675,000	2.0
FTEs	0.0	0.0	0.0	N/A

COMMITTEE COMMENTS AND ANALYSIS

Alliance Health Insurance Program

The DC Healthcare Alliance Program (Alliance) is a locally funded program designed to provide medical assistance to District residents who are not eligible for Medicaid. This

program serves low-income District residents who have no other health insurance and are not eligible for either Medicaid or Medicare. The vast majority of the beneficiaries for Alliance are undocumented residents.

The Department has long struggled with determining how it could financially provide the same or similar application and rectification process under Alliance as those seeking Medicaid or Medicare benefits. Before the pandemic, District residents had to apply for the Alliance program and recertify in-person, a difficult process considering that English was not the first language for many applicants and it frequently meant several appointments were necessary to gather documentation for the application. The Committee passed B23-890, the "Prescription Drug Monitoring Program Query and Omnibus Amendments Act of 2020" which if funded would have allowed Alliance applicants to apply over the telephone, or website. Recertifications would have been limited to once a year.

Funding the law proved challenging with a steep financial impact despite the Committee push back on the cost analysis. However, when the District government halted all non-essential in-person government services, DHCF allowed for remote application to Alliance and suspended recertification requirements and allowed all enrolled beneficiaries to remain in the program. The Committee commends the Mayor and DHCF Director, Deputy Mayor Wayne Turnage for their leadership and commitment in ensuring health benefits for the District's undocumented residents during the pandemic which likely saved many lives as people with chronic illness could continue to receive care.

Following the Committee's budget markup for FY22, Deputy Mayor Turnage, in his capacity as Director of DHCF assured the Committee that there would be an additional study to review the data of enrollees int the Alliance program to determine the true cost of removing in-person enrollment and the six-month recertification requirements. Further, he clarified that DHCF would no longer remove beneficiaries from Alliance while their application was being processed or pending review. Last fall, efforts to resume in-person and remote recertification failed due to numerous issues with processing paper and electronic applications. DHCF suspended the recertification plans. In March 2022, the Council passed Rulemaking for the Alliance program that ended in person application for the program. The six-month recertification requirement was also removed if funding was provided in the FY23 budget. The Committee applauds the Mayor for funding the language which removed the six-month recertification requirement. The Committee believes that this action will encourage more preventive health visits and lead to a healthier community as was envisioned by extending health care access under the Affordable Care Act of 2010.

Workforce Development

The Department has taken steps to increase the wages for certain health care professionals using federal healthcare funds from the American Rescue Act (ARPA). In Subtitle A. the "Medicaid Home and Community Based-Services Enhancement Fund" the Mayor proposes to create a special fund to hold the federal funding. While some of the funds are allocated for one-time bonuses dedicated to named purposes such as for hiring, retention, training, transportation of healthcare workers and vaccination incentives, the majority of the funding will help increase wages for the designated healthcare populations. The Committee applauds any effort to increase wages for healthcare workers, however, the Committee is concerned that unless there is a concentrated and sustained effort to increase health care wages, especially for entry level work, people will not be attracted to the health care profession especially those largely funded by Medicaid reimbursement. It was noted by several witnesses during the budget oversight hearing that it is easier to take a job as a dog walker and earn more money with less stress than become a health care worker which requires training that people often have to pay out of pocket.

The Committee appreciates Deputy Mayor Turnage efforts to increase wages for healthcare workers however, the Committee is concerned that not enough is being done to ensure this critical workforce is protected and there is a strong pipeline for new workers. The healthcare profession has been strained tremendously by COVID-19. Calls for home health workers to assist people in the community are too often going unanswered because of the shortage in the workforce. This workforce shortage impacts hospitals' ability to discharge patients to rehabilitation or homes in the community, the ability for people to return to work because they must care for family at home, and further stresses employees who are trying to cover work when others quit due to the demands of the job.

The Committee believes that every effort should be made to increase wages for health care workers, particularly those who are largely reimbursed by Medicaid. Further, the Committee would like to work with providers and DHCF to find a path to increase entry level pay to a sufficient level to strengthen the workforce pipeline.

2. COMMITTEE BUDGET RECOMMENDATIONS

Fiscal Year 2023 Capital Budget Recommendations

The Committee makes no changes to the capital budget for this agency.

3. COMMITTEE POLICY RECOMMENDATIONS

1. The Committee supports DHCF's commitment in increase healthcare wages but urges DHCF to work with providers to ensure the base wages for entry level health care workers reimbursed by Medicaid are at least 120% above the living wage or minimum wage, whichever is higher.

2. The Committee applauds DHCF's work to remove barriers to healthcare with Alliance reforms removing in-person applications and six-month recertification requirements. The Committee is still concerned that there is a break down in the application and recertification process which leaves many unsure if they have insurance. The Committee urges DHCF to work with the Department of Human Services to find solutions to improve the application and recertification process.

E. OFFICE OF THE DEPUTY MAYOR FOR HEALTH AND HUMAN SERVICES

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.

The Office 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)

Human Support Services – 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.

Program Structure Change
The Office of the Deputy Mayor for Health and Human Services has moved the Thrive By Five Coordinating Council to the Office of Woman's Policy and Initiatives. The change has been reflected in the FY23 proposed budget.

MAYOR'S FISCAL YEAR 2020-2023 OPERATING BUDGET SUMMARY

Description	*FY 2021 Actual*	*FY 2022 Approved*	*FY 2023 Proposed*	*% Change from FY22*
The Office of the Deputy Mayor for Health and Human Services				
Operating Budget	$2,726,195	$2,922,542	$2,861,218	-2.1
FTEs	12.6	15.8	14.8	-6.3
Capital Budget	0.0	0.0	0.0	N/A
FTEs	$0.0	$0.0	$0.0	N/A

COMMITTEE COMMENTS AND ANALYSIS

The agency's encampment response

DMHHS continues to help combat homelessness in the District by providing outreach services and programs to many encampments within the District. The Encampment Team conducts welfare checks and provides services to over 280 encampment sites in the District. In addition to these services, DMHHS has implemented Mayor Bowser's CARE Pilot Program to decrease homelessness in the District. This is a "Housing First" model for persons living in encampments.

The goal of this Pilot Program is to establish permanent housing as the platform from which all other needs of those experiencing homelessness can be addressed. It is a cross agency coordination with DBH, DPW, DHS, and the federal government through the National Park Service (NPS) along with Community Based Organizations (Pathways to Housing and Miriam's Kitchen). The Program's goal is to clear encampments by housing people either in leased housing or in bridge housing (motels or hotels). This allows the homeless to gain the stability necessary to deal with any other issues impacting their lives.

The Program has focused on four encampments in the District. First, outreach teams would reach out and meet with residents of the encampments over several weeks to inquire into their needs and interest in joining the program. Those who engaged with the Program were given opportunities to gain housing. Then, agencies and outreach services would provide housing over several weeks for those who had expressed interest at some point during the program. Finally, the encampments are completely cleared, which includes any of the people, tents, belongings, and services that are present.

According to Deputy Mayor Wayne Turnage and his team at DMHHS, the CARE Pilot Program has been successful so far in their mission. There are 139 people in the program from certain identified encampments and of those 139, there were 109 people who engaged with the program. The other 30 persons declined services. Of those 109 who successfully engaged, 74 are in leased housing and 17 are in bridge housing. The success rate of those who engaged in the program is 84%. Additionally, the success rate of the whole pilot including those who engaged and those who did not engage in the program from the start is 64%. This success frees up space in the city and most importantly, moves homeless District residents into housing. This has ended homelessness for many people.

However, there are still many concerns and criticisms for this program by many advocates and advocacy groups in the District. Some advocates are from Miriam's Kitchen and D.C. Fiscal Policy, while others are from Sunrise D.C. and the National Homelessness Law Center. The biggest concern is that these encampments clearings and no encamping zones are harmful to those who are homeless and to those who are not engaging in the program. Those who refuse engagement are forced to clear out of the area they have set up as their home, a place where they feel safe, a place that houses their belongings their paperwork, and themselves. Additionally, there have been several incidents where people have been inside tents that were taken and cleared by forklifts and other construction vehicles. These forced clearings also damage the relationship between outreach programs and services and those persons who are homeless. It has built distrust and other negative feelings between the groups by destroying belongings, forcing people to move somewhere else, and using the police and large groups of people to enforce the clearings and prevent harm.

There are also some economic concerns about the expense of this program. Advocates for the homeless raised the possibility that there are less harmful and more cost-effective methods that are not being used. Advocates continue to appreciate the trash pick-up, porter potties, and handwashing stations services, but want these services to be extended. Some advocates want the program to be terminated as it goes against the Center for Disease Control guidelines enacted during COVID-19 and violates their rights.

DMHHS has responded to these concerns and criticisms by providing numerical data regarding the program's success rate and disagreeing with many of the criticisms. This Agency focuses on the goal of housing those who are homeless in these encampments through the program's methods. Due to the program's success, the Agency will want to expand the program to other encampments within the District. DMHHS will report to the Mayor's Office once all four encampments have been cleared.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. Fiscal Year 2023 Operating Budget Recommendations

The Committee approves the operating budget as proposed by the Mayor.

b. Fiscal Year 2023 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

DMHHS has continued to respond to the needs of District residents considering the continued effects COVID-19 has had on the health and safety of its citizens, especially those most vulnerable. The Committee makes the following policy recommendations:

1. Incorporate an objective for outreach to acquire responses or reviews from individuals in and out of the Pilot Program before, during, and after encampment clearing. The agency should adapt the Care Program as needed to better align with the needs of those in and outside the Program.

2. The Committee recommends that the Care Pilot Program not destroy or throw-out the belongings of those living in the homeless encampments. Instead, to allow the homeless to collect their belongings from a warehouse or storage facility if they are not present during the clearing or refusing to engage in the program.

F NOT-PROFIT-HOSPITAL CORPORATION & SUBSIDY

1. AGENCY MISSION AND OVERVIEW

The Not-For-Profit Hospital Corporation (NFPHC), commonly known as United Medical Center (UMC), is an independent District instrumentality, created by legislation adopted by the Council of the District of Columbia. It provides inpatient, outpatient, psychiatric, and emergency care. NFPHC is located east of the Anacostia River in the Southeast section of Washington, D.C. Its primary service market includes residents of Wards 7 and 8 and the state of Maryland's Prince George's County. Approximately 88 percent of United Medical Center's hospital admissions were paid for by the public programs Medicare or Medicaid.

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

A. The Chief Financial Officer of the District of Columbia, or his or her designee, who shall serve as chair of the Fiscal Management Board;

B. The Deputy Mayor for Health and Human Services, or his or her designee;

C. One citizen member from either Ward 7 or Ward 8, appointed by the Mayor, who has experience in public health or health care delivery;

D. A citizen member, appointed by the Mayor, who has experience serving as the City Administrator of the District of Columbia;

E. An individual with expertise in hospital management or finance, appointed by the Mayor; and

F. One representative from each of the two unions, selected by each representative union, maintaining the largest collective bargaining units at United Medical Center; and

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

The Not-For-Profit Hospital Corporation operates through revenues generated primarily, though not exclusively, through its hospital patient and Skilled Nursing Facility (SNF) resident operations.

Hospital Services – NFPHC operates an acute care program with 234 licensed acute care beds, which provides medical, surgical, and psychiatric care. Other hospital services include adult emergency care and outpatient and diagnostic services. Children's National Medical Center, through a lease arrangement and as a separately licensed organization, provides pediatric emergency care on the campus of NFPHC.

Skilled Nursing Facility (SNF) Services – With a capacity of 120 beds, the SNF provides skilled nursing services to chronically ill residents, with a significant percentage of the patients being the elderly.

The Not-For-Profit Hospital Corporation Subsidy provides a direct payment to the Not-For-Profit Hospital Corporation (NFPHC).

MAYOR'S FISCAL YEAR 2020-2023 OPERATING BUDGET SUMMARY

Description	*FY 2021 Actual*	*FY 2022 Approved*	*FY 2023 Proposed*	*% Change from FY22*
The Not-for-Profit Hospital Corporation				
Operating Budget	$0.0	$155,000,000	$155,000,000	0.0
FTEs	0.0	0.0	0.0	N/A
Capital Budget	$0.0	$0.0	$0.0	N/A
FTEs	0.0	0.0	0.0	0.0

Description	*FY 2021 Actual*	*FY 2022 Approved*	*FY 2023 Proposed*	*% Change from FY22*
The Not-for-Profit Hospital Corporation Subsidy				
Operating Budget	$40,000,000	$15,000,000	$15,000,000	0.0
FTEs	0.0	0.0	0.0	N/A
Capital Budget	$0.0	$0.0	$0.0	N/A
FTEs	0.0	0.0	0.0	N/A

COMMITTEE COMMENTS AND ANALYSIS

2. COMMITTEE BUDGET RECOMMENDATIONS

a. Fiscal Year 2023 Operating Budget Recommendations

The Committee approves the operating budget as proposed by the Mayor.

b. Fiscal Year 2023 Capital Budget Recommendations

The Mayor's proposed budgets for the NFPHC and NFPHC Subsidy do not include any capital funds.

3. COMMITTEE POLICY RECOMMENDATIONS

1. In proposing any reductions to United Medical Center, the Fiscal Management Board shall preserve the emergency department and behavioral health services and should ensure that the preservation of management positions is not prioritized over front-line staff.

2. Mazars needs to correct the contracting and procurement problems they have had and hire staff who can submit contracts to the Council in a timely manner.

G. DC HEALTH BENEFIT EXCHANGE AUTHORITY

1. AGENCY MISSION AND OVERVIEW

In March of 2010, the Patient Protection and Affordable Care Act of 2010 was signed into law with the central goal of ensuring that all Americans have access to quality, affordable health care. It enabled implementation of significant health insurance reforms including the establishment of Health Benefit Exchanges nationwide. The D.C. 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.

The Health Benefit Exchange operates DC Health Link, an online marketplace for District residents and small businesses to compare private health insurance plans, learn if they are eligible for tax credits or subsidies to purchase private insurance or qualify for Medicaid, and enroll in a health plan that best meets their needs. The Health Benefit Exchange enables individuals and small businesses and their employees to find affordable and easier-to-understand health insurance. The District of Columbia Health Benefit Exchange Authority is now in its tenth year of operation and concluded its ninth open enrollment period for people purchasing individual insurance on January 31, 2022.

The Health Benefit Exchange Authority operates through the following 5 programs:

Consumer Education and Outreach – educates and informs District residents, small business owners, and small business employees about health coverage options available through DC Health Link by organizing special events, participating in sponsored activities, conducting educational seminars, partnering with other District agencies and organizations as well as conducting intensive outreach through all of these methods.

This program contains the following 3 activities:

- **Consumer Education and Outreach Support Services** – educates District residents, small business owners and small business employees about health coverage options available through DC Health Link by organizing special events, participating in outside events, conducting educational seminars, partnering with other District agencies and organizations, and conducting intensive outreach through all of these methods;

- **Marketing and Communication** – provides support and awareness for DC Health Link through development of an earned media plan, printed materials for distribution, paid media campaigns that may include outdoor advertising, broadcast, newspapers and other publications, digital, and social media avenues; and

- **Navigators, Counselors, and In-Person Assisters (IPA)** – required for state-based marketplaces and is a condition for certification as a state-based marketplace. Navigators, Certified Application Counselors, and In-Person Assisters provide people one-on-one help with enrollment.

Marketplace Innovation Policy and Operations – performs functions required of all state-based marketplaces, including plan management eligibility determinations, and certification of qualified health and dental plans, as well as to ensure the efficient operation of an online insurance marketplace where individuals, families, small businesses, and their employees can shop and enroll in health insurance.

This program contains the following 6 activities:

- **Contact Center** – required for state-based marketplaces and is a condition for certification as a state-based marketplace. Contact center takes calls to assist consumers with DC Health Link questions and on-line applications. Processes paper applications and provides information for escalated cases to the HBX and Economic Security Administration (ESA);

- **Plan Managemen**t – required for state-based marketplaces and is a condition for certification as a state-based marketplace. Working in conjunction with local and federal regulatory bodies, establishes and oversees the process to certify, recertify, and decertify Qualified Health Plans and Qualified Dental Plans available through DC Health Link. Also manages enrollment issues with Qualified Health Plan and Qualified Dental Plan carriers including the coordination of all Electronic Data Interchange (EDI)-related transactions to and from DC Health Link;

- **Eligibility and Enrollment** – required for state-based marketplaces and is a condition for certification as a state-based marketplace. With the support of IT, designs and manages the eligibility and enrollment process through a seamless, web-based application to determine individual and family member eligibility for Medicaid and/or advanced premium tax credits and to enable individuals and families to enroll in qualified health plans and qualified dental plans available through DC Health Link, manages and facilitates a legally required consumer appeals process; and, as required by federal law, provides tax reporting information to consumers and the IRS;

- **Member Services** – responsible for core customer service responsibilities essential to successful Exchange operations and evaluated as part of the state-based marketplace certification process. The program researches complex customer service problems and works with multiple stakeholders to resolve those issues. It also provides assistance to consumers with complex circumstances and to those needing extra help navigating the DC Health Link online marketplace, resolving any technical difficulties a customer may experience, ensuring that changes to eligibility and enrollment information are quickly updated and processed, enabling consumers to conduct certain services (such as address changes, reporting of life events, or special enrollment period transactions) over the phone, and resolving all escalated cases from the Contact Center and other sources;

- **Data Analytics and Reporting** – responsible for the development and implementation of federally required data reporting requirements and consumer-related surveys. This team manages the end-to-end process of developing

functionality for electronic federal data reporting as well as the creation and dissemination of required IRS 1095A forms for tax reporting purposes. Develops consumer-related surveys around enrollment and satisfaction with DC Health Link; and

- **S.H.O.P. Operations** – required for state-based marketplaces and is a condition for certification as a state-based marketplace. Develops, operates, and manages DC Health Link's Small Business Health Options Program (SHOP). The SHOP facilitates enrollment into qualified health plans for employees of small businesses that purchase coverage through DC Health Link. This team manages that process from end-to-end, designs system improvements, and troubleshoots systems issues to ensure effective operation of the SHOP Marketplace. Works with IT on design, manages broker relationships, training, certification, and cases. Conducts outreach and works with the small business community.

IT Related Operations – provides critical development, maintenance, and support for DC Health Link. The work includes providing operations and maintenance of HBX systems, managing the team of consultants that develop functionality for DC Health Link, and managing the EDI Operations team that oversees information transmitted between carriers and DC Health Link.

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.

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 program is standard for all agencies using performance-based budgeting.

MAYOR'S FISCAL YEAR 2020-2023 OPERATING BUDGET SUMMARY

Description	*FY 2021 Actual*	*FY 2022 Approved*	*FY 2023 Proposed*	*% Change from FY22*
DC Health Benefit Exchange Authority				
Operating Budget	$49,239,520	$32,841,979	$35,684,055	8.7
FTEs	96.0	109.0	117.0	7.3
Capital Budget	$0.0	$0.0	$0.0	N/A
FTEs	0.0	0.0	0.0	N/A

COMMITTEE COMMENTS AND ANALYSIS

2021 American Rescue Plan: The Committee commends Director Mila Kofman and her staff at the DC Health Benefit Exchange Authority for their continued efforts in facilitating a nearly 100% insured rate in the District, as well as maintaining one of the most cost-effective and state of the art health insurance marketplaces in the nation. In 2021, the Biden administration brought a new level of optimism for health care; while the prior four years created serious threats to the Affordable Care Act, this new administration has already

worked to increase access to quality affordable health care, particularly during the COVID-19 pandemic. In March of last year, President Joe Biden signed into law the American Rescue Plan, which effectively reduced premiums for health insurance through DC Health Link and provides health insurance for as little as $11 per month. The American Rescue Plan enhanced premium tax credits for 2021 and 2022, and placed caps on insurance premiums for people at all income levels who purchased individual health insurance coverage through an Affordable Care Act exchange, resulting in approximately $36 million in lower premiums for District residents. The Committee applauds the Health Benefit Exchange for its efforts in keeping insurance premiums as low as possible for District residents and hopes that Congress extends the ARP expansion past December 31, 2022.

Social Justice Working Group: Also worth highlighting is the agency's efforts with its Executive Board's Working Group and its focus on analyzing outcomes and promoting health equity in the District. Comprised of stakeholders committed to social justice and health equity, including DC Health Link carriers, patient advocates, health equity experts, members of the broker community, and providers, the Social Justice and Health Disparities Working Group was convened in February of 2021 and met bi-monthly until its recommendations were adopted by the Executive Board in July of 2021. The report, titled "How Health Insurance Companies Offering Coverage through DC Health Link are Taking Steps to Improve Access to Services for District Residents East of the River" issues recommendations for expanding access to providers and health systems for communities of color in the District, eliminating health outcome disparities for communities of color in the District, and ensuring equitable treatment for patients of color in health care settings and in the delivery of health care services in the District. Recommendations also put an emphasis on increased cultural competency training among carriers and promote providing incentives for both primary care and specialist physicians to practice in underserved areas in DC. The Committee applauds the HBX Executive Board for adopting these initiatives and for its continued work to expand access to providers for communities of color in the District.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. Fiscal Year 2023 Operating Budget Recommendations

The Committee approves the operating budget as proposed by the Mayor.

b. Fiscal Year 2023 Capital Budget Recommendations

The Mayor's proposed budget for the Health Benefit Exchange Authority does not include any capital funds.

3. COMMITTEE POLICY RECOMMENDATIONS

1. Continue to monitor the stability of District health insurance rates and explore opportunities to health care more accessible.

2. Continue developing strategies around addressing health equity and racism in health care.

3. Strengthen outreach to DC Health Link health insurance carriers to devise ways to expand access to providers on the East End of the District

4. Ensure the long-term implementation of President Biden's American Rescue Plan, and keep the Committee apprised of any future advancements the federal administration makes in the health insurance marketplace.

5. Increase utilization of Certified Business Enterprises (CBE) in the procurement of services.

III. TRANSFERS TO OTHER COMMITTEES

The Committee has no transfers to other Committees.

IV. BUDGET SUPPORT ACT RECOMMENDATIONS

On Wednesday, March 16, 2022, Chairman Mendelson introduced, on behalf of the Mayor, the "Fiscal Year 2023 Budget Support Act of 2022" (Bill 24-0714). The bill contains two subtitles for which the Committee has provided comments. The Committee also recommends the addition of two new subtitles. The Committee on Health describes the purpose, fiscal impact, committee reasoning, and a section-by-section analysis for each of the subtitles it recommends for inclusion in the Budget Support Act and has attached the legislative language in Attachment B to this report.

A. RECOMMENDATIONS ON MAYOR'S PROPOSED SUBTITLES

The Committee provides comments on the following subtitles of the "Fiscal Year 2023 Budget Support Act of 2022":

1. Subtitle V-A. Medicaid Home and Community-Based Services Enhancement Fund
2. Subtitle V-C. Alliance Enrollment

The legislative language is included in Attachment B.

1. Subtitle V-A. Medicaid Home and Community-Based Services Enhancement Fund

a. Purpose, Effect, and Impact on Existing Law

This subtitle would establish the new special fund, the Medicaid Home and Community-Based Services Enhancement Fund, which the District CFO will deposit federal funds received as authorized by section 9817 of the approved March 11, 2021 (135 Stat. 216; 42 U.S.C. 1396d, note) (the "Section 9817 Enhancement Amount"). Money in the Fund shall only be used to fund the implementation of activities that enhance, expand, or strengthen Medicaid home and community-based services, as described in the District's Initial Spending Plan and Narrative for Enhanced Funding for Medicaid Home and Community-Based Services under Section 9817 of the American Rescue Plan Act of 2021 (ARPA) or as authorized by the Centers for Medicare and Medicaid Services (CMS).

b. Committee Reasoning

The District continues to receive federal funding through ARPA. The Department of Healthcare Finance (DHCF) has created the District's Initial Spending Plan and Narrative for Enhanced Funding for Medicaid Home and Community-Based Services which details how the federal healthcare funding will be spent. By creating this special fund, the money the District receives for healthcare under ARPA will be secured in a non-lapsing fund and available for the purposes offered and approved by CMS regardless of the fiscal year.

The plan, which is publicly available on the DHCF website details some one-time bonuses that can be used for retention for employees who worked though the height of the COVID-19 pandemic, hiring bonuses to attract new employees into the healthcare field, reimbursement funds for vaccine and booster incentives, among other incentive funding. The bulk of the funds are expected to bolster the average wages in the District for certain categories of health professionals to 117.6% if the living wage or minimum wage, whichever is higher. While the wages for healthcare professionals need to be at least 120% of the living wage to continue to attract people to this field, the Committee finds that this is a good beginning and use of funds. Therefore, the Committee recommends inclusion of this subtitle in the Budget Support Act, which would establish this new special fund.

c. Section-by-Section Analysis

Sec. 5001. Short title.

Sec. 5002. Amends The Department of Health Care Finance Establishment Act of 2007 by establishing as a special fund the Medicaid Home and Community-Based Services Enhancement Fund ("Fund"), which shall be administered by the Department. Money in the Fund shall be used only to fund the implementation of activities that enhance, expand, or strengthen Medicaid home and community-based services, as described in the Initial Spending Plan and Narrative for Enhanced Funding for Medicaid Home and Community-Based Services under Section 9817 of the American Rescue Plan Act of 2021.

d. Fiscal Impact

The fiscal impact of this subtitle was incorporated into the FY 22 Budget and Financial Plan.

2. Subtitle V-C. Alliance Enrollment

a. Purpose, Effect, and Impact on Existing Law

The purpose of this subtitle is to amend Section 7b of the Health Care Privatization Amendment Act of 2001, effective December 13, 2017 (D.C. Law 22-35; D.C. Official Code § 7-1407) to remove language that could allow the Mayor to require enrollees in the Alliance Health Insurance Program to appear in person for enrollment into the program or recertification of their eligibility for the program. Further, this subtitle repeals language that permitted biannual recertification and amends the law so that enrollees of Alliance are only required to recertify annually.

b. Committee Reasoning

The Committee has long since championed the having the Alliance Program, the District's local health insurance program for low-income residents on parity in enrollment and recertification with the Medicaid program. Without the proposed subtitle, District residents would be required to apply for the Alliance Program in person and recertify every six months which was an arduous process.

This subtitle now permanently amends the Health Care Privatization Amendment so that it no longer requires resident to apply and recertify for the Alliance program in person or have face-to-face interviews. Further, the requirement for biannual recertification has been repealed. These changes in the subtitle now allows application for the Alliance program to be similar to the application process for those seeking Medicaid benefits.

c. Section-by-Section Analysis

Sec. 5021. Short title.

Sec. 5022. Amends Section 7b of the Health Care Privatization Amendment Act of 2001 by striking the phrase "; except that that the Mayor may require enrollees to complete one in-person certification each year in Fiscal Years 2023, 2024, and 2025", and adding a new subsection that establishes that enrollees in the Alliance shall be required to recertify their enrollment on an annual basis.

d. Fiscal Impact

The fiscal impact of this subtitle was incorporated into the FY 22 Budget and Financial Plan.

B. RECOMMENDATIONS FOR NEW SUBTITLES

The Committee on Health recommends the following new subtitles to be added to the "Fiscal Year 2023 Budget Support Act of 2022":

1. **Subtitle X. Behavioral Health Awareness Fund**
2. **Subtitle X. First-Time Mothers Home Visiting Program**
3. **Subtitle X. Maternal Mental Health Task Force**

The legislative language is included in Attachment B.

1. Subtitle X. Behavioral Health Awareness Fund

a. Purpose, Effect, and Impact on Existing Law

This subtitle would amend the Department of Behavioral Health Establishment Act of 2013 to establish the new Behavioral Health Awareness Fund, to allow for the collection and dedication of funds received by the District for the new Behavioral Health Awareness motor vehicle identification tag. The subtitle also establishes that money in the fund is to be used solely to support behavioral health prevention and treatment programs administered by the Department of Behavioral Health.

b. Committee Reasoning

On February 9, 2022, Chairman Mendelson, on behalf of the Mayor, introduced the Behavioral Health Awareness Motor Vehicle Identification Tags Amendment Act of 2022, which authorized the Mayor to design and issue motor vehicle license plates with a design promoting behavioral health awareness. Funding from those plates was proposed to flow into anew Behavioral Health Awareness Special Purpose Revenue Fund and dedicated to support the Department of Behavioral Health in its efforts to provide support, prevention, and treatment for those seeking out behavioral health services.

To expedite the creation of this new license plate, the Committee on Transportation has recommended inclusion of a subtitle in the Budget Support Act that would create this new plate. However, because that Committee does not have jurisdiction over the Department of Behavioral Health, it could not establish the new fund necessary to collect and dedicate these funds, as proposed. Thus, the Committee recommends inclusion of this subtitle in the Budget Support Act, which would establish this new fund.

c. Section-by-Section Analysis

Sec. XX01.	Short title.
Sec. XX02.	Amends the Department of Behavioral Health Establishment Act of 2013 to establish the new Behavioral Health Awareness Fund.

d. Fiscal Impact

The fiscal impact of this subtitle was incorporated into the FY 21 Budget and Financial Plan.

2. Subtitle X. First-Time Mothers Home Visiting Program

a. Purpose, Effect, and Impact on Existing Law

Previously, the Committee funded subtitle "Leverage for Our Future Amendment Act of 2019". This subtitle limited the funding for the home visiting party awarded the competitive grant to deliver evidence- based home visiting services for organizations that focuses exclusively on low-income, Medicaid eligible, first-time mothers. This subtitle adds additional funds for this Program.

b. Committee Reasoning

DC Health has previously awarded funds through a grant for a home visiting program for first-time mothers who are eligible for Medicaid. A delay in implementation due to COVID meant that the program was not funded promptly. Due to the pandemic, the provider who was awarded the funding began the program in unfavorable conditions. However, initial reports from the provider appear promising.

The Committee heard from the current provider that they are now fully operational and would like additional time and resources to show the effectiveness of the program. The Committee believes limited additional funding is necessary to evaluate the effectiveness of this type of home visiting program in the District. The Committee would like to continue funding this first-time mother's home visiting program an additional year to review results and determine the success of this type of home visiting program in the District.

c. Section-by-Section Analysis

Sec. 5xxx. Short title.

Sec. 5xxx. Limit's the Department of Health from providing an amount that exceed $150,000 to the home visiting provider who was awarded the competitive grant pursuant to paragraph (1) of this subsection.

d. Fiscal Impact

The fiscal impact of this program is the funding granted for the First-Time Mother's Home Visiting Program which has been funded by the Committee at $150,000.

3. Subtitle X. Maternal Mental Health Task Force

a. Purpose, Effect, and Impact on Existing Law

This subtitle would establish a Maternal Mental Health Task Force to study maternal mental healthcare, make recommendations regarding specified matters pertaining to maternal mental healthcare, and report its findings and recommendations to the Mayor and the Council by August 31, 2023.

b. Committee Reasoning

The Council unanimously passed B22-172, the Maternal Mental Health Task Force Establishment Act of 2018 on May 1, 2018, which as passed subject to appropriation. In the Fiscal Year 2022 Budget Support Act of 2021, the law was repealed as it had not been funded within the required amount of time.

At the hearing on B22-172, the former Director of the Department of Behavioral Health, Dr. Tanya Royster, testified that the Department of Behavioral Health recognizes that maternal mental health affects not only the health of mothers, but also the health of their child before and after birth, as well as their entire family. "Recent research has found that 15 percent, or one in seven, new moms face significant symptoms of depression or anxiety, commonly called 'postpartum depression'. For poor or lower income women, the rate jumps to 25 percent" she expressed. If left untreated, maternal mental health disorders can cause serious health risks for both the mother and infant, increasing the risk for costly complications during birth and causing long-lasting impacts on child development and well-being. Dr. Royster highlighted several ways in which DBH has invested in maternal mental health, noting that the District has a strong base of community-based programs serving pregnant and new moms that provide models and invaluable lessons for future recommendations. Among these initiatives is the Parent Infant Early Childhood Enhancement Program (the PIECE Program), operated by DBH, which screens for mental or emotional challenges, and offers evidence-based practices to strengthen the parent/child bond. Dr. Royster also highlighted Mary's Center's Maternal Mental Health Program,

which provides mental health treatment and supports for pregnant women and women with young children. While Dr. Royster expressed that good work is being done across the city, she recognized that more is needed to meet the mental healthcare needs of new mothers.

The language included in this subtitle is nearly identical to the passed language of B22-172 with technical edits. The Committee accepts a transfer in the amount of $118,000 from the Committee on Judiciary and Public Safety for one-time FY23 funding to support this subtitle.

c. Section-by-Section Analysis

Sec. XX01. States the short title and states the definitions.

Sec. XX02. Establishes the Maternal Mental Health Task Force to provide policy recommendations for the improvement of maternal mental health. The Task Force for shall study: vulnerable populations and risk factors, barriers to screening, emerging treatment options, provider and patient needs to improve diagnosis and treatment, effective treatment strategies, successful postpartum recovery, evidence based practices for providers, and models for private and public funding. It further establishes August 31, 2023, as the date by which the Task Force shall submit a comprehensive report to the Mayor and Council making findings and recommendations to address maternal mental health needs. It states that the Task Force shall consist of 19 members and 2 co-chairs. It establishes a process for filling vacancies and states that the Department of Behavioral Health shall publish on its website a public listing of Task Force Members, meeting notices, and meeting minutes. Finally, it stablishes the dissolution of the Task Force after compliance with subsection (b) is complete.

Sec. XX03. Amends Section 2(f) of the Confirmation Act of 1978, adding a new paragraph (71) establishing the Maternal Mental Health Task Force by way of the Maternal Mental Health Task Force Establishment Act of 2022.

d. Fiscal Impact

The fiscal impact of this subtitle is $118,000 to provide for a Grade-13, Step 1 FTE with a salary of $93,000 and fringe benefits of $25,000, totaling $118,000

V. COMMITTEE ACTION AND VOTE

On Wednesday, April 20, 2022, the Committee on Health met to consider the Report and Recommendations of the Committee on Health on the Fiscal Year 2023 Budget for Agencies Under Its Purview. The meeting was called to order at 10:35 a.m.

Chairperson Gray began the meeting with a brief opening statement, highlighting key funding priorities that the Mayor included in the FY23 budget that help to advance public health equity in the District - notably additional funding for school nurses, increases in pay for health care workers whose wages are largely from Medicaid reimbursement, and DC Healthcare Alliance reforms that ended the requirement for in-person enrollment and recertification, and 6-month recertifications. He stressed that these investments will do much in keeping people healthy, as they will be able to remain insured and engage in preventative care. Chairperson Gray also commended the leadership of the executive branch for their hard work in keeping the public safe throughout the COVID-19 health emergency. He then briefly summarized the changes that the committee made to the operating budgets under its purview, which are included in this report.

Chairperson Gray shifted his focus to highlight the additional funding received through transfers from other committees, which was allocated towards initiatives that would help further improve public health outcomes in the District. These initiatives include mental health services for young girls and women, food security programs, a maternal mental health task force, HIV/AIDS prevention, and a crisis response team pilot to support survivors of natural and man-made disasters like flooding or housing fires, among others. After thanking his colleagues for these transfers, he briefly discussed the five subtitles included in the report, and thanked his fellow Councilmembers and their staff for working closely with him. He thanked Committee on Health staff - Michelle Loggins, Malcolm Cameron, and Kaitlyn Casey- as well as Council budget office staff Errol Spence, Anne Phelps, and Jen Budoff. Lastly, he gave thanks to David Guo of the Office of the General Counsel, and the entire staff of the Office of the Chief Financial Officer for promptly responding to requests for financial data. He then moved, *en bloc*, the proposed FY2023 operating and capital budgets for the agencies under the Committee on Health's purview, including the budget support act subtitles and policy recommendations, immediately opening the floor for discussion.

Councilmember Charles Allen thanked Chairperson Gray and his staff, as well as the Council's Budget Office, for its efforts during this year's budget process. He thanked the Committee for accepting $118k from the Committee on Judiciary and Public Safety to fund the Maternal Mental Health Task Force legislation at the request of Councilmember Henderson, as well as accepting $200k from to support the creation of a DBH pilot program to provide counseling support to survivors of natural and human-made disasters. He stressed how important this support will be and gave examples of fires at Arthur Capper Senior Building and Capitol Tower in Ward 6 where DBH and Red Cross didn't have the capacity to meet the needs of affected residents. In addition, he thanked the Committee and Councilmember Cheh for working together to enhance funding for Produce Plus and Food and Friends. He stressed that these programs are critical for ensuring that seniors and

other vulnerable residents have the good, nutritious food they need - especially as the District enters a recovery period from the pandemic.

Councilmember Allen noted that one of the recommendations in the report from the Special Committee on COVID-19 Pandemic Recovery was to expand access to healthcare in schools; therefore, he thanked Chairperson Gray for adding funding to the Department of Health budget to move closer to the goal of full-time nursing coverage in every school.

Similarly, he was glad to see the Mayor's increase in funding for school-based mental health services, and even more grateful for the Committee's addition of nearly $2.5 million to get closer to the ultimate goal of all District students having access to behavioral and mental health services. He also emphasized his support for the report's recommendation to continue to ensure that MPD and EMS personnel are equipped with naloxone.

Lastly, Councilmember Allen stressed that DHCF's shift from requiring Alliance enrollees to recertify annually instead of every 6 months is going to greatly ease the burden of some of the District's most vulnerable residents and provide them with access to high quality healthcare. He also echoed the comments in the committee report that call on DHCF to do even more than is proposed in the budget to increase wages for healthcare workers, and to aim for at least 120% of the minimum wage.

Councilmember Brianne Nadeau gave remarks, stating that the report and recommendations prepared by the committee represent a victory for District families, highlighted increased investments in school-based mental health, home visiting, and other services for children and families. She was pleased to see that the committee is not only reversing the reduction in CBO grant money for school-based clinicians, but also making it easier for providers to start or continue their careers in the District. She also highlighted committee funding for 10 new licensing specialists, which has the potential to turn Department of Health application processes marked by months-long delays into a fast track to practice that is fair, accessible, and ensures patient access to high-quality providers.

Among other key enhancements, Councilmember Nadeau voiced her support for the committee's increased investments in effective home visiting programs, early childhood consultation and development, and the preservation of funding for the First-time Mothers Home Visiting Program Amendment Act of 2022, which aims to improve maternal health in the District. Lastly, she highlighted the extension of the Health Care Alliance enrollment period from 6 months to 12, as well as the elimination of the in-person recertification requirement, stressing that this was a years-long process that she's glad to have finally seen finalized. She concluded her statement by thanking Chairperson Gray and the Committee on Health staff.

Councilmember Henderson continued the discussion by thanking Chairperson Gray, and emphasizing that this budget makes very important investments for the District. Last year, the Committee on Health and Councilmember Henderson's office worked closely to pass and fund the Maternal Health Resources and Access Act, which would

reimburse transportation costs for expecting mothers, and certify and reimburse doulas. She noted that she is pleased to continue this important work in this year's budget, with the inclusion of the subtitle that brings back the Maternal Mental Health Task Force and funds the requisite FTE at the Department of Behavioral Health. The task force will study an array of maternal mental health issues, including risk factors of vulnerable populations, barriers to screening, emerging treatment options, provider and patient needs to improve diagnosis and treatment, and successful post-partum recovery, among others. She voiced her desire to continue to work with the committee to update the language in the subtitle to ensure that it adequately captures the scope of the task force, as well as its membership. She stressed that this work is necessary to continue to improve maternal health in the District of Columbia, along with the $150,000 investment to continue the home visiting program for first-time mothers eligible for Medicaid.

She also acknowledged and thanked Chairperson Gray for the added investments in the School Based Mental Health program, including the additional $2.4 million to support District clinicians, which will add to the Mayor's proposed $33.6 million investment. She stressed that this is an incredibly important program and hopes that she can continue to partner on oversight to ensure that all Districts schools have a school based mental health clinician. She championed the committee's attempts to support and grow the city's health care workforce through multiple programs including the creation of a student loan repayment assistance program at DBH for clinicians in medically underserved areas, increasing licensing personnel to 10 FTE's at DC Health, and urging the Department of Health Care Finance to explore ways to increase entry level pay to a sufficient level to strengthen its pipeline.

Finally, Councilmember Henderson noted the committee's recommendation of an additional $1.46 million for school nurses - on top of the Mayor's $4.5 million enhancement for FY23. She hopes that the Committee can continue to work on ensuring every school has a nurse, and that it can get this money to count toward the subject to appropriation repeal rule for Public-School Health Services Amendment Act of 2018.
Among other key highlights, Councilmember Henderson expressed her support for:

- The recommendation to increase the number of Community Response Teams;
- The Mayor's $2.2 Million for the operation of Sobering and Stabilization Centers;
- An additional $1 million for the expansion of Healthy Future and Healthy Steps Programs;
- Investments in other food security programs, such as Healthy Corners, Food and Friends, and Produce Plus;
- $250,000 for opioid services for the LGBTQ+ community;
- Investments in community organizations for HIV/AIDS prevention;
- And the Crisis Response Pilot program within DBH to provide counseling support of survivors of natural and human-made disasters.

Councilmember Henderson concluded her statement by thanking the Committee on Transportation and the Environment and Councilmember Cheh for sending $100,000 to

DC Health for a Diaper Bank Program, before again acknowledging the Committee on Health for drafting the report, and reiterating her support for these investments that ensure every District resident has an opportunity for success.

Councilmember Mary Cheh gave brief remarks, thanking the Committee for all of its hard work and reiterating that the agencies under its purview are vital to the health and wellbeing of District residents, particularly those who are most vulnerable, such as seniors and children, the homeless, and those living with chronic health conditions. She highlighted the committee's commitment to funding food access programs, such as Produce Plus, DC Central Kitchen's Healthy Corners, and Food & Friends, stressing the importance of all residents having access to fresh produce and vegetables, as well as nutritional education and support - especially on the heels of a public health emergency. She was thankful to see that this year's funding will allow for the expansion of these critical programs in the coming future. She also emphasized her support for increased funding for both nurses and behavioral health clinicians in District schools, as well as the establishment of a new animal shelter by the Department of Health.

After discussion, Chairperson Gray moved for approval, *en bloc,* the proposed FY 2023 operating and capital budgets for the agencies under the purview of the Committee on Health. The vote on the budget report and Budget Support Act comments were unanimous (Chairperson Vincent C. Gray and Councilmembers Mary M. Cheh, Brianne K. Nadeau, Charles Allen, and Christina Henderson voted "aye".) The meeting adjourned at 11:19 a.m.

VI. ATTACHMENTS

A. Committee Adjustments (spreadsheet)
B. FY23 Capital Improvements Plan for Agencies under the Committee on Health
C. Bill 24-0714, Fiscal Year 2023 Budget Support Act of 2022 Recommended Subtitles
   1. Subtitle V-A. Medicaid Home and Community-Based Services Enhancement Fund
   2. Subtitle V-C. Alliance Enrollment
   3. Subtitle X. Behavioral Health Awareness Fund
   4. Subtitle X. First-Time Mothers Home Visiting Program
   5. Subtitle X. Maternal Mental Health Task Force
D. Committee on Health Fiscal Year 2023 Hearing Witness Lists and Testimony
   1. March 21, 2022 - DC Health Benefit Exchange Authority
   2. March 21, 2022 - Department of Behavioral Health
   3. March 28, 2022 - Office of the Deputy Mayor for Health & Human Services
   4. March 28, 2022 - Department of Health Care Finance
   5. March 28, 2022 - Not-for-Profit Hospital Corporation
   6. April 4, 2022 - Department of Health (DC Health)
E. DC Hospital Association HRLA FTE Request Letter

ATTACHMENT A

ATTACHMENT B

ATTACHMENT C

TITLE V. HUMAN SUPPORT SERVICES

SUBTITLE A. MEDICAID HOME AND COMMUNITY-BASED SERVICES ENHANCEMENT FUND

Sec. 5001. Short title.

This subtitle may be cited as the "Medicaid Home and Community-Based Services Enhancement Fund Establishment Amendment Act of 2022".

Sec. 5002. The Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.01 *et seq.*), is amended by adding a new section 8d to read as follows:

"Sec. 8d. Home and Community-Based Services Enhancement Fund.

"(a) There is established as a special fund the Medicaid Home and Community-Based Services Enhancement Fund ("Fund"), which shall be administered by the Department in accordance with subsections (c) and (d) of this section.

"(b)(1) On or before October 1, 2022, the District CFO shall deposit into the Fund an amount of local funds equal to the amount of federal funds received by the District attributable to the increase in the federal medical assistance percentage authorized by section 9817 of the American Rescue Plan Act of 2021, approved March 11, 2021 (135 Stat. 216; 42 U.S.C. 1396d, note) (the "Section 9817 Enhancement Amount"), minus the amount of the Section 9817 Enhancement Amount expended by the District before the date the District CFO makes the deposit required by this paragraph.

"(2) There shall be deposited into the Fund after the date the District CFO makes the deposit required by paragraph (1) of this subsection an amount of local funds equal to the amount of any additional federal funds received by the District attributable to the increase in the

federal medical assistance percentage authorized by section 9817 of the American Rescue Plan Act of 2021, approved March 11, 2021 (135 Stat. 216; 42 U.S.C. 1396d, note).

"(c) Money in the Fund shall be used only to fund the implementation of activities that enhance, expand, or strengthen Medicaid home and community-based services, as described in the District's Initial Spending Plan and Narrative for Enhanced Funding for Medicaid Home and Community-Based Services under Section 9817 of the American Rescue Plan Act of 2021 and as may be updated from time to time, or as otherwise authorized by the Centers for Medicare and Medicaid Services.

"(d)(1) The money deposited into the Fund but not expended in a fiscal year shall not revert to the unassigned fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time.

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

SUBTITLE C. ALLIANCE ENROLLMENT

Sec. 5021. Short title.

This subtitle may be cited as the "Alliance Enrollment Amendment Act of 2022".

Sec. 5022. Section 7b of the Health Care Privatization Amendment Act of 2001, effective December 13, 2017 (D.C. Law 22-35; D.C. Official Code § 7-1407), is amended as follows:

(a) Subsection (b) is amended by striking the phrase "; except, that the Mayor may require enrollees to complete one in-person certification each year in Fiscal Years 2023, 2024, and 2025." and inserting a period in its place.

(b) Subsections (c) and (d) are repealed.

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

“(e) Enrollees in the Alliance shall be required to recertify their enrollment on an annual basis.”.

SUBTITLE X. BEHAVIORAL HEALTH AWARENESS FUND.

Sec. XX01. Short title.

This subtitle may be cited as the "Behavioral Health Awareness Fund Amendment Act of 2022".

Sec. XX02. The Department of Behavioral Health Establishment Act of 2013, effective December 24, 2013 (D.C. Law 20-61; D.C. Official Code § 7-1141.01 *et seq.*), is amended by adding a new section 5117a to read as follows:

"Sec. 5117a. Behavioral Health Awareness Fund.

"(a) There is established as a special fund the Behavioral Health Awareness Fund ("Fund"), which shall be administered by the Department in accordance with subsection (c) of this section.

"(b) The application and display fees collected pursuant to section 2p of Title IV of the District of Columbia Revenue Act of 1937, approved by the Committee of the Whole on May 10, 2022 (Committee print of Bill 24-714), shall be deposited in the Fund.

"(c) Money in the fund shall be used to support behavioral health prevention and treatment programs administered by the Department.

"(d)(1) The money deposited into the Fund but not expended in a fiscal year shall not revert to the unassigned fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time.

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

SUBTITLE x. FIRST-TIME MOTHERS HOME VISITING PROGRAM

Sec. 5xxx. Short title.

This subtitle may be cited as the "First-Time Mothers Home Visiting Program Amendment Act of 2022".

Sec. 5xxx. Section 105a of the Birth-to-Three for All DC Amendment Act of 2018, effective September 11, 2019 (D.C. Law 23-16; D.C. Official Code § 4-651.05a), is amended as follows:

(a) The section heading is amended by striking the phrase "First Time Mothers" and inserting the phrase "First-Time Mothers" in its place.

(b) Subsection (a) is amended as follows:

(1) Paragraph (2) is amended by striking the phrase "in accordance with the subsection" and inserting the phrase "in accordance with this subsection" in its place.

(2) A new paragraph (4) is added to read as follows:

"(4) In Fiscal Year 2023, DOH shall provide an amount not to exceed $150,000 to the home visiting provider who was awarded the competitive grant pursuant to paragraph (1) of this subsection.".

SUBTITLE x. MATERNAL MENTAL HEALTH TASK FORCE

Sec. 5xxx. Short title.

This subtitle may be cited as the “Maternal Mental Health Task Force Establishment Act of 2022”.

Sec. 5xxx. Definitions.

For the purposes of this subtitle, the term:

(1) "Health care provider" shall have the same meaning as provided in section 2(1B) of the District of Columbia Public Emergency Act of 1980, effective March 5, 1981 (D.C. Law 3-149; D.C. Official Code § 7-2301(1B)).

(2) "Home visiting program" means an entity that:

(A) Supports expectant parents, and parents or legal guardians with infants, toddlers, and children between 3 and 5 years of age; and

(B) Provides access to health, social, and educational services through weekly or monthly home visits to promote positive child health and development outcomes, including healthy home environments, healthy birth outcomes, and a reduction in adverse childhood experiences.

(3) "Postpartum recovery" shall have the same meaning as provided in section 151(5) of the Department of Youth Rehabilitation Services Establishment Act of 2004, effective July 25, 2015 (D.C. Law 20-280; D.C. Official Code § 2-1515.51(5)).

(4) "Task Force" means the Maternal Mental Health Task Force established by section 5xx2.

Sec. 5xx2. Maternal Mental Health Task Force.

(a) There is established a Maternal Mental Health Task Force to provide comprehensive policy recommendations for the improvement of maternal mental health in the District. The Task Force shall study:

(1) Vulnerable populations and risk factors for maternal mental health disorders that may occur during pregnancy and postpartum recovery;

(2) Barriers to screening and identifying maternal mental health disorders;

(3) Evidence-based and emerging treatment options for individuals suffering from maternal mental health disorders;

(4) Health care provider and patient needs to improve diagnosis and treatment of maternal mental health disorders;

(5) Effective, culturally competent, and accessible screening, identification, and treatment strategies for maternal mental health disorders, including public education efforts, health care provider education and training, and the provision of social support services;

(6) Successful postpartum recovery mental-health initiatives throughout the United States;

(7) Evidence-based practices for health care providers and public-health systems; and

(8) Models for private and public funding of maternal mental health initiatives.

(b) By August 31, 2023, the Task Force shall submit to the Mayor and the Council a comprehensive report setting forth its findings and providing recommendations regarding legislation, policy initiatives, and the funding requirements of initiatives to address maternal mental health needs in the District.

(c) The Task Force shall consist of 19 members as follows:

(1) The Deputy Mayor of the Office of the Deputy Mayor for Health and Human Services or his or her designee;

(2) The Director of the Department of Behavioral Health or his or her designee;

(3) The Director of the Department of Health or his or her designee;

(4) The Director of the Department of Health Care Finance or his or her designee;

(5) The Chairperson of the Council's Committee on Health or his or her designee;

(6) The Chairperson of the Council's Committee on Human Services or his or her designee; and

(7) The following members appointed by the Mayor in accordance with section 2(f) of the Confirmation Act of 1978, effective March 3, 1979 (D.C. Law 2-142; D.C. Official Code § 1-523.01(f)):

(A) A representative from the health insurance industry;

(B) A representative from La Clinica del Pueblo, a nonprofit health center;

(C) A nurse psychotherapist experienced in providing perinatal mental health services in the District;

(D) A registered nurse experienced in providing perinatal mental health services in the District;

(E) A licensed clinical social worker experienced in providing perinatal mental health services in the District;

(F) A licensed pediatrician experienced in providing perinatal mental health services in the District;

(G) An obstetrician experienced in providing perinatal mental health services in the District;

(H) A reproductive psychiatrist practicing in the District;

(I) A reproductive therapist practicing in the District;

(J) A perinatal mood and anxiety disorders survivor;

(K) A pediatric primary care provider located in the District;

(L) An individual with experience in working with homeless families in the District; and

(M) A representative of a home visiting program operating in the District.

(d) The Mayor shall designate 2 co-chairs of the Task Force, one each from the government and non-government sectors.

(e) Vacancies shall be filled in the same manner as the original appointment to the position that became vacant.

(f) The Department of Behavioral Health shall publish on its website a public listing of Task Force members, meeting notices, and meeting minutes.

(g) The Task Force shall dissolve after submitting the report required pursuant to subsection (b) of this section.

Sec. 5xx3. Section 2(f) of the Confirmation Act of 1978, effective March 3, 1979 (D.C. Law 2-142; D.C. Official Code § 1-523.01(f)), is amended as follows:

(a) Paragraph (69) is amended by striking the phrase “; and” and inserting a semicolon in its place.

(b) Paragraph (70) is amended by striking the period and inserting the phrase “; and” in its place.

(c) A new paragraph (71) is added to read as follows:

“(71) The Maternal Mental Health Task Force, established by the Maternal Mental Health Task Force Establishment Act of 2022, passed on 2nd reading on _____ (Enrolled version of Bill 24-714).".

ATTACHMENT D

ATTACHMENT 1

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
WITNESS LIST – FY23 BUDGET OVERSIGHT HEARING
1350 PENNSYLVANIA AVE., N.W., WASHINGTON, D.C. 20004

COUNCILMEMBER VINCENT C. GRAY, CHAIRPERSON
THE COMMITTEE ON HEALTH

ANNOUNCES A FISCAL YEAR 2023 BUDGET OVERSIGHT HEARING ON

THE DC HEALTH BENEFIT EXCHANGE AUTHORITY

AND

THE DEPARTMENT OF BEHAVIORAL HEALTH

MONDAY, MARCH 21, 2022, 10:00 A.M. – 6:00 P.M.
REMOTE HEARING VIA WEBEX
STREAMED LIVE ON YOUTUBE AT TINYURL.COM/COHFY23.

WITNESS LIST

DC Health Benefit Exchange Authority

Public Witnesses

Panel 1

1. Reverend Patricia Hailes Fears	Pastor, Fellowship Baptist Church
2. Barbara Kittridge	Public Witness
3. Angela Franco	President & CEO, DC Chamber of Commerce
4. Kristal Williams	Co-owner & Director of Operations, FishScale

Executive Witnesses

Panel 2

5. Mila Kofman	Executive Director, DC Health Benefit Exchange Authority
6. Diane C. Lewis	Chair, D.C. Health Benefit Exchange Authority Executive Board

Department of Behavioral Health

Public Witnesses

Panel 3

7. Sarah Barclay Hoffman	Community Mental Health CORE Program Manager, Children's National Hospital
8. Amber Rieke, MPH	Director of External Affairs, DC Health Matters Collaborative
9. Hannah Garelick	Jews United for Justice, Community Organizer
10. Mark LeVota	Executive Director, District of Columbia Behavioral Health Association

Panel 4

11. Qubilah Huddleston	Education Policy Analyst, DC Fiscal Policy Institute
12. Tami Weerasingha-Cote	Supervising Attorney of Policy, Children's Law Center
13. Kerry Savage	Director of Policy at PAVE
14. Joshua Hodge	Policy and Communications Manager, Education Reform Now D.C.

Panel 5

15. Betty Gentle	Senior Advocacy and Community Engagement Specialist, SOME, Inc. (So Others Might Eat)
16. Mark C. Miller	State Ombudsman, Office of the D.C. Long-Term Care Ombudsman
17. Justin Palmer	DC Hospital Association
18. Jarred Bowman	Early Childhood Policy Analyst, DC Action

Panel 6

19. Jaclyn Verner	Staff Attorney, Disability Rights DC at University Legal Services
20. Tammy Seltzer, Esq.	Director of the DC Jail & Prison Advocacy Project, Disability Rights DC at University Legal Services
21. Donald Hines	Disability Rights DC at University Legal Services
22. Jennifer Ubiera	Council for Court Excellence

Panel 7

23. Nadia Gold-Moritz	Executive Director, Young Women's Project
24. Anna Mable Jones CPRS, NCPRSS	Resources Coordinator, Oxford House
25. Latonya Graham	Parents Amplifying Voices in Education
26. Mary Mccane	Parents Amplifying Voices in Education

Panel 8

27. Kelita Boyd	Parents Amplifying Voices in Education
28. Tara Brown	Parents Amplifying Voices in Education
29. Tyesha Andrews	Parents Amplifying Voices in Education
30. Renee Davis	Parents Amplifying Voices in Education
31. Randee Grant	Parents Amplifying Voices in Education

Executive Witness

Panel 9

32. Dr. Barbara J. Bazron	Director, Department of Behavioral Health

LCHC Leadership Council for Healthy Communities

Testimony of

Reverend Patricia Hailes Fears, Pastor
Fellowship Baptist Church
5605 Colorado Avenue Northwest
Washington D.C., DC 20011-7803

Before the

Council of the District of Columbia
Committee on Health and Human Services
Chairperson, Councilmember Vincent C. Gray

FY23 Budget Oversight Hearing

DC Health Benefit Exchange Authority

Monday, March 21, 2022

10:00 a.m.

Via WebEx

Good morning Chairman Gray and members of the DC Council Committee on Health, I am Reverend Patricia Hailes Fears, pastor of Fellowship Baptist Church, which was organized in 1994 here in Washington, DC. I also serve as a member of the Wednesday Clergy Fellowship, a group committed to ensuring the faith community is well informed on health issues and resources available throughout the District. Today I am here representing the Leadership Council for Healthy Communities (LCHC), an organization for which I have been affiliated from its beginning. LCHC is an organization comprised of clergy leaders, medical professionals, public and community leaders working together to help African Americans and other communities of color eliminate health disparities and promote healthy communities through comprehensive health programs.

I'm excited to share some of the work LCHC has been empowered to do through the support of the DC Health Benefit Exchange Authority. As an Assister Organization of the Health Benefit Exchange since its inception, we have been able to witness and partake in the amazing work the Exchange has been able to do, enrolling the community in health insurance programs and raising awareness about the resources available to residents across the District.

With the success of the Affordable Care Act (ACA), expanded under the Biden administration, many uninsured residents finally gained access to health insurance coverage. The strengthened and affordable coverage under the American Rescue Plan has also allowed us to be even more effective and expand our reach with new methods.

Our commitment to the cause hasn't wavered, as the LCHC Assisters have persevered to continue to provide ways to reach the community, through in person and online events. Throughout the COVID-19 pandemic, Assisters have

completed outreach via phone, video calls, and in-person community outreach events. Our staff has completed hundreds of calls to assist community members in securing health insurance during and after challenging moments in their lives. Through our expansive network of clergy members, faith institutions and staff, we continuously foster a far-reaching web of connections that allow us to engage the community on a variety of fronts. From making ourselves available at the Metropolitan Police Department's community outreach events to providing assistance at the Mayor's Office of Asian and Pacific Islander Affairs' "Resilience and Women's Public Safety" event and the Greater Washington Hispanic Chamber of Commerce Business Expo, we've established a presence in several communities of color and continue to expand our reach. We have also continued to participate in virtual one-touch events where assisters answer questions regarding health insurance and help attendees enroll.

At the last hearing, you heard of our work during DC Health Link's African American and Faith-in Action weeks. We have continued these efforts, conducting socially distanced outreach to barbershops and salons, such as Midtown Barbershop, and Jon Scott Cuts.

We have also continued to utilize our network of faith institutions, encouraging pastors to highlight the need for coverage from the pulpit and beyond. We encourage our institutions to use every method of communication they have available to reach their congregations, including the use of virtual worship services, church bulletins, and programs to serve as reminders when there are no events for LCHC Assisters to attend.

LCHC offers continued support of the Health Benefit Exchange. It is an honor to be able to participate in the sacred duty of improving individual and community health. I pray they will continue to be successful in their service to DC residents.

Respectfully submitted,

Reverend Patricia Hailes Fears
Pastor, Fellowship Baptist Church

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Fiscal Year 2023 Budget Oversight Hearing

Testimony of
Barbara J. Bazron, Ph.D.
Director

Before the
Committee on Health
Council of the District of Columbia
The Honorable Vincent C. Gray, Chairperson

Remote Hearing by WebEx
March 21, 2022
10:00 a.m.

Good Morning, Chairperson Gray, Councilmembers, and Council staff.

I am Dr. Barbara J. Bazron, Director of the Department of Behavioral Health (DBH). I am pleased to testify before you today on Mayor Muriel Bowser's proposed Fiscal Year 2023 Budget and Financial Plan. Mayor Bowser's proposed FY 23 budget invests in building safer and stronger communities and in helping us emerge from the pandemic stronger and more ready to thrive than ever before. Under the Mayor's leadership, DBH supports these goals with a range of prevention, treatment and recovery services and supports that improve the health of individuals and the social and emotional well-being of our communities.

Like people across the country, the mental health of District residents has been impacted by the grief, loss, and physical isolation of the last two years. In a national survey, two out of five adults report symptoms of anxiety or depression. The U.S. Surgeon General issued an advisory to highlight the urgent need to address the impact of the pandemic on youth and families.

Studies show that people often turned to alcohol, opioids and other drugs to help them cope with the pandemic. For people already facing mental illness, opioid addiction or other substance use disorders, pandemic related disruptions in treatment regimes, social networks and daily routines challenge their recovery. Gun violence and safety concerns place additional stress for too many in our communities. Longstanding health disparities across populations were exacerbated by the COVID-19 pandemic with people of color disproportionately affected by severe illness, death and associated economic loss.

Mayor Bowser's proposed FY 23 budget for DBH ensures that residents can get connected to the care they need—by phone, at home, in school or in the community.

The FY 23 budget supports the work underway with the Department of Healthcare Finance to integrate behavioral health services into the Medicaid managed care program effective October 1, 2023. Whole person care recognizes that physical, behavioral, and social health are interdependent and must be treated together to achieve optimal health. Bringing these services into the managed care program supports better care coordination and alleviates the need for residents to navigate multiple systems. The promise of integrated care is healthier people living longer, more fulfilling lives.

The integration to managed care provides the opportunity for DBH to embrace its role as the behavioral health state authority and transform behavioral health in the District to be more holistic and equitable. DBH's role as a state authority includes establishing District-wide standards and policies for behavioral health care delivery, monitoring quality of care, promoting behavioral health education and disease prevention, and defining and measuring population health outcomes.

Let's take a moment to recall how far we have come in building a behavioral health system that residents need and deserve. Just 10 years ago, the District ended 37 years of federal oversight of our public mental health system during your administration, Chair Gray. A year later, the Department of Behavioral Health was established to bring together treatment and services for residents with mental health and substance use disorders to promote better health, prevent

behavioral health problems, and support better outcomes for individuals with co-occurring mental health and substance use disorders.

Today, the integration of behavioral health and primary care moves us to whole person care. To prepare providers for this transition, DBH and the Department of Health Care Finance are engaging in planning and readiness activities with providers to ensure the smooth transition of behavioral health services to managed care. We are surveying providers to identify their needs, providing multiple technical assistance opportunities, and providing grants to support IT development. We also are conducting a rate study to determine the appropriate payment for behavioral health services.

As we move toward the whole person health model of care DBH works to provide high quality care for residents who rely on the public behavioral healthcare system as well as for residents who may be experiencing common disorders such as depression and anxiety related to the pandemic.

In FY 21, the utilization of mental health services increased by 14 percent while the number of residents receiving substance use disorder services was essentially the same. The accelerated use of telehealth allowed for continuity of care as well as more frequent consumer engagement. Data from the first quarter of FY 2022 indicate that services are being delivered in a hybrid environment of in person and telehealth based on consumer preference. The proposed FY 23 budget anticipates that increased service utilization and increased use of telehealth will continue.

DBH has certified a robust number of providers across the District with particular attention to locations in Wards 7 and 8. However, research shows that less than half of people with mental health conditions receive treatment. Too often, people are misunderstood, blamed, or are embarrassed to get the help they need. We want to make it as easy as possible for people to get the help they need when they want it.

Under the direction of Deputy Mayor Wayne Turnage, DBH works with agencies within the Health and Human Services cluster and throughout government to integrate the work they are doing to support residents with behavioral health needs. DBH has partnerships with the Office of the Deputy Mayor for Planning and Economic Development, the Department of Human Services, the Department of Employment Services, and the Department of Corrections to co-locate staff to normalize behavioral health treatment as a resource just like housing or a job to support daily living.

We know that residents need varying levels of mental and emotional support. The proposed FY 23 includes a 24-hour Mental Health Hotline for people who may just need to talk or want help with problem solving and self-care techniques. Any resident can talk with a clinician for up to three sessions with no enrollment papers to fill out and no cost sharing.

The proposed FY 23 budget includes funds to promote broadly the availability of the supports for all District residents and to target communities most at risk of behavioral health challenges. The proposed budget includes $250,000 to fund prevention of opioid use disorders in the LGBTQ community.

DBH also supports residents to access behavioral health care through their insurance coverage. By law, insurance companies generally must offer behavioral health benefits at the same level of support as physical health care benefits. DBH supports the work of the Health Benefit Exchange Authority and DC Health Links to promote healthcare parity.

Support the mental well-being of our frontline health workers.

Through grant partnerships with the Wendt Center and Howard University, we have continued to provide support for frontline health workers including our own employees through promoting self-care and encouraging seeking help. About 70 percent of DBH employees continued to report onsite during the pandemic. I can't express my appreciation often enough so I want to take this opportunity to thank them again. They were there when we needed them the most.

I will now discuss in more detail various aspects of the proposed FY 2023 budget for DBH.

FY 23 Proposed Gross Budget

The proposed FY 23 gross budget is $369,419,870 million which is a 3.7 percent increase over the FY 22 approved budget. The increase includes a $10.7 million increase in local funds and a $16 million dollar increase in federal funds.

The proposed FY 23 capital budget is $12.7 million for information technology equipment upgrades and Saint Elizabeths Hospital facilities projects.

The FY 23 Proposed Budget by Funding Source

The largest source of funds is the local budget of $298 million—a 3.7 percent increase over the FY 22 budget. The second largest source of funds is $55 million in Federal Grants which includes funds through the federal American Rescue Plan Act and the State Opioid Response grant.

DBH Administrations

DBH is anchored by eight administrations including Saint Elizabeths Hospital, which together, oversee, manage, and deliver behavioral health services and supports to District residents and establish the policy and regulatory framework for behavioral health care for the District of Columbia.

FY 23 Budget Overview

The Mayor's proposed FY 23 budget for DBH funds a projected increase in utilization of services, continues investments that support our most vulnerable residents, and and enhances early intervention services and school-based supports for children and their families. The proposed budget also includes $1 million for facility maintenance at Saint Elizabeths Hospital which is now a 12-year-old facility.

The proposed budget includes:

- $36.5 million for mental health services which leverages $121.7 million in services
- $28.4 million to maintain supported housing for 1,700 residents
- $41 million for substance use disorder services
- $10.9 million for mental health services for uninsured residents
- $33.6 million to expand school-based services
- $18.3 million for crisis services
- $7.3 million for prevention and early identification services, and
- $104.4 million to support Saint Elizabeths Hospital

The proposed budget realizes $2.6 million in savings through maximizing the use of Medicaid for crisis services, aligning the supportive housing model to expand capacity and maintain clinical support, and contract efficiencies.

The proposed budget supports new and existing priority services, including:

- $8.9 million to support behavioral health transformation services and increased utilization by Medicaid eligible residents
- $3.7 million to expand school-based services
- $2.5 million for the Sobering and Stabilization Center
- $250,000 to prevent opioid abuse in the LGBTQ community, and
- $213,000 to support health promotion and public engagement

I've already talked about most of these initiatives so I'll focus on expanded school-based services.

Expansion of school-based services

Children and young people have been particularly impacted by the pandemic as disruptions in routines and relationships have led to increased social isolation, anxiety, and learning loss. Some research suggests that youth who have been exposed to multiple traumas, have a history of anxiety issues, or have experienced family adversity face a much higher risk of prolonged stress. As the Surgeon General's advisory notes, before the pandemic, an alarming number of young people struggled with feelings of helplessness, depression, and thoughts of suicide — and rates have increased over the past decade. Further, in one study, more than half of parents expressed concern over their children's mental well-being.

Studies show that half of all lifetime mental health disorders start by the age of 14 and school-based services have proven to be an effective, safe environment to reach students who need mental health support and their families. Our goal is to support the "conditions of learning" that have been shown by the research to be linked to students' academic success, graduation, and post-secondary success. The results of this strategy may contribute to decreasing the learning gap between Black and White students.

Through multi-year investments by Mayor Bowser and the Council, the proposed FY 23 budget funds a clinician in every public school. Behavioral health clinicians from DBH or contracted

community-based organizations (or CBOs) are now in 158 or 63 percent of public schools and we continue to expand in partnership with the DC Public Schools and the DC Public Charter School Board. In addition to a clinician in every public school, the proposed budget includes $1,758,341 to add clinicians in 25 schools with the most significant needs. DBH will collaborate with our education partners to select the schools.

New High Fidelity Wraparound Services

To support treatment, the proposed budget will allocate $829,000 to provide High Fidelity Wraparound in six schools. This service will be available to a total of 60 children and their families. Care Coordinators work closely with students and their families to remove barriers to learning, access needed behavioral health services and support academic abilities and improved functioning.

Strengthening Technical Assistance and Support

Like many fast-growing programs, the school-based program is experiencing challenges related to maintaining fidelity to the model, reporting quality data, supporting the workforce, and infusing youth and family voice. To help address these challenges, the proposed budget includes $907,978.00 for eight positions to work with CBOs to provide technical assistance, assist with data reporting and collection, and support fiscal and program integrity and accountability.

Using a public health model, school-based clinicians are expected to provide prevention, intervention, and treatment services. Along with funding supervisors, DBH provides $53,667 for each clinician to support the delivery of non-reimbursable services. The pandemic created unique challenges to reaching students, so we provided an additional $9,316 for each clinician in FY 21 and another $7,461 in FY 22.

Working through the Coordinating Council, we are examining closely conditions in each school to identify any barriers to providing services and the Community of Practice will focus individualized training and support. We also are ready to reexamine the service delivery model and will conduct a rate study to determine if the current funding is sufficient to support the program.

Support for Workforce Development

To complete our expansion to all public schools will require recruiting and retaining a significant number of licensed clinicians during the current national shortage of licensed clinicians. In fact, we are competing within DBH as we also are recruiting clinicians for our Community Response Team and other clinical services.

We recognize that recruiting more than 100 licensed clinicians is a challenge that will require focused effort, careful planning, and coordination with community-based organizations (CBOs) who contract with DBH to deliver services in our schools. I am encouraged by our ability to meet this challenge since funding has been allocated in the Mayor's budget to support our workforce development initiative to attract and retain licensed clinicians.

Full funding for supervisors. The proposed budget includes $100,000 to support supervisors at a ratio of one supervisor for six clinicians. In addition to providing appropriate guidance, this strategy aims to attract graduate social workers who can obtain the supervised hours required to advance to independent licensure.

Intern agreements with local universities. DBH has multi-year affiliation agreements with Howard University, the Catholic University of America, and the University of Maryland to host graduate-level interns. DBH is working to finalize agreements with Delaware State and Morgan State University.

The proposed budget allocates $281,000 to support the costs of licensure which can be burdensome to graduates. The funds will provide $1,000 for each CBO clinician and $500 for DBH clinicians who already are independently licensed clinicians. In addition, DBH is collaborating with DC Health to connect our CBO partners to the Health Professional Loan Repayment Program.

FY 23 Budget Advances Health Equity

The DBH is committed to addressing health equity for all District residents in need of behavioral health care. Health equity is achieved when every person has the opportunity to attain his or her full health potential and is not prevented from achieving this potential because of race, social position, or other social determinants of health. The Mayor's FY 23 budget provides resources for DBH to advance health equity as follows:

- Making substance use treatment easily accessible through the new Sobering and Stabilization Center.

Our proposed budget includes $2.2 million to continue operating the Sobering and Stabilization Center expected to open this summer. The Sobering Center is an important addition to our health care system to support individuals under the influence of alcohol or drugs who require stabilization services and support but do not need to be transported to hospital emergency departments. Induction in Buprenorphine will be offered to survivors of an opioid overdose. Peers also will remain engaged with them after they leave the Sobering Center to encourage care.

- Increasing the number of Community Response Teams to increase engagement of residents with behavioral health needs, connect them to care and address crisis.
- Ensuring that residents receive the right services from the right provider at the right time by working in collaboration with the Office of Unified Communications to respond to certain 911 calls to support individuals experiencing a behavioral health crisis.
- Offering behavioral health services to children and youth through the school-based program to address emotional or behavioral concerns that can negatively impact learning.
- Expanding the number of individuals with lived experience who can provide engagement and support to those facing from addiction and serious mental health issues.
- Providing housing to returning residents from incarceration, and

- Offering supported employment to assist residents with mental health and/or substance use disorders to get and keep a job.

Consumer and Family Voice.

The proposed FY 23 budget supports strong consumer voice and presence throughout our system of care. We know that peer support is effective in engaging individuals in treatment and helping them maintain recovery. Peer leaders model our conviction that treatment works, and sustained recovery is possible. Further, peer leadership is essential to our fight to reduce stigma that can prevent people from getting the help they need. DBH has strong partnerships with consumer leaders and advocates along with the Behavioral Health Planning Council who advise me on policy and strategic direction.

Peer specialists now work in the provider network as integral members of treatment teams, in community hospital emergency departments, our emergency facility, and Saint Elizabeths Hospital. DBH is working to adopt a national certified peer specialist certification program to standardize training and incentivize hiring of peers in the workforce.

Mayor Bowser's Fiscal Year 2023 budget provides new and ongoing investments that support whole person care and the opportunity for all residents to live longer, healthier lives.

Mr. Gray, this concludes my testimony. We appreciate our partnership and the work of the Committee and look forward to our continued work together. I am ready with my team to answer any questions. Thank you.

DC Health Benefit Exchange Authority

Mila Kofman, J.D., Executive Director

HBX Proposed Budget FY23
Budget Oversight Hearing
DC Council Committee on Health
Chairperson Councilmember Gray
March 21, 2022

DC HEALTH LINK
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DC Health Link: Affordable Care Act State-Based Online Health Insurance Marketplace

- **Private-public partnership** (private Executive Board)
- Last state to start IT build, 1 of 4 state marketplaces opened for business on time (& stayed open) Oct 1, 2013
- **Small group & individual market through DC Health Link**:
  - 100,000 covered lives with private health insurance: 80,000+ people in SHOP (5,300 District small businesses; 11,000 Congress -- Members and designated staff in district offices and on the Hill); 15,000 - 20,000 residents (individual market paid covered lives)
- **Responsible for over $620 million** in annual premiums
- **Cut uninsured rate in half** since DC Health Link opened for business. Near universal coverage with more than 96% of DC residents covered
  - ✓ DC ranks **#2** in U.S. for lowest uninsured

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2022 HEALTH INSURANCE OPTIONS THROUGH DC HEALTH LINK

Plans:

- **157** Small Group Plans
  - 36 plans with lower premiums than in 2021
- **27** Individual Plans (includes 2 catastrophic)
  - 6 plans with lower premiums than in 2021

HBX: Advocate for lowest possible premiums for all customers

Insurers:

- 3 UnitedHealthcare Companies (group only);
- 2 Aetna Companies (group only);
- CareFirst Blue Cross Blue Shield; and
- Kaiser Permanente.

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State-Based Marketplace Advantage

- ✓ ***Standard Plans: No deductibles*** for primary care, specialists, mental and behavioral health, urgent care and generic Rx.
  - ➢ Design: copays (not coinsurance) for easier comparison; 2022 insulin and diabetic supplies covered at no cost to patient
- ✓ **All plans** cover diagnosis, testing & treatment for COVID-19.
- ✓ **More residents qualify for lower monthly premiums** because of new federal law, American Rescue Plan.
  - ➢ Of the 20,000 residents with individual coverage, 16% qualify for lower premiums (APTC)
  - ➢ **Premiums as low as $11/month**

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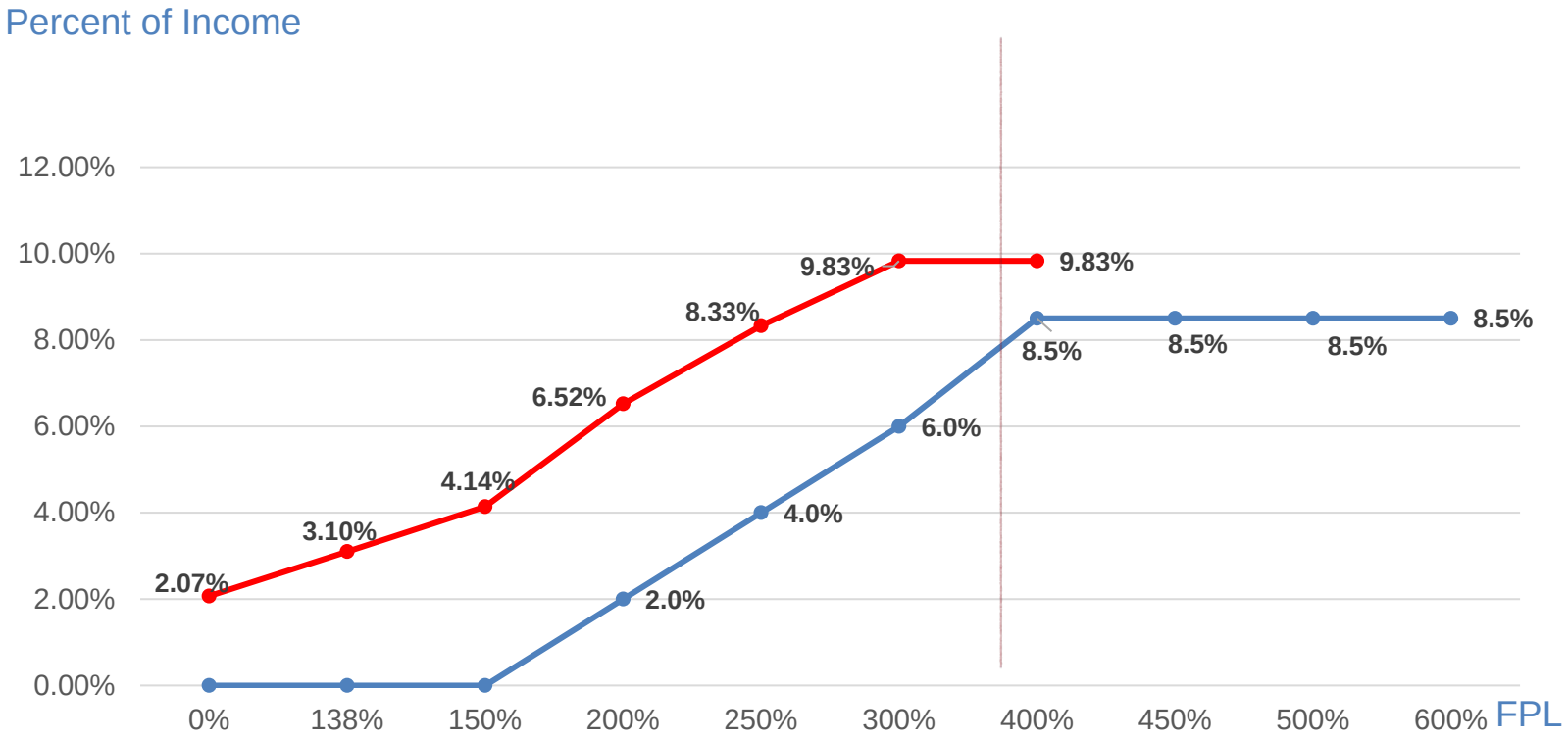
American Rescue Plan (ARP) Lowered Health Insurance Premiums



ACA (red line) caps premiums for people with incomes up to 400% of federal poverty level. The ARP (blue line) caps premiums for people at **all** income levels.

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American Rescue Plan (ARP)

- ✓ **Quickly updated DCHealthLink.com for all new benefits (March 29, 2021) for new and existing customers:** Two weeks after legislation was signed by President Biden, launched all new benefits on DCHealthLink.com.
- ✓ **ARP lowered health insurance premiums through 2022.**
- ✓ **Approximately $36 MILLION per year in lower premiums** for District residents with individual marketplace coverage through DC Health Link.
- ✓ **Premiums as low as $11/month** for quality health through DC Health Link.
- ✓ **Uninsured?** Get covered now at **DCHealthLink.com**

DC HEALTH LINK
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American Rescue Plan (ARP)
Lower Premiums End December 2022

Lower premiums under ARP end on December 31, 2022. If Congress does not extend APTC expansion, millions of Americans will become uninsured and millions will lose low monthly premiums.

- DC residents currently getting lower premiums will pay 48% more on average (plus annual premium increases if premiums rise); and
- More than 1,600 DC residents will lose their individual marketplace health insurance.

If Congress makes APTC expansion permanent:

- 4.1 million people will become newly insured;
- an additional 8.3 million people will get lower monthly premiums nationally;
- premiums will <u>decrease</u> by 10% due to a younger risk pool. (Source Oliver Wyman Aug 2021 Analysis)

DC HEALTH LINK
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Emergency COVID-19 Relief for Employers & Residents with DC Health Link Health Insurance in Arrears

- ✓ **Using funds the ARP provided to DC**, Mayor Bowser established a $15 million Emergency COVID Relief fund through HBX to help District employers and residents stay insured. This paid for DC Health Link health insurance premiums that were overdue (in arrears).
- ✓ **Councilmember Gray prioritized this** Supplemental FY21 Budget request and DC Council approved the funding in June 2021.
- ✓ **Health Plans wrote-off an additional estimated $1.4 million** for DC Health Link customers in arrears who did not qualify for COVID relief arrears program.
- ✓ **Emergency relief program had significant impact:** approx. 500 District employers covering 5,000 people with small group coverage and 1,800 residents with individual health insurance were able to stay insured during the pandemic and have a fresh start with premiums.
- ✓ **Continuing to help employers with economic recovery,** Mayor Bowser included an additional $3.75 million in the FY2022 Revised Budget Act. If Council approves, this will total nearly $19 million for FY21 and FY22 -- providing relief, keeping employers and their workers insured, and helping District employers to recover from COVID's devastating economic impact.

DC HEALTH LINK
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HBX PROPOSED BUDGET FY23

- PROCESS: Staff, Board Finance Committee, Standing Advisory Board (diverse stakeholders) & HBX Executive Board (November 2021).
- Efficiency: Leverage DC gov't agencies; phase-out consultants and transition to FTEs and reduce operational costs through partnership with the Massachusetts Health Connector.
  - **$1,257,000 savings with MA partnership**
- FY23 PROPOSED BUDGET **$35,684,055** with a **$34,327,055** PROPOSED BUDGET FOR ASSESSMENT.
  - Increase from FY22 reflects call center cost allocation changes
- **Funded through an assessment on health carriers (0.90%).**

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ANNUAL ASSESSMENT ON HEALTH CARRIERS

- Projected assessment collection at 0.90% assessment rate for FY23 is $34,608,151

To fund (FY)	Assessment Rate
FY23	**0.900%**
FY22	**0.825%**
FY19, FY20, FY21	0.900%
FY15, FY16, FY17, FY18	1.000%

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BUDGET COMPARISON: FY22 & FY23

	FY22 APPROVED BUDGET	FY23 PROPOSED BUDGET	$ CHANGE	% CHANGE
MARKETPLACE INNOVATION POLICY AND OPERATIONS (Marketplace Operations)	$11,728,423	$13,325,626	$1,597,203	13.62%
CONSUMER EDUCATION AND OUTREACH	$2,995,798	$3,231,707	$235,908	7.87%
IT (DCHealthLink.com)	$11,534,130	$12,346,018	$811,888	7.04%
AGENCY MANAGEMENT PROGRAM	$5,810,791	$5,974,210	$163,419	2.81%
AGENCY FINANCIAL OPERATIONS	$772,837	$806,495	$33,658	4.36%
TOTAL BUDGET	**$32,841,979**	**$35,684,055***	**$2,842,077**	**8.65%**

***FY23 BUDGET FOR ASSESSMENT: $34,327,055**

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BUDGET RECONCILIATION TO ASSESSMENT BUDGET

FY23 Proposed Budget	**$35,684,055**
Less:	
6.0 FTEs Budgeted for MA Health Connector	(800,000)
Admin Fees Budgeted for MA Health Connector	(237,000)
Contact Center Costs Budgeted for MA Health Connector	(180,000)
Mailing and Postage Fees Budgeted for MA Health Connector	(40,000)
FY23 Investment and Interest Earnings	(100,000)
Net FY23 Budget for Assessment Calculation	**$34,327,055**

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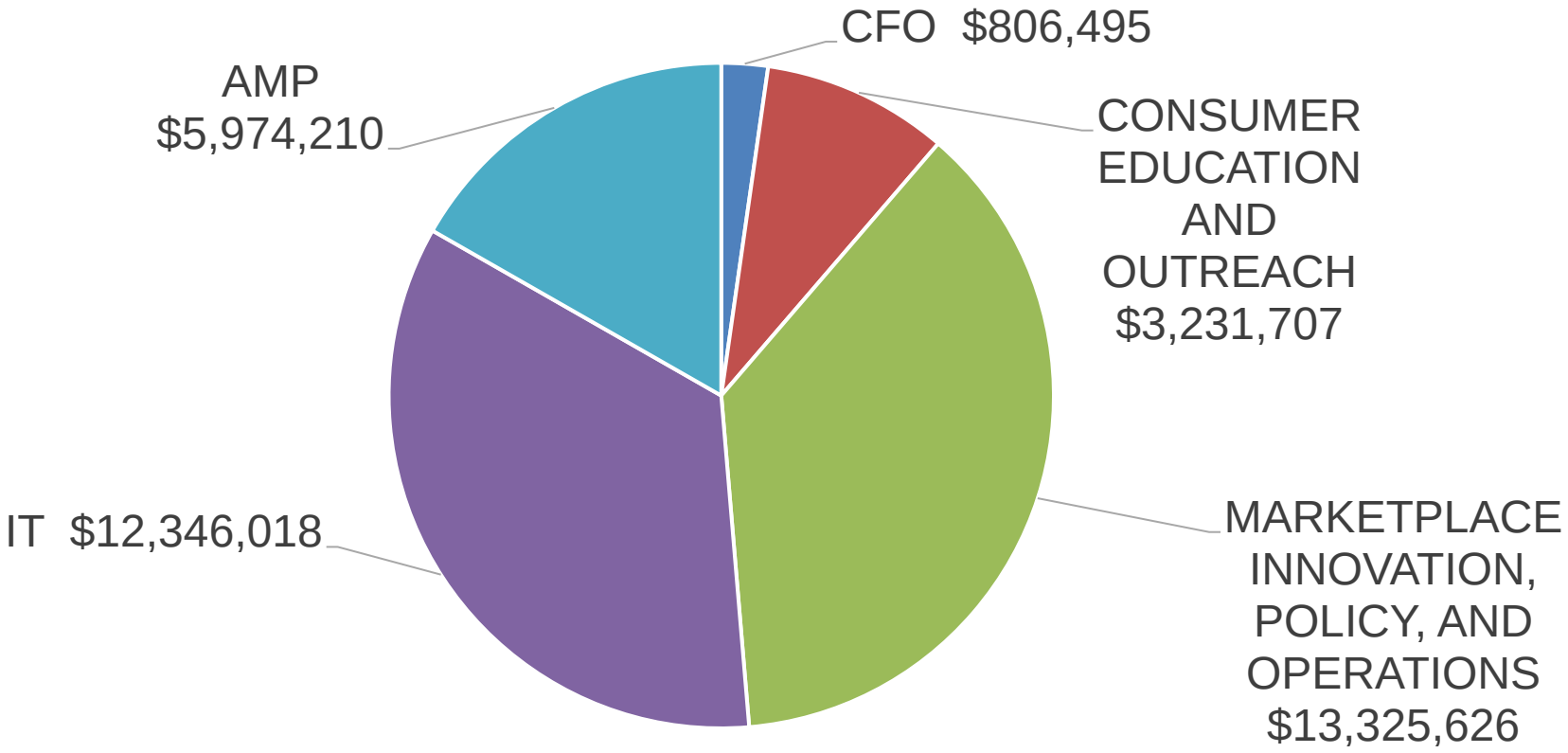
FY23 REDUCTION IN HBX OPERATING COSTS THROUGH MA HEALTH CONNECTOR PARTNERSHIP

Category	FY23 Budget
Personnel – 6.0 FTEs	800,000
Admin Fees	237,000
Premium Aggregation*	317,544
Contact Center Fees	180,000
Mailing and Postage	40,000
Total	**$1,574,544**

* SAVINGS ALREADY REFLECTED IN FY23 PROPOSED BUDGET

PROPOSED FY23 BUDGET BY AREA



FY23 BUDGET FOR ASSESSMENT: $34,327,055

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MARKETPLACE INNOVATION, POLICY AND OPERATIONS (MIPO)

PROPOSED FY23 BUDGET: $13,325,626 (FY22 BUDGET $11,728,423)

- FY23 PERSONNEL SERVICES BUDGET FOR 54 FTEs: $6,726,701
- NON-PERSONNEL SERVICES (NPS): $6,598,925

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MIPO: CONTACT CENTER

CONTACT CENTER PROPOSED NPS FY23 BUDGET: $4,220,103 (FY22 BUDGET $3,332,546)

- CONTACT CENTER SERVICE CONTRACT: $3,871,341
- SALESFORCE LICENSES: $164,782
- SALESFORCE DEVELOPMENT AND MAINTENANCE: $74,880
- MICROSOFT 365 LICENSES: $15,000
- ADMIN (courier service, equipment, computer refresh): $31,700
- LANGUAGE LINE: $62,400

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MIPO: ELIGIBILITY AND ENROLLMENT (INDIVIDUAL MARKETPLACE)

ELIGIBILITY AND ENROLLMENT PROPOSED NPS FY23 BUDGET: $467,000 (FY22 $512,000)

- MOA WITH OFFICE OF ADMINISTRATIVE HEARINGS FOR ELIGIBILITY APPEALS: $10,000
- NOTICE PRINTING/MAILING: $180,000
- AMHARIC/SPANISH TRANSLATION OF NOTICES: $27,000
- CONSULTING SERVICES: $250,000

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MIPO: PLAN MANAGEMENT

PLAN MANAGEMENT PROPOSED NPS FY23 BUDGET: $835,000 (FY22 $845,000)

- ACTUARIAL SERVICES: $175,000
- PLAN MATCH (ANONYMOUS SHOPPING); DOCTOR DIRECTORY, HEALTH PLAN MATCH, PRESCRIPTION DRUG FORMULARY LOOKUP TOOL, DENTAL PLAN MATCH: $660,000

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MIPO: SMALL BUSINESS MARKETPLACE

PROPOSED NPS FY23 BUDGET: $899,822 (FY22 $873,000)

- PREMIUM AGGREGATION: $504,822*
- CONSULTING SERVICES: $250,000
- MAILING AND POSTAGE: $120,000**
- TRANSLATION: $25,000

**REFLECTS SAVINGS OF $317,544 FROM MA HEALTH CONNECTOR PARTNERSHIP*
***INCLUDES $40,000 TO BE REIMBURSED BY THE MA HEALTH CONNECTOR*

DC HEALTH LINK
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MIPO: PERFORMANCE MANAGEMENT

PERFORMANCE MANAGEMENT PROPOSED NPS FY23 BUDGET: $177,000 (FY22 $151,500)

- COMPUTER REFRESH, SUPPLIES, TRAINING, NAHU, POSTAGE AND SHREDDING; SURVEY TOOL: $142,000
- EMMA EMAIL TOOL: $35,000

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CONSUMER EDUCATION AND OUTREACH

CONSUMER EDUCATION AND OUTREACH PROPOSED FY23 BUDGET: $3,231,707 (FY22 BUDGET $2,995,799)

- PERSONNEL SERVICES FOR 7 FTEs: $1,017,657
- NON-PERSONNEL SERVICES: $2,214,050
  - OUTREACH AND ENROLLMENT (DCCC, GWHCC, RAMW) AND NAVIGATORS/ASSISTERS: $1,000,000
  - OUTREACH AND MARKETING: $1,092,050
  - HEALTH INSURANCE LITERACY CAMPAIGN: $90,000
  - DATA RESOURCES: $25,000
  - ADMIN: $7,000

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IT (DCHealthLink.com)

IT PROPOSED FY23 BUDGET: $12,346,018 (FY22 BUDGET $11,534,130)

- PERSONNEL SERVICES FOR 34 FTEs: $5,246,120
- NON-PERSONNEL SERVICES BUDGET: $7,099,898 (FY22 BUDGET $6,678,361)
  - IT CONSULTANTS: $5,525,549
  - SOFTWARE: $1,401,980
  - MICROSOFT 365 LICENSES: $35,000
  - OCTO: $86,369
  - ADMIN: $51,000 (computer refresh, copier, supplies, training)

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AGENCY MANAGEMENT PROGRAM (AMP)

AMP PROPOSED FY23 BUDGET: $5,974,210 (FY22 BUDGET $5,810,791)

- PERSONNEL SERVICES FOR 19 FTEs: $3,555,230
- NON-PERSONNEL SERVICES BUDGET: $2,418,980
  - FIXED COST (INCLUDES RENT, TELEPHONE): $1,827,383
  - MOA WITH DCHR FOR HR SUPPORT SERVICES: $107,250
  - MOA WITH DCHR FOR CAPITAL CITY FELLOWS: $83,522
  - MOA WITH DISB FOR ASSESSMENT SERVICES: $50,000
  - MOA WITH CONTRACT APPEALS BOARD: $1,000
  - MOA WITH DSLBD FOR LICENCES: $225
  - LEGAL EXPENSES (CONSULTANTS, WESTLAW, ETC): $43,500
  - EMPLOYEE TRAINING (INCLUDING SOCIAL JUSTICE INITIATIVE TRAINING): $150,000
  - MEMBERSHIPS & SUBSCRIPTIONS (INCLUDING NASHP): $24,000
  - CONSULTING SERVICES: $3,600
  - ADMIN (COMPUTER REFRESH, EQUIPMENT, TRAVEL, OFFICE SUPPLIES): $128,500

AGENCY FINANCIAL OPERATIONS (AFO)

AFO PROPOSED FY23 BUDGET: $806,495 (FY22 BUDGET $772,837)

- PERSONNEL SERVICES FOR 3 FTEs: $642,495
- NON-PERSONNEL SERVICES: $164,000
  - AUDITING SERVICES (including Annual Comprehensive Financial Report and SMART Audit): $150,000
  - EMPLOYEE TRAINING AND TRAVEL: $7,000
  - ADMIN (COMPUTER REFRESH, SUPPLIES): $7,000

DC HEALTH LINK
Get the facts. Get covered.

HBX Awards and Recognition

- ✓ **Won 2019 Sustainability and Equity Award:** Amazon Web Services (AWS) City on a Cloud international competition
- ✓ **Featured in the Fall 2019 AWS City on a Cloud International Announcement For Applications:** https://aws.amazon.com/stateandlocal/cityonacloud/
- ✓ **Won 2018 & 2016 Best Practices in Innovation:** Amazon Web Services (AWS) City on a Cloud international competition
- ✓ **Ranked #1 for consumer decision support tools (ranking of State-Based Marketplaces and Federal Exchange 2018 and 2017)**
- ✓ **Five PR News Awards in 2019 and 2018**
- ✓ **2017 AWS IT case study on cloud solutions:** https://aws.amazon.com/solutions/case-studies/DC-HBX/
- ✓ **First in the nation SBM partnership:** Selected by the Massachusetts Health Connector to provide IT solution and on-going operations support for the MA SHOP (Feb 2017)

DC HEALTH LINK
Get the facts. Get covered.

greaterwashington
hispanic chamber of commerce

RAMW
RESTAURANT ASSOCIATION METROPOLITAN WASHINGTON

PROTECTING THE CONSUMER'S FUTURE
NAHU
National Association of Health Underwriters
AMERICA'S BENEFITS SPECIALISTS

ATTACHMENT 2

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
WITNESS LIST – FY23 BUDGET OVERSIGHT HEARING
1350 PENNSYLVANIA AVE., N.W., WASHINGTON, D.C. 20004

COUNCILMEMBER VINCENT C. GRAY, CHAIRPERSON
THE COMMITTEE ON HEALTH

ANNOUNCES A FISCAL YEAR 2023 BUDGET OVERSIGHT HEARING ON

THE DC HEALTH BENEFIT EXCHANGE AUTHORITY

AND

THE DEPARTMENT OF BEHAVIORAL HEALTH

MONDAY, MARCH 21, 2022, 10:00 A.M. – 6:00 P.M.
REMOTE HEARING VIA WEBEX
STREAMED LIVE ON YOUTUBE AT TINYURL.COM/COHFY23.

WITNESS LIST

DC Health Benefit Exchange Authority

Public Witnesses

Panel 1

1. Reverend Patricia Hailes Fears	Pastor, Fellowship Baptist Church
2. Barbara Kittridge	Public Witness
3. Angela Franco	President & CEO, DC Chamber of Commerce
4. Kristal Williams	Co-owner & Director of Operations, FishScale

Executive Witnesses

Panel 2

5. Mila Kofman	Executive Director, DC Health Benefit Exchange Authority
6. Diane C. Lewis	Chair, D.C. Health Benefit Exchange Authority Executive Board

Department of Behavioral Health

Public Witnesses

Panel 3

7. Sarah Barclay Hoffman	Community Mental Health CORE Program Manager, Children's National Hospital
8. Amber Rieke, MPH	Director of External Affairs, DC Health Matters Collaborative
9. Hannah Garelick	Jews United for Justice, Community Organizer
10. Mark LeVota	Executive Director, District of Columbia Behavioral Health Association

Panel 4

11. Qubilah Huddleston	Education Policy Analyst, DC Fiscal Policy Institute
12. Tami Weerasingha-Cote	Supervising Attorney of Policy, Children's Law Center
13. Kerry Savage	Director of Policy at PAVE
14. Joshua Hodge	Policy and Communications Manager, Education Reform Now D.C.

Panel 5

15. Betty Gentle	Senior Advocacy and Community Engagement Specialist, SOME, Inc. (So Others Might Eat)
16. Mark C. Miller	State Ombudsman, Office of the D.C. Long-Term Care Ombudsman
17. Justin Palmer	DC Hospital Association
18. Jarred Bowman	Early Childhood Policy Analyst, DC Action

Panel 6

19. Jaclyn Verner	Staff Attorney, Disability Rights DC at University Legal Services
20. Tammy Seltzer, Esq.	Director of the DC Jail & Prison Advocacy Project, Disability Rights DC at University Legal Services
21. Donald Hines	Disability Rights DC at University Legal Services
22. Jennifer Ubiera	Council for Court Excellence

Panel 7

23. Nadia Gold-Moritz	Executive Director, Young Women's Project
24. Anna Mable Jones CPRS, NCPRSS	Resources Coordinator, Oxford House
25. Latonya Graham	Parents Amplifying Voices in Education
26. Mary Mccane	Parents Amplifying Voices in Education

Panel 8

27. Kelita Boyd	Parents Amplifying Voices in Education
28. Tara Brown	Parents Amplifying Voices in Education
29. Tyesha Andrews	Parents Amplifying Voices in Education
30. Renee Davis	Parents Amplifying Voices in Education
31. Randee Grant	Parents Amplifying Voices in Education

Executive Witness

Panel 9

32. Dr. Barbara J. Bazron	Director, Department of Behavioral Health

Testimony of Sarah Barclay Hoffman
Children's National Hospital and Early Childhood Innovation Network

Department of Behavioral Health Budget Oversight Hearing
Committee on Health
Council of the District of Columbia
March 21, 2022

Good afternoon Chairman Gray and members of the Committee, my name is Sarah Barclay Hoffman and I serve as a Program Manager with the Community Mental Health CORE at Children's National Hospital and Director of Policy for the Early Childhood Innovation Network. The Community Mental Health CORE aims to improve access to and utilization of high-quality behavioral health services for children and families, advance racial and health equity, and promote sustainability and system-level change through research, policy, advocacy, and community engagement. ECIN is a local collaborative that promotes resilience in families and children from pregnancy through age 5 in Washington, DC. ECIN joins community and clinical expertise to develop innovative multigenerational programs in health and education settings. We work to advance systemic changes that will eliminate health disparities that impact children and families in our most under-resourced communities. We are also members of the Strengthening Families through Behavioral Health and Under 3 DC coalitions. Thank you for the opportunity to testify today regarding the Department of Behavioral Health (DBH) budget, with a focus on Healthy Futures, School-Based Behavioral Health and Medicaid rates.

My work at Children's National and the Early Childhood Innovation Network (comprised of partners such as Parent Watch, Total Family Care Coalition, SPACES in Action, Health Alliance Network and MedStar Georgetown University Hospital, among others) affords me the privilege to hear on a regular basis from those who are on the front lines of caring for the emotional well-being of our city's children: families, behavioral health clinicians, pediatricians, family run organizations and child care providers. These voices, while from across the wards and in differing sectors, are nonetheless aligned, urgent and unwavering in their strain: Our beautiful and precious children are suffering. They are suffering from the myriad tragedies COVID-19 has inflicted, from violence ravaging their neighborhoods, from family financial strain and stress, and from already existing, pre-pandemic mental health conditions. Anecdotally, our psychiatrists, psychologists and pediatricians at Children's National speak of grim and gut-wrenching patient scenarios – such as behavioral health inpatient and outpatient acuity increases, the likes of which some of these professionals state they have not seen during their careers. Numerous local data also show that we are in a child and adolescent behavioral health crisis in the District.[1] And yet, this chorus of voices is resolute in the belief that with smart, adequate and consistent investments in an integrated, place-based behavioral health ecosystem, we can move from crisis to flourishing. Through expanded and sustained investments in areas such as prevention and early

intervention, infant and early childhood mental health, and the provision of mental health services in education and community-based settings, we can meet the demands of this moment in time for the District's young people. We thank Mayor Bowser, the Council and DBH for making investments in behavioral health across the system of care and urge specific investments in the following areas:

Healthy Futures. Healthy Futures is an evidence-based, early childhood mental health consultation program, which promotes positive social and emotional development in young children, as well as attending to child-specific needs, including facilitating referrals for community-based services. The aim is to build the capacity of adults who are in early learning environments, such as child care, to optimally support the healthy social and emotional development of children. Healthy Futures is a prevention and early intervention program that has shown high-quality outcomes, has a strong evidence base, has successfully pivoted to meet varying needs of child care providers, young children and families during the pandemic, and is a trusted program in the community. We should build upon what is working.

- **We urge the Council to enhance funding for Healthy Futures by $700,000** so more infants, toddlers and young children, families and staff at child development centers will have access to critical mental health services. This funding will support the Department of Behavioral Health in advancing the program's infrastructure, hire consultant and supervisory personnel, and increase the program's capacity to expand by 25 to 35 additional child development facilities next fiscal year. These steps will significantly advance our efforts to reach all subsidy-participating child development programs in the District as indicated in the Birth to Three law.

School-Based Behavioral Health Services. The presence of behavioral health services in the public-school setting in DC represents a protective factor for children's behavioral health. Ensuring access to behavioral health care in every school is essential, and I commend the District's leaders for their strong support of the School-Based Behavioral Health program. While Children's National is **not** a provider in DBH's School-Based Behavioral Health program, we recognize the costs inherent in attracting and retaining a high-quality workforce and how adequate financing is key to ensuring a stable behavioral health care program, especially in our current environment of workforce shortages and inflation. Our clinicians speak consistently and often about the positive difference school-based behavioral health services can and do make for their patients. Therefore, we encourage the Council to:

- **Appropriate $300,000 in one-time local dollars for the School-Based Behavioral Health Expansion program to fund a cost study to right-size the grant amounts for participating CBOs.** The current grant amount is outdated, undermining the success of the program.
- **Ensure School-Based Behavioral Health Community-Based Organization (CBO) grant amounts are at $80,000 for FY23.** We must ensure that the FY23 budget supports a clinician in every school and at a CBO grant level that bolsters consistency and longevity of the program, which requires Council restoring CBO grant levels to $80,000.

Community-Based Behavioral Health Services and Medicaid Rates. Families and others who care for children know the value and necessity of a high-quality community-based behavioral health system that can deliver timely care. Yet, community-based, DBH-certified providers are operating in a system with Medicaid reimbursement rates that were calculated using data from seven years ago and have never been adjusted for inflation. We urge the Council to:

- **Allocate $10.3M for community-based behavioral health services (i.e., therapy, community support) to adjust for inflation**. Provider reimbursement rates were last calculated using 2016 data and current reimbursement rates are not financially sustainable to meet demand.[2]

We commend DBH for areas where they continue to advance behavioral health care programs, and their commitment to children and families. Thank you for the opportunity to testify and I'm happy to answer any questions you may have.

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[1] Local data on children's behavioral health is available in the following two recent reports: A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia and COVID-19 and Children's Behavioral Health in the District of Columbia: The Pandemic's Impact on Child Behavioral Health Outcomes and the Behavioral Health Care System

[2] The $10.3M is inclusive of $8.2M to increase Medicaid billable services through BHRS Local (Medicaid) Match and $2.1M to increase non-Medicaid billable services through BHRS.

Testimony of the DC Health Matters Collaborative
to the Committee on Health
Department of Behavioral Health Performance Oversight Hearing

Monday, March 21, 2022

My name is Amber Rieke. I am the Director of External Affairs for the DC Health Matters Collaborative. Thank you for the opportunity to testify today about the Department of Behavioral Health's Fiscal Year 2023 budget.

The DC Health Matters Collaborative is a partnership of hospitals and health centers that work together to achieve one healthy and thriving capital city, holding the same promise for all residents regardless of where they live. Collaborative membership includes three non-profit DC hospitals (Children's National Hospital, Howard University Hospital, and Sibley Memorial Hospital); four community health centers (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care); and three associations (DC Behavioral Health Association, DC Hospital Association and DC Primary Care Association).

DC Health Matters conducted community health needs assessments in 2013, 2016 and 2019. A new assessment will be released this summer. The Collaborative's work is built around the priority areas identified in these assessments: Mental Health, Care Coordination, Health Literacy, and Place-Based Care.

We have been focusing the last couple of years on the shortage of the behavioral health services and workforce in DC. This is because the community has been telling us to do so since 2016, but also because everything else we try to work on keeps bringing us back to *this issue*. We simply cannot achieve equitable well-being in DC without a strategic investment to retain and expand our behavioral health workforce.

DC Health Matters Collaborative is part of the Strengthening Families Through Behavioral Health Coalition's – with the mission to ensure DC has a fully integrated behavioral health care system in which all DC students, children, youth, and families have timely access to high-quality, consistent, affordable, and culturally responsive care that meets their needs and enables them to thrive. You're going to hear from many of my colleagues today.

By now, it's common knowledge that DC's residents are suffering from an ongoing behavioral health crisis that we see in our young people rising rates of depression, anxiety, and suicidality. We also have an opioid overdose epidemic, trauma from community violence, and the inability

for people with mental illness or substance use to connect easily to treatment; about 60% of adults and youth with mental illness are not receiving treatment.

We are grateful for the Mayor's continued investments in the School-Based Behavioral Health Expansion program. The Fiscal Year 2023 budget includes essential resources, but the full cost of operating the program – and expanding to every school in DC – requires permanent, stabilized funding, based in today's costs, for the grants to community-based organizations (CBOs).

- We ask for **$2.4 million more in *recurring* local dollars to ensure that CBO grants fund $80,000 per clinician.** For the past two years, the grant amount per clinician has been approximately $70,000, based on estimates regarding the costs of the program, such as the amount of work that would be reimbursable by Medicaid. The estimate turned out to be too low for the last two years, so the Council added one-time dollars to enable CBOs to do the work.
  Pay is one reason we are still struggling to staff all schools; although the majority of the 160 schools in Cohorts 1, 2, and 3 have full-time behavioral health clinicians providing services in school, less than a quarter of the 91 schools in Cohort 4 have hired clinicians. In the meantime, the Mayor's proposed budget includes funding for 50 new clinicians, but these positions will still be difficult to fill if we aren't paying enough at a baseline.
- We ask for **$300,000 in this Fiscal Year to fund a cost study to right-size provider grants.** Without knowing the true cost of implementing the School-Based Behavioral Health program in our present reality, DC can't ensure adequate funding to sustain the program and realize its full potential. DC needs to conduct a comprehensive study to determine how student, provider, and community needs impact SBBH costs, and identify a more sustainable CBO funding model. And outside of the school walls, but linked:
- **Current community-based behavioral health services should receive an additional $10.3 million in recurring local dollars.** Current reimbursement rates are based on 2016 cost data, are not financially sustainable, and are not adjusted for inflation. Most of these funds would be matched with federal dollars three-to-one, resulting in an additional $24.6 million in spending on behavioral health services in the District.

We celebrate the progress that the District has made on the program to date. We are proud that our community is leading the nation with its model to integrate mental health services into schools. As the program takes root and grows, we realize the cost estimates are outdated and inadequate. This is not a flaw or criticism, it's a natural growing pain of a new, progressive, one-of-a-kind program. Today, at the fourth year, we see the program's struggle to hire and retain clinicians, that costs have steadily increased over the past few years to meet the need, and that the public's overall demand for mental health treatment has increased exponentially during the pandemic. Yet the grant amount has not changed.

The expectation that Medicaid reimbursements would braid with grant funds has not played out as hoped. The current grant amount is based on a certain percentage of the clinician's time being billable to Medicaid (Tier 3 services). But different schools have different needs – and some schools need their clinicians to prioritize Tier 1 and Tier 2 work. Further, many aspects of Tier 3 services aren't billable (for example, following up with that child's parents and teacher). As a result, the billing expectation isn't achievable in all schools, which means some CBOs are operating at a loss.

The Mayor's proposed budget include $3.8 million for school-based behavioral health services. These new funds have been designated for hiring additional clinicians, adding new DBH staff to support the program's infrastructure and evaluation, and boosting DBH's workforce pipeline efforts. Since we are struggling with a workforce shortage that is echoed nationwide, these are important areas of focus. We thank the Mayor and Dr. Bazron for attending to this essential strategic element.

Unfortunately, under these investments, the Mayor's proposal also cuts provider grants by about $10,000 apiece (back down to $70,000 per clinician). Expansion of the program should not be done at the cost of undercutting the existing core. If the Council doesn't stabilize the foundation of this program and ensure it is financially sustainable for CBOs to provide behavioral health services, I believe we will find ourselves here next year discussing why we still haven't staffed every school with their first clinician.

Last Friday when the DBH budget was released, I had to take a break from my testimony because it was the most perfect day outside, and I couldn't resist some spring gardening. As I was doing this, I started to think about a metaphor for the school-based behavioral health program and my budget asks:

The District planted a garden. It was a wonderful policy, and it will do so much good. It will produce beautiful blooms and nourish many with what grows there. But when we planted our seeds, we didn't know that a storm was in the forecast; it would throw off our plans and the weather and every plant's health for two years. (This was the COVID-19 pandemic.) So, the weather seems better now, but we see how many plants were bent, stopped growing, are still struggling toward the sun.

We have more work to do tending to these beds, and we realize that we need to do more intensive care than we thought, but the whole rest of the garden still needs planting. Now, we are ambitious and dedicated gardeners, but we need more resources, more tools, more nutrients to really achieve the potential we imagined. This is how we might think about each school and the amazing members of a behavioral health team. They are hardy and vigorous, but we need to enrich our soil and give them the best light and conditions to thrive and keep coming back year after year.

To keep straining this metaphor, I'm going to come back to the request for a cost study; we need to get a little scientific with our garden. I learned through gardening that the arc of the sun changes pretty significantly through the year, so something you thought would get great sun could actually be in deep shade by the end of the season. Conditions change. I've also learned that soil is not only essential, but very complicated. It's a delicate balance of minerals and nutrients, different plants need different conditions. Even if you get that balance spot on in the spring, all of it can be completely depleted at the end of a growing season. Sunflowers, for example, take an amazing amount of nitrogen from the soil. Now imagine six years of sunflowers in the same soil. How's the soil doing? Are your sunflowers still growing as tall? You should probably study the conditions, send samples to a lab, and don't be surprised when you need a few truckloads of resources to create optimum conditions.

Now, I know that is a little cute for something that's quite serious. In talking with the providers who work in schools, as well as in clinics and emergency rooms, I've heard stories that break my heart and keep me up at night. I've worked with many who have left their positions, or gone into private practice. But I also have hope that we can stabilize these services and meet the tremendous need. To have and realize that hope, we must imagine what could bloom with the right conditions.

There's a quote by H. Jackson Brown, Jr.: "Remember that children, marriages, and flower gardens reflect the kind of care they get." We have set out on this vision, we must give it all the resources it needs to nourish it to fruition. We need to do it now, and next year, and next.

In addition to school-based investments, we need a District-wide, cross-sector strategic plan for workforce development in behavioral health, As we testified last year, we believed the proposed Interagency Council on Behavioral Health Establishment Amendment Act of 2021 would establish interagency, cabinet-level leadership to develop a behavioral health system of care, that includes prevention, harm reduction, treatment, and recovery support services related to mental health disorders, addictions, and other substance abuse. We had hoped this could be the entity to effectively plan and implement the needed comprehensive strategy, and especially to draw on young and long-time District residents of color to serve. If this bill does not pass, we strongly recommend that this committee engage with the Committee on Labor to hold a joint hearing about the behavioral health workforce.

DC Health Matters held listening sessions in summer 2021 with behavioral health professionals and summarized the findings and themes in a white paper entitled "Improvements to Behavioral Health Provision and Integration in D.C.: Listening to our Behavioral Health Workforce and Youth." Our goal was to start building a better understanding of the dynamics and demands of current providers, including peer support positions and community health workers, and how the system could improve pay and retention strategies.

In speaking with providers and leadership, we heard several themes and recommendations:

1. **Reduce obstacles to entering behavioral health fields**: address costs to pursue formalized clinical education; address lack of awareness of non-clinical roles and/or different types of behavioral health roles, including in harm reduction; address credentialing timelines, requirements, and processes; and inadequate pay;
2. **Make targeted improvements to reimbursements, billing, contract and grant opportunities, and insurance structures**: increase opportunities for behavioral health coverage, to provide sufficient pay for behavioral health workers, including peer support roles and community health workers;
3. **Address existing and emerging challenges for organizational recruitment and behavioral health provider retention**: address provider satisfaction, incentives and pay; address credentialing, competition, diversity and inclusion, and turnover issues; and address the need for a provider pipeline in coordination with local colleges and universities; and
4. **Increase attention from policymakers and D.C. government agencies to behavioral health providers and organizations**: increasing reimbursement rates and billing opportunities, funding mutual aid systems, and citywide collaboration and investment into cohesively integrated referral systems, care coordination, and consultation.

Our participants also delved further into how to build the behavioral health workforce, how to increase provider satisfaction, and what system improvements to implement. To truly improve mental health in our community, we must have the workforce to support treatment and create a stronger system for insurance coverage for ongoing care.

Conclusion

We celebrate the investments in behavioral health services that the District has made in recent years. As we work to achieve the vision of this program, we must be attentive to the conditions we create to best care for the mental and emotional health of children and families in DC. Only with serious and dedicated attention to workforce capacity and adequate funding can we hope to reach the imagined potential.

Thank you for the opportunity to share our testimony. We will make ourselves and our providers available to assist in any way possible.

Budget Oversight of the Department of Behavioral Health

Committee on Health

Councilmember Vince Gray

March 21, 2022

Testimony of Hannah Garelick

Jews United for Justice

Good morning. Thank you, Councilmember Gray and members of the committee. My name is Hannah Garelick and I am a community organizer with Jews United for Justice, a local grassroots organization that mobilizes thousands of Jews and allies in DC to fight for social, racial, and economic justice. Thank you Councilmember Gray for your continued work championing the Birth-to-Three Law. We are disappointed to see that the Mayor did not include any funding increase to the Healthy Futures program, or any of the other Birth-to-Three family health support programs. As a member of the Under 3 DC Coalition, JUFJ asks that the DC Council allocate at least $700,000 to expand Healthy Futures, which provides child-focused behavioral health support to educators in child care settings. This increased funding can strengthen the program's infrastructure, including hiring additional staff, addressing staffing needs, and providing professional training.

Jewish tradition teaches us the value of "Ki shama Elohim el kol ha'na'ar ba'asher hu sham: For the Holy One heard the voice of the child who was there."[1] Our tradition tells us that just as the Holy One listened to each of us, so too should we listen to the experiences of those who are experts in their own lives – of the children, parents, and educators. Those who are involved in the growth and development of young children should have the resources and training to listen and support the voices of young children.

Effective social-emotional skills and supporting mental health challenges are key to a child's healthy development. These skills play a vital role in helping children make friends, learn new skills, and succeed in school in the early childhood years and beyond. Healthy Futures has had success doing all of this. The program provides an evidence-based, early childhood mental health consultation program that promotes positive social and emotional development in young children.

Increasing funding for the Healthy Futures program by at least $700,000 will enable the Department of Behavioral Health to make much-needed updates to the program's infrastructure, hire personnel, and increase the program's capacity to expand by 25 to 35 additional child development facilities next fiscal year.

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[1] (Genesis 21:17)

These steps will significantly advance efforts to reach all subsidy-participating child care development programs in the District. The funds could be used to hire three to five new consultants and more supervisors, with additional funds to cover overhead costs associated with the additional professionals and implementation of the program.

In reports and data collected by providers in the District, teachers participating in Healthy Futures reported improvements in classroom management and more positive interactions with children and parents. These improved relationships contribute to more positive and collaborative learning environments for students, staff, and families. Reports showed improvements in educators' ability to manage challenging student behavior, their knowledge of how to refer children and families to mental health services, and their comfort with mental health services.[2] Now more than ever, we know that mental health services are vital to the strength of families and the community.

As a member of the Under 3 DC Coalition, we have seen great strides in the funding of the Birth-to-Three Law. JUFJ enthusiastically supported taxing high-income residents last year and we are grateful to see this increased revenue being used to support the higher compensation of early childhood educators. Greater investments in family health support programs like Healthy Futures also help children and families in the District continue to grow and thrive. We hope you rectify the lack of funding from the Mayor's budget proposal and ensure the final FY23 DC budget includes at least $700,000 to expand Healthy Futures.

Thank you for the opportunity to testify today.

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[2] Perry, Deborah. Healthy Futures: Year Three Evaluation Of Early Childhood Mental Health Consultation by the District of Columbia Department of Mental Health. Georgetown University Center for Child and Human Development. 2013. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/HealthyFuturesThreeYearEvaluationReport.pdf

District of Columbia Behavioral Health Association
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Statement of the District of Columbia Behavioral Health Association
Department of Behavioral Health FY '23 Budget Oversight

To the District of Columbia Council Committee on Health
March 21, 2022

Chairman Gray and Members of the Council,

Thank you for the opportunity to testify today. My name is Mark LeVota. I am the Executive Director of the District of Columbia Behavioral Health Association and a Ward 2 homeowner. The District of Columbia Behavioral Health Association works to advance high-quality, whole-person care for all District residents with mental illness or substance use disorders, including the 35,000 District residents our 32 member organizations serve annually. With the Department of Behavioral Health budget book released only this immediate past Friday, many questions remain about exactly what is or is not funded. As the Council moves through its oversight process for the Mayor's proposed FY '23 budget, I encourage Councilmembers to seek assurances from DBH and to identify additional funds, if necessary, to meet the needs of District residents still facing unprecedented emotional distress and a higher rate of opioid fatalities than the already unacceptable rate of homicides.

An initial review of the proposed DBH FY '23 budget does not clarify whether there are sufficient funds to provide DBH-certified provider organizations with an inflationary rate adjustment while waiting for results from a cost study underway. A temporary 20% rate increase is in effect for substance use disorder American Society of Addiction Medicine Level 1 and 2 providers that serve about 2,500 of DBH's 35,000 enrolled consumers. Otherwise, provider rates remain based on 2016 costs. The Department of Health Care Finance has requested a 1.8% inflationary cost adjustment from the Center for Medicaid Services for DBH-certified providers to help offset future increases in inflation, but this does not close the 10.8% gap from the fourth quarter of 2016 to the second quarter of 2021 shown in Medicare Economic Index[1] data used by DHCF for rate-setting. There is a 16.1% gap from the fourth quarter of 2016 to CMS's projection for the first quarter of 2023. The Council should ask DBH whether anything in the Mayor's FY '23 proposed budget is expected to be used to adjust provider rates for inflation since 2016. If there is not enough funding, the Council should fill the gap.

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[1] Centers for Medicare and Medicaid Services. Market Basket Data. Online. Available 3/21/2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

Mental Health Community Residential Facility housing operators also face pressure from high inflation, and the DBH FY '23 proposed budget does not clarify whether there are sufficient funds to update CRF housing operator contract rates. Housing operator costs are not reflected in the adjustments used for health services in the Medicare Economic Index. Instead, the Bureau of Labor Statistics reports a Consumer Price Index change (15.5%) from December 2016 to December 2021. BLS does not provide a forecast, so the Council should note costs have continued to rise since December and can be expected to do so through FY '23. The Council should ask DBH whether anything in the Mayor's FY '23 proposed budget is expected to be used to adjust CRF housing operator rates for inflation since costs were last evaluated. If not, the Council should fill the gap.

Initial review of DBH's proposed FY '23 budget also does not clarify whether there are funds to stabilize school behavioral health expansion grants at the $80,000 per clinician level funded in the past two years through a combination of recurring and one-time funds. The Mayor's presentations last week highlighted $3.8M in new school behavioral health spending, and the budget book shows a little over $4M in increases to the school behavioral health line. There also appear to be millions of dollars in new expenses for program infrastructure, wrap around services, and workforce pipeline initiatives. We join the Strengthening Families Coalition in asking for grant amounts to be set level at $80,000 per clinician for school year '23 / fiscal year '23 by replacing $2.4M of one-time funds with recurring funding and asking for $300,000 to be spent on a cost study to right-size grant amounts to reflect a more accurate understanding of clinician costs, supervision costs, overhead costs, and expectations for successful use of blended grant funding along with funding through billing for Tier 3 services. The Council should ask DBH whether the Mayor's FY '23 proposed budget stabilizes CBO grants at $80,000 per clinician. If DBH believes a different number of clinicians or a different number of schools will participate in the school behavioral health expansion in FY '23, the Council should continue to ask whether the funding available will support grants of $80,000 per clinician. If not, the Council should fill the gap.

The budget does make clear that DBH has renewed funding for the expanded 911 diversion, Community Response Team, Access Helpline, intensive care coordination for challenging cases, and expanded Healthy Futures. We praise these decisions and encourage the Council to seek assurances early that these items, funded in the FY '23 budget as District Recovery Plan services, are expected to be permanent components of the District's commitment to ensure DBH can meet the needs of people served through these services, and not only so long as federal funds are available.

Thank you again for the opportunity to testify today. I look forward to answering any questions that you might have.

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childrenslawcenter.org

Testimony Before the District of Columbia Council
Committee on Health
March 21, 2022

Public Hearing:
Budget Oversight Hearing
Department of Behavioral Health

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Introduction

Good morning, Chairman Gray and members of the Committee. My name is Tami Weerasingha-Cote. I am the Supervising Policy Attorney at Children's Law Center[1] and a resident of the District. I am testifying today on behalf of Children's Law Center, which fights so every DC child can grow up with a stable family, good health, and a quality education. With nearly 100 staff and hundreds of pro bono lawyers, Children's Law Center reaches 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year.

Children's Law Center is also a Co-Chair of the Strengthening Families Through Behavioral Health Coalition. Currently in its third year of advocacy, the Strengthening Families Coalition brings together a diverse group of advocates focused on education, juvenile justice, child welfare, and health, as well as representatives of the provider community and community-based organizations who share a commitment to improving DC's behavioral health care system for children and families. Our Coalition's mission is to ensure DC has a fully integrated behavioral health care system in which all DC students, children, youth, and families have timely access to high-quality, consistent, affordable, and culturally responsive care that meets their needs and enables them to thrive.

Thank you for this opportunity to testify regarding the proposed FY2023 budget for the Department of Behavioral Health (DBH). Although the Mayor's proposed

budget includes some new investments in the school-based behavioral health expansion program, the Mayor's proposed budget also reduces the amount of the provider grants that get clinicians into schools, making it less likely that students will be able to access the behavioral health services they need.[2] Further, the Mayor's budget includes no new investments in DBH's early childhood mental health consultation program, Healthy Futures.[3]

As we discussed in our Performance Oversight testimony for DBH in January, DC's children and youth are suffering from an ongoing behavioral health emergency that we see reflected in rising rates of depression, anxiety, and suicidality.[4] To stem the tide of this expanding crisis, the District must increase access to quality behavioral health services. This requires investments in both immediate solutions – such as increasing the capacity of existing programs that connect children with behavioral health services – and longer-term structural reforms that seek to transform our behavioral health system entirely.[5]

We recognize that as we start to move away from the pandemic, the District is facing many calls to fund various aspects of pandemic recovery. The pandemic impacted every aspect of our lives, and as a result, investments in recovery and revitalization are needed across every economic sector and every Ward of the city. Investments in expanding behavioral health services must be prioritized, however, because behavioral health underlies so many aspects of pandemic recovery. If we fail to

meet the behavioral health needs of District residents, it will undermine their ability to recover from the pandemic in every way – from rebuilding their physical health, to regaining ground lost in school and work, to stabilizing their housing and their families, to reinvigorating their communities.

In addition, we are fortunate in that the District's financial recovery from the pandemic is looking much better than expected. According to the latest projections from the Office of the Chief Financial Officer (OCFO), the District will take in approximately $506 million more in revenue for FY2022 than was anticipated when the Council approved the FY2022 budget in August 2021.[6] This is in addition to the over $570 million excess surplus from FY2021.[7] Projected revenues for each year of the upcoming financial plan are also higher than previously anticipated.[8] OFCO estimates that FY2023 revenues will be 3.9 percent more than FY2022 revenues – an increase of nearly $360 million dollars.[9] Given this unanticipated additional revenue and the projected financial strength of the city, the Council is well-positioned to prioritize much-needed investments in our behavioral health system.

To this end, my testimony identifies key programs and areas where funding needs to be increased to improve access to behavioral health services for children and families. Specifically, we urge the Council to commit:

- **$300,000 in one-time local dollars for the School-Based Behavioral Health Expansion program to fund a cost study to right-size provider grants.** The

current grant amount is outdated, undermining the longevity and success of the program.

- **$2.4 million in additional recurring local dollars for the School-Based Behavioral Health Expansion program to stabilize provider grant funding at $80,000 per clinician.** For the past two years, DC has provided one-time adjustment to address the financial strains of the pandemic on providers. This rate needs to be made permanent, and the grant amount should cover inflationary cost increases over the next three years while the cost study is conducted.
- **$700,000 in additional recurring local dollars for Healthy Futures to expand capacity to additional child development centers during the next fiscal year.** This additional funding is needed to hire additional early childhood mental health professionals and continue to build the program's infrastructure to support sustained growth and services to District families.
- **$10.3 million in additional recurring local dollars to increase funding for community-based behavioral health services by adjusting for inflation.** Provider reimbursement rates were last calculated using 2016 cost data, and current reimbursement rates are not financially sustainable for critical community-based behavioral healthcare providers. Most of these

funds would be matched with federal dollars 3-to-1, resulting in an additional $24.6 million in spending on behavioral health services in the District.

Funding for the School-Based Behavioral Health Expansion Program Must Enable Providers to Cover Their Costs

Last spring, the Mayor and the Council made significant investments in the school-based behavioral health expansion program, with the goal of placing at least one behavioral health clinician in every DC public school (traditional and charter).[10] Both Children's Law Center and the Strengthening Families Coalition supported this goal for FY2022 – placing a behavioral health clinician in every public school is an excellent start to building a school-based behavioral health system that meets the needs of DC's children and youth.[11]

As of the date of this budget hearing, we are approximately halfway through FY2022, which is the fourth year of DBH's implementation of the school-based behavioral health expansion program. Although the majority of the 160 schools in Cohorts 1, 2, and 3 have full-time behavioral health clinicians providing services in school, less than a quarter of the 91 schools in Cohort 4 have hired clinicians.[12] There are several reasons for the slower implementation for Cohort 4 – including long-term workforce shortages and a significant delay in issuing the Request for Applications (RFA) needed to identify additional community-based organizations (CBOs) needed to staff the Cohort 4 schools.[13] More fundamentally, however, the program's struggle to

hire and retain clinicians is rooted in the fact that this program is not sufficiently or sustainably funded at the level needed to place a clinician in every school.

The school-based behavioral health expansion program funds clinicians in schools through an annual grant to CBOs, who in turn partner with schools to hire clinicians to provide full-time behavioral health services in those schools. (See Exhibit A for an overview of the school-based behavioral health expansion program). For the past few years, the grant amount allocated per clinician has been approximately $70,000.[14] This grant amount was based on estimates regarding the costs of the program and the amount of work clinicians could do that would be reimbursable by Medicaid, offsetting their costs. For the past two years, the Council supplemented these grants with one-time dollars to ensure the grants were sufficient to enable CBOs to do the work.[15] For many CBOs, these supplemental funds were necessary to make participating in this program financially feasible – and without them, DBH would have found it even more challenging to place clinicians in schools from the earlier cohorts.

To be clear – $70,000 grants are simply not sufficient to enable CBOs to place clinicians in every DC public school. This is true for several reasons:

- **Costs for providers have steadily increased** over the past few years and yet the grant amount has not changed.
- **Workforce shortages are driving increases in clinician salaries.** There is a nationwide shortage of behavioral health clinicians and mental health

professionals – the same is true here in DC. The public's overall demand for mental health treatment has increased exponentially during the pandemic.[16] Further, the demand for mental health professionals in the District has increased tremendously as more and more programs and sectors across the city are looking to mental health professionals and behavioral health supports to address social problems such as community violence.[17] CBOs cannot hire clinicians to work in schools if they cannot pay them competitive salaries.

- **The Medicaid reimbursements that the current funding model depends on are not consistent across all schools.** The current grant amount is based on a certain percentage of the clinician's time being billable to Medicaid (Tier 3 services).[18] But different schools have different needs – and some schools need their clinicians to prioritize Tier 1 and Tier 2 work.[19] Further, many aspects of Tier 3 services aren't billable when you are providing services to children (e.g., a counseling session with the child may be billable, but following up with that child's parents and teacher would not be). As a result, the billing expectation isn't achievable in all schools, which means some CBOs are operating at a loss in some schools. This is not sustainable.

Taking a step back to consider the broader context – this program is only in its beginning stages. To fully meet the behavioral health needs of all DC public school students, there is more infrastructure to build – some schools have so many students

requiring Tier 3 services that they will need multiple full-time clinicians, while other schools need more help delivering Tier 1 and Tier 2 services and may need to hire other types of non-clinical behavioral health professionals. A great deal of work is needed to increase awareness of the program amongst students, families, and teachers. The program must build communication pathways with school communities that enable accurate assessments of behavioral health needs, help families and students understand what services are available and how they can access them, and provide opportunities for families to give feedback on the program so that it can be strengthened and improved.

Before we can do any of this, however, we must build a stable foundation for this program by placing a clinician in every school and ensuring this resource is sufficiently and sustainably funded. Underfunding the grant undermines the stability of the whole program – it makes it harder to hire and retain the professionals needed, risks the financial viability of the CBOs that the program relies on to staff and supervise the program, and leaves schools uncertain whether this is a program they can rely on in the long-term and whether it's worth the time and effort needed to integrate the clinician into their community.

Although the Mayor's proposed budget appears to include $3.8 million for school-based behavioral health services, these funds have been designated for hiring additional clinicians, adding new DBH staff to support the program's infrastructure and

evaluation, and boosting DBH's workforce pipeline efforts.[20] These are all valuable new investments, but the Mayor's proposal also cuts provider grants by about $10,000 apiece (back down to $70,000 per clinician). While we certainly support expansion of the program, it should not be done at the cost of undercutting the existing core. If the Council doesn't stabilize the foundation of this program and ensure it is financially sustainable for CBOs to provide behavioral health services in schools, we risk losing ground on the progress that we've made in recent years.

We therefore urge the Council to commit $300,000 in one-time local dollars to fund a cost study to determine what it actually costs to implement the school-based behavioral health program now and in the future.[21] Consistent and adequate funding is crucial to the longevity and success of this program. Without comprehensive data and analysis, it is impossible to accurately calculate the cost of implementing the program or determine the grant amounts needed for CBO clinicians to sustainably deliver services to students. The District needs to conduct a comprehensive study to determine how the needs of individual schools, providers, and communities impact program costs and build a sustainable funding model for the program.

To bridge the gap while this cost study is conducted, we ask the Council to reverse the Mayor's cuts to provider grants and restore CBO grants to the financially sustainable level of $80,000 per clinician (for a total investment of $2.4 million in additional recurring local dollars in the FY2023 budget).[22] Since it will take several

years for the cost study to completed, we also ask the Council to ensure grant amounts are appropriately adjusted for inflation each year during this time. By doing this, the Council will both preserve the progress we've already made and pave the way for the continued expansion of the school-based behavioral health program DC students need and deserve.

Continued Investment in Healthy Futures is Needed

DBH's Early Childhood Mental Health Consultation program, Healthy Futures, provides critical support to child development centers (CDCs) and home care providers, as well as direct services to children ages birth to five and their families.[23] Through Healthy Futures, early childhood mental health consultants help teachers and caregivers understand and build their own capacity to better interact and support children's social, emotional, and relational health, with the goal of reducing challenging behaviors and promoting positive social-emotional development in infants and toddlers.[24]

Healthy Futures has been responsive and adaptive to the needs of caregivers and teachers during the ongoing pandemic.[25] Moreover, the program has continued to expand during the pandemic – despite the operational and financial challenges faced by child development centers and workforce shortages. Healthy Futures is currently in the process of hiring three more early childhood consultants. When fully staffed the

program will have a total of 23 early childhood consultants with a capacity to serve 138 child development facilities in FY2022.[26]

In light of the pandemic-related increase in children's behavioral health issues that caregivers and educators are encountering now, Healthy Futures is an even more essential tool for meeting the behavioral health needs of children and families in the District.[27] Continuing to expand the capacity of this program is essential to achieving the underlying goal laid out in the Birth-to-Three for All Act of 2018, which is for Healthy Futures to reach all subsidy-participating CDCs and home providers in the District.[28] To this end, we ask the Council to commit $700,000 in additional recurring local dollars for Healthy Futures in the FY2023 budget. This will allow DBH to continue to expand the program by 25 to 35 additional child development centers and home providers in FY2023.[29] This investment is on track with the expansion of Healthy Futures consultation services in FY21 and to date in FY22.[30] Continued strong investment in Healthy Futures is critical to the continued success of this program and we look forward to seeing Healthy Futures grow in its reach to District children, caregivers, and educators.

Community-Based Behavioral Healthcare Provider Reimbursement Rates Must Be Adjusted for Inflation

The current reimbursement rates for DBH-certified providers were set in 2016 and have never been adjusted for inflation.[31] Although we recognize that DC is currently undergoing a behavioral health reimbursement rate study to improve

reimbursement rates and rate-setting methodologies, the results of this study will not be available in time to inform the FY2023 budget.[32] More immediate action is needed in the interim. At minimum, provider reimbursement rates should be adjusted for inflation.[33]

At the current reimbursement rates, behavioral health providers in the public system cannot be adequately paid for their services, often meaning they seek employment with private institutions or outside the District.[34] It is a basic requirement for a functioning public behavioral health system that reimbursement rates be sufficient to make it financially feasible for providers to offer the full range of behavioral health services needed in our community.[35] Behavioral health reimbursement rates should also be on par with reimbursement for physical health conditions – and must be adequate for assessment and diagnosis.[36]

As we explained in our performance oversight testimony in January, DC's behavioral health system for children lacks an adequate supply and range of behavioral health supports.[37] Services are often fragmented and inaccessible due to the scarcity of a particular service or provider, treatment location, inadequate transportation, long wait times, and insufficient care coordination. The current behavioral health workforce is already insufficient to meet the growing needs of District families and their children.[38] At the District's current rates the provider network will continue to shrink, and DC's

behavioral health system will continue to fail to meet the needs of children and their families.[39]

We therefore urge the Council to adjust provider reimbursement rates for inflation by increasing Medicaid billable services through Behavioral Health Rehabilitative Services (BHRS) Local Match (line 6980) by $8.2 million and increasing non-Medicaid billable services through BHRS (line 6970) by $2.1 million, for a total of $10.3 million in additional recurring local dollars.[40] The $8.2 million for Behavioral Health Rehabilitative Services (BHRS) Local Match would be matched with federal dollars 3-to-1, resulting in an additional $24.6 million in spending on behavioral health services in the District.

Conclusion

Thank you for the opportunity to testify today. I welcome any questions the Committee may have.

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[1] Children's Law Center fights so every child in DC can grow up with a loving family, good health and a quality education. Judges, pediatricians, and families turn to us to advocate for children who are abused or neglected, who aren't learning in school, or who have health problems that can't be solved by medicine alone. With more than 100 staff and hundreds of pro bono lawyers, we reach 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year. And, we multiply this impact by advocating for city-wide solutions that benefit all children.

[2] Mayor's Proposed FY 2023 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Behavioral Health [RM0], p. E-34.

[3] Mayor's Proposed FY 2023 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Behavioral Health [RM0], p. E-19 through E-35.

[4] Tami Weerasingha-Cote, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (January 24, 2022), *available at*: https://childrenslawcenter.org/wp-content/uploads/2022/01/TWeerasingha-Cote_Childrens-Law-Center-Testimony-for-Jan.-24-2022-DBH-Oversight-Hearing_FINAL-1.pdf. Tami Weerasingha-Cote, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (January 24, 2022), *available at*:

https://childrenslawcenter.org/wp-content/uploads/2022/01/TWeerasingha-Cote_Childrens-Law-Center-Testimony-for-Jan.-24-2022-DBH-Oversight-Hearing_FINAL-1.pdf. "In October 2021, The American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association – together representing more than 77,000 physicians and more than 200 children's hospitals – declared a national state of emergency in child and adolescent mental health." *AAP, AACAP, CHA declaration of a national emergency in children's mental health. American Academy of Pediatrics,* October 19, 2021, *available at:* https://publications.aap.org/aapnews/news/17718/AAP-AACAP-CHA-declare-national-emergency-in. In December 2021, the U.S. Surgeon General issued an advisory highlighting the urgent need to address the nation's youth mental health crisis. *U.S. Surgeon General Issues Advisory on Youth mental Health Crisis Further Exposed by COVID-19 Pandemic,* HHS.gov, December 7, 2021, *available at:* https://www.hhs.gov/about/news/2021/12/07/us-surgeon-general-issues-advisory-on-youth-mental-health-crisis-further-exposed-by-covid-19-pandemic.html. Representing the unified voices of national experts and thousands of medical practitioners working with children across the country, both of these public statements recognize that the pandemic has accelerated trends in worsening mental health for children and youth, creating a deepening crisis that requires urgent action by policymakers to improve access to and quality of behavioral health care for children and youth. Over the past decade, mental health symptoms – including depressive symptoms and suicidal ideation – have been steadily increasing among youth. U.S. Surgeon General's Advisory, *Protecting Youth Mental Health,* p. 8, 2021, *available at:* https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf. Between 2009 and 2019, the proportion of high school students reporting persistent feelings of sadness or hopelessness increased by 40%; the share seriously considering attempting suicide increased by 36%; and the share creating a suicide plan increased by 46%. *Id.* Between 2007 and 2018, suicide rates for youth aged 10 to 24 years old increased 57% and became the second leading cause of death for youth in this age group. U.S. Surgeon General's Advisory, *Protecting Youth Mental Health,* p. 8, 2021, *available at:* https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf; *AAP, AACAP, CHA declaration of a national emergency in children's mental health. American Academy of Pediatrics,* October 19, 2021, *available at:* https://publications.aap.org/aapnews/news/17718/AAP-AACAP-CHA-declare-national-emergency-in. DC has not been immune to these national trends – in the District's most recent Youth Risk Behavior Survey, approximately a third of DC's high school students (over 10,000 youth) reported depressive symptoms, and 14% of middle school students and 15% of high school students (cumulatively representing over 19,000 children) attempted suicide in the past year. Office of the State Superintendent of Education. "2019 DC High School Sample Statistics," 2019 DC Youth Risk Behavior Survey, p. 3-4, *available at*: https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2019DCBH%20Sample%20Statistics.pdf; "2019 DC Middle School Summary Graphs", 2019 DC Youth Risk Behavior Survey, slide 1, *available at*: https://osse.dc.gov/page/2019-dc-yrbs-data-files. The pandemic has only worsened these disturbing trends. The pandemic has upended social connections in every aspect of children's lives – undermining their sense of safety, security, and belonging. Medical practitioners report "soaring rates of depression, anxiety, trauma, loneliness and suicidality" in children that will have a long-lasting impact on their lives. *AAP, AACAP, CHA declare national emergency in children's mental health. American Academy of Pediatrics,* October 19, 2021, *available at:* https://publications.aap.org/aapnews/news/17718/AAP-AACAP-CHA-declare-national-emergency-in. Since the start of the pandemic, more than 140,000 children have experienced a pandemic-related death of a caregiver, and emergency department visits for children with mental health emergencies have risen sharply. *Id.* In early 2021, emergency department visits for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same time period in early 2019." U.S. Surgeon General's Advisory, *Protecting Youth Mental Health,* p. 9, 2021, *available at:* https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.

[5] Over the past few years, several local organizations, including the Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition, have worked together to develop a plan of action to ensure DC children and families have the behavioral health supports and services they need to thrive. The resulting report, *A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia,* was just released in December 2021 and provides a blueprint for creating a successful public behavioral health system. *A Path Forward* identifies gaps and offers concrete, actionable recommendations in the six domains that the World Health Organization identifies as necessary to a functioning public health system: leadership and governance, financing, workforce, service delivery, information and communications, and technology. These recommendations are informed by best practices around the country, feedback and input from expert stakeholders across the District, and focus groups conducted with District youth and caregivers. *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District,* December 2021, *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf. [hereinafter "*A Path Forward*].

[6] On September 30, 2021, the Office of the Chief Financial Office (OCFO) released the September 2021 Revenue Estimates Letter, which reported that for the May 2021 Revenue Estimate used for the FY2022 Budget was adjusted to $8,580.1 Billion. On February 28, 2022, the OCFO reported the February 2022 revenue estimate for FY2022 was reported as $9,086.7 Billion. Therefore, the revenue used to set the FY2022 budget as compared to the current revenue estimate is a difference of $506.6 Million ($9,086.7-$8,580.1 = $506.6). *See* Government of the District of Columbia, Office of the Chief Financial Officer, *Re: September 2021 Revenue Estimates,* September 30, 2021, *available at*: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/Sept_2021%20Revenue%20Estimate%20Letter.pdf. Government of the District of Columbia, Office of the Chief Financial Officer, *Re: February 2022 Revenue Estimates,* February 28, 2022, *available at*: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/February%202022%20Revised%20Revenue%20Estimates%20for%20FY%202022%20-%202026.pdf.)

[7]Government of the District of Columbia, Office of the Chief Financial Officer, *Re: February 2022 Revenue Estimates,* February 28, 2022, *available at*: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/February%202022%20Revised%20Revenue%20Estimates%20for%20FY%202022%20-%202026.pdf.)

[8] *Id.*)

[9] *Id.*

[10] Mayor Bowser Presents Fair Shot Budget Proposal, Thursday, May 27, 2021, *available at*: https://mayor.dc.gov/release/mayor-bowser-presents-fair-shot-budget-proposal; Report and Recommendations of the Committee of the Whole on the Fiscal Year 2022 Budget and Corresponding Budget Support Act, July 1, 2021, *available at*: https://static1.squarespace.com/static/5bbd09f3d74562c7f0e4bb10/t/60de31f31217463998caf97e/1625174516309/DRAFT+COW+FY2022+Budget+Recommendations.pdf.

[11] Tami Weerasingha-Cote, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (June 4, 2021), *available at*: https://childrenslawcenter.org/resources/budget-testimony-dbh-0/; Children's Law Center, *DC Kids and Families Need Access to Behavioral Health, Strengthening Families Coalition, available at*: https://childrenslawcenter.org/dc-kids-and-families-need-access-behavioral-health/; Strengthening Families Coalition, 2021 Joint Letter: DC Leaders Must Invest Further to Ensure the Long-Term Stability of the School-Based Behavioral Health Program, December 10,

2021, *available at*: https://childrenslawcenter.org/resources/2021-joint-letter-dc-leaders-must-invest-further-to-ensure-the-long-term-stability-of-the-school-based-behavioral-health-program/.

[12] Department of Behavioral Health, UPDATED CBO and DBH Clinicians_MASTERLIST 1.21.2022, *available* at: https://dbh.dc.gov/node/1500291; Cohort 1 School/Provider Status - As of 3.9.2022 ; Cohort 2 School/Provider Status - As of 3.9.2022; Cohort 3 School/Provider Status - As of 3.9.2022; and Cohort 4 School/Provider Status - As of 3.9.2022. All School/Provider Status reports are on file at the Children's Law Center.

[13] Updates provided at Coordinating Council on January 19, 2022 at the monthly Coordinating Council meeting, on file with the Children's Law Center; Updates provided at Coordinating Council on February 23, 2022 at the monthly Coordinating Council meeting, on file with the Children's Law Center.; Department of Behavioral Health, Request for Applications, School-Based Behavioral Health Services Comprehensive Expansion (Cohort 4), January 21, 2022, *available at*: https://dbh.dc.gov/page/request-applications-01.

[14] Department of Behavioral Health, November 2021 Coordinating Council on School Behavioral Health Slides, on file with Children's Law Center.

[15] District of Columbia FY2021 Department of Behavioral Health Budget, RM0, p. E-48; District of Columbia FY2022 Department of Behavioral Health Budget, RM0, p. E-48.

[16] KKF, *Mental Health in the District of Columbia*, December 13, 2021, *available* at: https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/; American Psychological Association, *Demand for mental health treatment continues to increase, says psychologists,* October 19, 2021, *available at*: https://www.apa.org/news/press/releases/2021/10/mental-health-treatment-demand; District of Columbia Department of Health, *COVID-19 Pandemic Health and Healthcare Recovery Report,* May 2021, *available at*: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Pandemic-Recovery-Report_May-2021.pdf. .

[17] Elliot C. Williams, *D.C. extends program to dispatch more 911 mental health calls to social workers,* NPR WAMU 88.5, November 15, 2021, *available at*: https://www.npr.org/local/305/2021/11/15/1055789888/d-c-extends-program-to-dispatch-more-911-mental-health-calls-to-social-workers#:~:text=D.C.%20is%20extending%20a%20pilot%20program%20that%20calls%20on%20the,news%20of%20the%20program's%20extension; Sam P.K. Collins, *D.C. Students Voice Demands for More Mental Health Services,* The Washington Informer, February 2, 2022, *available* at: https://www.washingtoninformer.com/d-c-students-voice-demands-for-more-mental-health-services/. Melissa Millar and Amber Rieke, *Re-Routing Behavioral Health Crisis Calls from Law Enforcement to the Health System,* DC Health Matters Collaborative, May 2021, *available at*: https://www.dchealthmatters.org/content/sites/washingtondc/ReRouting_Crisis_Response_white_paper_May_2021.pdf.

[18] DBH FY2020 Performance Oversight Response, response to Q27, *available at*: https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf.

[19] DBH began to implement the expansion of the school-based mental health expansion program during the 2018-2019 school year. The goal of the program is for all public schools to provide a full array of behavioral health supports at three tiers: (1) Tier 1 encompasses mental health promotion and prevention for all students; (2) Tier 2 includes focused interventions for students at risk of developing a behavioral health problem; and (3) Tier 3 is comprised of intensive support/treatment for individual students who are experiencing a behavioral health problem. *See* Department of Behavioral Health, Guide to Comprehensive Behavioral Health, p. 2-4, available at: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/PRIMARY%20GUIDE_SCHOOL%20BEHAVIORAL%20HEALTH_JUNE%202019.pdf.

[20] Mayor's Proposed FY 2023 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Behavioral Health [RM0], p. E-32; Mayor Bowser Presents Fiscal Year 2023 Budget Proposal, Wednesday March 16, 2022, *available at:* https://mayor.dc.gov/release/mayor-bowser-presents-fiscal-year-2023-budget-proposal.

[21] This number is an estimate based on the cost of prior rate studies the District has commissioned. Ultimately, our request is for adequate funding to conduct a comprehensive and informative cost study of the program.

[22] According to DBH, the FY2022 grant amount per school is $77,515. See DBH, November 2021 Coordinating Council on School Behavioral Health Slides, on file with Children's Law Center. Of the $77,515, only $70,344 is funded with recurring dollars; $7,171 is covered by one-time funding from the Council. Adjusting for inflation (using Congressional Budget Office projected inflation and Consumer Price Index for All Urban Consumers monthly data), to keep funding levels consistent in FY2023, the grant amount per school should be $79,254. We are rounding up to $80,000 per school for ease of reference/calculation: $80,000 - $70,344 = $9,656 x 251 schools = $2,423,656 ($2.4 million) increase in FY2023.

[23] DBH FY2021 Performance Oversight Responses, response to Q45, *available at*: https://dccouncil.us/wp-content/uploads/2022/01/dbh.pdf.

[24] *Id.*

[25] DBH FY2021 Performance Oversight Responses, response to Q45, *available at*: https://dccouncil.us/wp-content/uploads/2022/01/dbh.pdf.

[26] *Id.*

[27] AAP, AACAP, CHA, Declaration and U.S. Surgeon General's Advisory, *supra* note 4; The White House, *FACT SHEET: Improving Access and Care for Youth Mental Health and Substance Use Conditions,* October 19, 2021, *available at*: https://www.whitehouse.gov/briefing-room/statements-releases/2021/10/19/fact-sheet-improving-access-and-care-for-youth-mental-health-and-substance-use-conditions/; *COVID-19 and Children's Behavioral Health in the District: The Pandemic's Impact on Child Behavioral Health Outcomes and the Behavioral Health Care System*, Children's National Hospital, June 2021, *available at:* https://childrensnational.org/-/media/cnhs-site/files/advocacy-and-outreach/child-health-advocacy-institute/covid19-and-childrens-behavioral-health-in-dc.pdf?la=en.

[28] DC Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[29] Ensuring funding of $700,000 can be used to hire three to five new consultants and more supervisors, with additional funds to cover overhead costs associated with additional professionals and implementation of the program. DC Action, *Under 3 DC FY23 Letter to Mayor Bowser*, February 4, 2022, *available at*: https://www.wearedcaction.org/blog/under-3-dc-fy23-letter-mayor-bowser.

[30] In FY21, Healthy Futures expanded to 29 CDCs. In FY22, Healthy Futures is finalizing agreements to expand to an additional 17 centers and is hiring to be staffed up to serve 138 centers by the end of FY22. *See* Department of Behavioral FY20 Health Performance Oversight Responses, response to Q54, attachment 1 of 3,*available at*: https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf; Department of Behavioral Health FY21 Performance Oversight Responses, response to Q45, *available at*: https://dccouncil.us/wp-content/uploads/2022/01/dbh.pdf.

[31] *A Path Forward*, Chapter 4, Section 4.3, p. 56.

[32]*A Path Forward*, Chapter 5, Section 5.2, p. 82.

[33] *See A Path Forward*, Chapter 4, Section 4.4, Recommendation 7, p. 64.

[34] Emily Becker-Haimer, David Mandell, and Rebecca Stewart, *It's time to pay for mental health care in America,* The Hill, October 29, 2021, *available at*: https://thehill.com/opinion/healthcare/578794-its-time-to-pay-for-mental-health-care-in-america; Institute of Medicine (US) Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care; Edmunds M, Frank R, Hogan M, et al., editors. Managing Managed Care: Quality Improvement in Behavioral Health. Washington (DC):

National Academies Press (US); 1997. 3, *Challenges in Delivery of Behavioral Health Care*. *Available at*: https://www.ncbi.nlm.nih.gov/books/NBK233224/.

[35] *See A Path Forward*, Chapter 4, Section 4.3 & 4.4, Gap 6 & Recommendation 7, p. 57, 64.

[36] *See A Path Forward*, Chapter 4, Section 4.4, Recommendation 7, p. 64.

[37] Tami Weerasingha-Cote, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (January 24, 2022), *available at*: https://childrenslawcenter.org/wp-content/uploads/2022/01/TWeerasingha-Cote_Childrens-Law-Center-Testimony-for-Jan.-24-2022-DBH-Oversight-Hearing_FINAL-1.pdf.

[38] Leah Castelaz, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 23, 2022), *available at*: https://childrenslawcenter.org/resources/fy22-oversight-testimony-dc-health/.

[39] Tami Weerasingha-Cote, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (January 24, 2022), *available at*: https://childrenslawcenter.org/wp-content/uploads/2022/01/TWeerasingha-Cote_Childrens-Law-Center-Testimony-for-Jan.-24-2022-DBH-Oversight-Hearing_FINAL-1.pdf.

[40] These are calculated using the Center for Medicare and Medicaid Services Medicare Economic Index change (16.1%) from 2016 Q4 provider costs that are the basis of current rates to Medicare Economic Index forecast 2023 Q1 costs. DHCF uses Medicare Economic Index data for healthcare providers instead of the Bureau of Labor Statistics Consumer Price Index. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

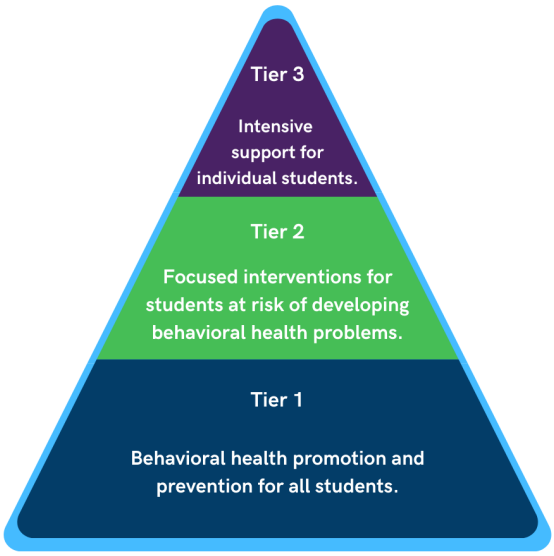
T. Weerasingha-Cote Testimony
Exhibit A

STRENGTHENING FAMILIES THROUGH BEHAVIORAL HEALTH

DC's School-Based Behavioral Health Expansion Program Bridges Gap Between Students and Vital Services

What is the School-Based Behavioral Health Expansion Program?

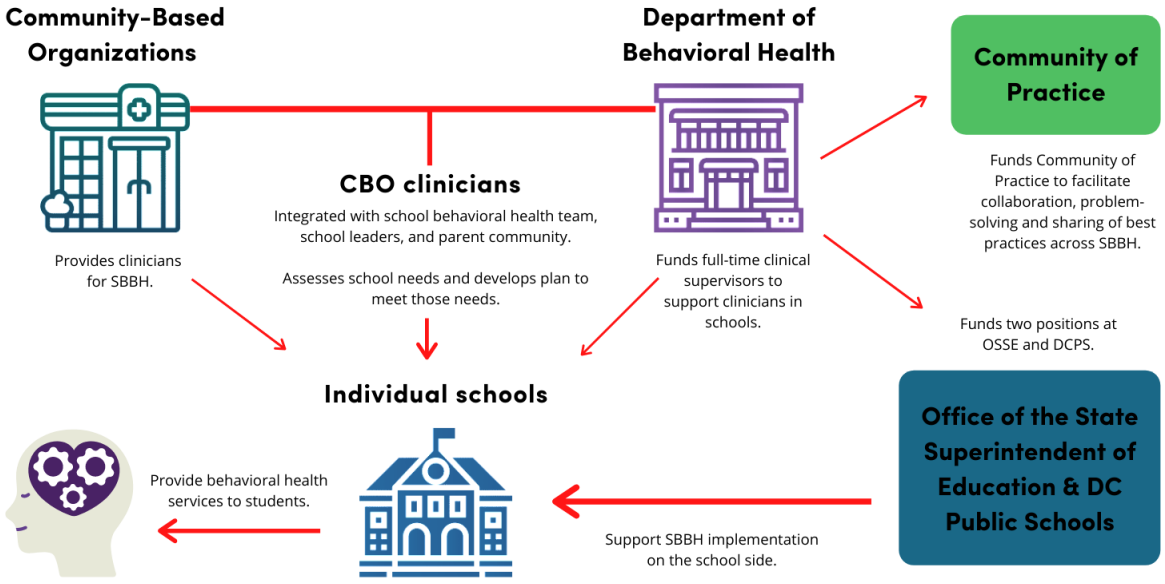
The School-Based Behavioral Health Expansion Program (SBBH) takes a public health approach to addressing children's mental and behavioral health. DC's Department of Behavioral Health (DBH) partners with community-based organizations (CBOs) to place at least one full-time clinician in every DC Public School (DCPS) and public charter school. The goal of SBBH is to provide an array of behavioral health services at three different tiers of support that address school-wide, targeted, and intensive student behavioral health needs.



Thanks to the DC Council's leadership and historic investment in children's behavioral health in the District's Fiscal Year 2022 budget, the SBBH expansion program now includes all 251 DCPS and public charter schools – **and thousands more kids can access the critical services they need.**

How Does SBBH Work?

SBBH relies on collaboration between key DC public health and education agencies, CBOs, and local schools. Through this interconnected system, SBBH clinicians can provide critical behavioral health services to all students in DC public schools – year-round and regardless of whether a student is learning remotely or in-person.



Why Do We Need SBBH?

This fall, thousands of child behavioral health professionals and children's hospitals across the nation declared a national state of emergency in child and adolescent mental health amid skyrocketing rates of negative behavioral health outcomes – such as depression, anxiety, and grief – induced by the physical, mental, social, and emotional toll of the pandemic. Black and brown children and children from low-income families, who already had far worse behavioral health outcomes prior to the pandemic, are especially vulnerable – as are their families and broader communities. Given that students spend most of their time in school, SBBH is one of DC's best tools for improving student access to behavioral health care.

Access to SBBH Has Led to Better Student Outcomes

As SBBH is fully expanded to all DC public schools this fiscal year, we value the positive feedback provided by clinicians so far – as well as their demonstrated impact on the well-being of District children and families:

- **From Victoria Isola, Simon Elementary School (Ward 8)**
  I started working with a student in January 2020. He had a hard time expressing what was bothering him and would shut down and start crying. We have been working on learning emotions, self-regulation, coping skills, using 'I' statements, brainstorming solutions and picking the best solution for conflicts. He has made great improvement in our sessions, in school, and at home. His mom reported that he is able to tell her what is bothering him without shutting down and crying. We had our last session on October 28th, and he expressed that he was excited and proud of himself!
- **From Molly Zinkgraf, Jefferson Middle School Academy (Ward 6)**
  A student was referred to me during the pandemic due to lack of engagement in school, sleeping most of the day, and reports of anger toward family members in response to his father's incarceration. I supported the student in developing coping tools to help with difficult emotions during the pandemic. He was discharged in October due to his progress and meeting his treatment goals. Today, the student is a member of the football team, receives multiple positive referrals from teachers, and is on track for the honor roll. He reports feeling excited about applying to high school and continuing to play football.
- **From Ta-Tanisha Hawkins, Patterson Elementary School (Ward 8)**
  Patterson successfully started off this new in-person learning with a bang. The behavioral health team conducted our first in-parent meeting of the 2021-22 school year. Due to new school safety protocols, we improvised outside and had ten parents and school staff members in attendance. The focus was to engage parents to provide them support in adjusting to this new normal of staying connected with the school and their student's teacher. September was also suicide prevention month, and parents were provided psychoeducation on how to identify signs and symptoms of distress, anxiety, and sadness in their children, as well as how to talk to their kids about managing their strong emotions and how to and who to seek out for help.

We urge the Mayor and the Council to continue providing the essential funding needed to fully realize SBBH's benefits – and to ensure that critical behavioral health services are accessible to thousands of DC children and families now and in the years to come.

For more information, contact Qubilah Huddleston at qhuddleston@dcfpi.org or Tami Weerasingha-Cote at tweerasi@childrenslawcenter.org.

DC FISCAL POLICY INSTITUTE

Independent Research. Poverty Solutions. Better DC Government.

Testimony of Qubilah Huddleston, Education Policy Analyst
at the Fiscal Year 2023 Proposed Budget Hearing on
Department of Behavioral Health
DC Council Committee of Health
March 21, 2022

Chairperson Gray and members of the Committee, thank you for the opportunity to submit testimony. My name is Qubilah Huddleston, and I am a Policy Analyst at the DC Fiscal Policy Institute (DCFPI). DCFPI is a non-profit organization that shapes racially-just tax, budget, and policy decisions by centering Black and brown communities in our research and analysis, community partnerships, and advocacy efforts to advance an antiracist, equitable future.

DCFPI is a Co-Chair of the Strengthening Families Through Behavioral Health Coalition (SFC). The SFC brings together a diverse group of advocates who share a commitment to improving DC's behavioral health care system for children and families. Our coalition's mission is to ensure DC has a fully integrated behavioral health care system in which all DC students, children, youth, and families have timely access to high-quality, consistent, affordable, and culturally responsive care that meets their needs and enables them to thrive.

Today, DCFPI urges the Health Committee to:

- Invest an additional $2.4 million to stabilize community-based organization (CBO) grant funding.
- Provide $300,000 to fund a cost study to determine the actual costs and needs of the District's School-Based Behavioral Health (SBBH) program.
- Adequately fund the Community of Practice.
- Invest in a workforce pipeline of culturally competent clinicians.
- Expand information-sharing and family engagement efforts. And,
- Invest $700,000 to the Healthy Futures program.

DC Must Immediately Stabilize CBO Grant Funding

While most children are no longer learning remotely, the mental, emotional, and physical toll of the pandemic on DC students is more pronounced than ever. Last fall, thousands of child health physicians and hundreds of children's hospitals declared a national state of emergency in child and adolescent mental health.[1] Additionally, new research is emerging that shows how damaging the pandemic has been to student mental health. For example, one new study found that early COVID-19 pandemic school closures were associated with negative student mental health symptoms, such as anxiety and distress, among students ages zero to 19.[2]

The Mayor and DC Council approved an FY 2022 budget with enough funding to both ensure that every DC Public School (DCPS) and public charter school could have at least one full-time clinician

through the SBBH program and that DBH could continue providing a $10,000 grant supplement to partnering behavioral health CBOs that place clinicians in schools. For FY 2023, the Mayor is proposing several new investments in SBBH, including funds for additional clinicians, new DBH staff to support the infrastructure and evaluation of the SBBH program, and boosting DBH's workforce pipeline efforts. While these investments are welcomed, the Mayor's proposal eliminates the $10,000 grant supplement that DBH has provided to CBOs over the last two years. The Health Committee must act so that DC does not lose ground on the progress the District has made to ensure that all students have access to SBBH services.

The pandemic has shifted both student and educator behavioral health needs in profound ways that has required CBOs to expand the breadth and depth of services they provide inside schools. Prior to the pandemic, most CBOs could expect to cover at least 50 percent of their expenses via billing Medicaid for intensive supports, or Tier 3 supports, they provided to individual students. Since the pandemic, however, CBOs have provided less Tier 3 services to students, with Medicaid billing declining by 50 percent during the pandemic, according to DBH.[3] CBOs have been providing more Tier 1 and 2 supports that are less intensive like mindfulness and anti-cyber bullying curricula, benefit the whole school.[4] Unfortunately, these services are not billable to Medicaid. If not for the $80,000 grant, many existing CBOs would find their partnership with DBH financially infeasible. Furthermore, a higher grant amount is better suited to attract new CBOs the District needs to reach its goal of at least one full-time clinician per school. Policymakers should pass a budget that permanently provides this amount to CBOs and provides annual inflation adjustments moving forward.

DC Needs to Determine What It Truly Costs to Implement the SBBH Program, Now and in the Future

DCFPI urges the Health Committee to provide $300,000 so that DBH can determine how the needs of individual schools, providers, and communities drive program costs and build a more financially sustainable model for the future.

Since 2016, DBH has provided CBOs a grant amount based on estimates and data the department gathered at that time. Without actual expenditure data and other statistics, it is a wonder how DBH is accurately calculating the cost of the program or determining the grant amounts that CBOs need to sustainably deliver vital behavioral health services to students. As previously mentioned, CBO clinicians provide a wide range of services, yet they are only able to be reimbursed by Medicaid for intensive services provided to individual students. At a time when clinicians are providing so much more to schools, such as school-wide suicide prevention curriculum or small-group sessions that target the needs of students at risk of developing more significant behavioral health challenges, policymakers must both ensure that DBH's budget meets the behavioral health demands of students today and that DBH can adequately fund CBO grants.

The DC Council Must Support Effective Implementation of the SBBH Program

DCFPI thanks the Mayor and DC Council for taking action to ensure that every DCPS and public charter school have at least one full-time clinician through the SBBH program. However, DCFPI and our allies know that one clinician per school is the floor, not the ceiling. Many more schools will likely need additional CBO clinicians to meet the full needs of their students. In addition, there are several other components of the SBBH program that the Mayor and DC Council should invest in to ensure that SBBH is implemented well.

Adequately Fund the Community of Practice

The Community of Practice (CoP) is a collaborative learning environment that brings providers, school staff, and school leaders together to share SBBH best practices, and provides technical assistance to all participating schools. The CoP has expanded the type and quantity of technical assistance and training to its members throughout the pandemic. However, given how the pandemic has changed CoP members' training and support needs and the fact that the CoP is now responsible for providing support to all 251 schools in the District, the CoP needs additional resources to build more capacity.

Invest in a Culturally Competent Clinician Workforce Pipeline

The pandemic has made an already limited school-based behavioral health workforce pool even smaller. Policymakers and DBH need to make a concerted effort to strengthen the pipeline of behavioral health providers in the District. More importantly, the city needs to make efforts to recruit clinicians that can relate to their students and be competently responsive to their students' cultural needs.

Workforce development strategies that policymakers should consider investing in include:

- Relationship building with area colleges and universities with social work and psychology graduate programs.
- Exam and certification prep programs, especially for Black and brown behavioral health professionals.
- "Grow your own" initiatives starting in local high schools to ensure a steadier pipeline of culturally competent school-based clinicians.

Expand Information-Sharing and Family Engagement Efforts

Not all students and families in DC are aware that behavioral health services are available at their school, even though many parents would first turn to a school-based behavioral health professional if their children had behavioral health needs.[5] Families are essential partners in making SBBH a success. Policymakers must address the current gaps in information-sharing and help DBH and

CBOs better mitigate the barriers that families are facing to ensure that ongoing investments in SBBH services truly reach the student and families who need them most. For example, DBH, the Office of the State Superintendent of Education, DCPS, and public charter schools should work together to list regularly updated contact information of behavioral health and wellness staff and behavioral health service offerings on school profiles and websites, My School DC, and the DC School Report Card.

Fund Healthy Futures

Healthy Futures is an evidence-based, early childhood mental health consultation program run out of DBH that promotes positive social and emotional development in young children. DCFPI asks the Committee to increase funding for the Healthy Futures program by at least $700,000 to enable DBH to make much needed updates to the program's infrastructure, hire personnel, and increase capacity to expand to 35 from 25 additional child care developmental facilities.

Consultants with the Healthy Futures program are doing an excellent job of making mental health services available to families trying to navigate their way through our shifting pandemic. This support has been invaluable to teachers, parents, and young children in these extraordinarily difficult and stressful times. The return to classrooms has been stressful for children and their parents in what feels like a never-ending pandemic. They need more mental and behavioral health supports now than ever to adjust to our ever-shifting new normal. Healthy Futures is the best-positioned program to respond to this impending stressor in many families' lives and should be expanded to meet this need.

Thank you for the opportunity to testify, and I am happy to answer any questions.

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[1] American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association, "Declaration of a National Emergency in Child and Adolescent Mental Health," October 19, 2021.
[2] Russell Viner, Simon Russel, and Rosella Saulle, "School Closures During Social Lockdown and Mental Health, Health Behaviors, and Well-being Among Children and Adolescents During the First COVID-19 Wave: A Systemic Review," JAMA Pediatrics, January 18, 2022.
[3] Department of Behavioral Health, "Question 24, FY 21 Pre-Hearing Performance Oversight Questions," DC Council, Committee on Health.
[4] Department of Behavioral Health, "Question 22, FY 21 Pre-Hearing Performance Oversight Questions," DC Council, Committee on Health.
[5] Parents Amplifying Voices in Education, "Back to School Survey Fall 2021," PAVE.

PARENTS AMPLIFYING VOICES in EDUCATION

Department of Behavioral Health
Budget Oversight Hearing
Committee on Health
Monday, March 21, 2022

To: DC Council Committee on Health, Committee on Health Chairman Vince Gray, Committee on Health Members, and Committee on Health Staff
From: Kerry Savage, Director of Policy at PAVE (Parents Amplifying Voices in Education)
Date: March 21, 2022

Good afternoon Chairman Gray, members of the Committee on Health, and Committee staff. My name is Kerry Savage, and I am the Director of Policy at PAVE. PAVE is also a member of the Strengthening Families Through Behavioral Health Coalition - a coalition committed to ensuring that DC children, youth, and families have access to a fully integrated behavioral health care system that meets the needs of the whole child.

PAVE parent leaders have been steadfastly advocating for school-based mental health since 2018. They have been tirelessly advocating for **their collective vision: an education system that prioritizes student mental health and wellness where all students and their families have readily accessible, high-quality school-based mental health services, supports, and education and is responsive to student needs.**

During this hearing, you'll hear from many PAVE parents - some who have been left in the dark on how to access mental health services and support for their children and some who have watched their child thrive at schools with the support of their CBO clinician. I urge you to listen to these stories today and take action to ensure this vital program is adequately and sustainably funded to support our students.

First, we want to thank the DC Council for providing enough funding in the Fiscal Year 2022 budget to provide at least one mental health clinician or professional in every DCPS and public charter school and finding the funds to provide CBO clinicians with stabilized grants for their work in schools this year.

We also want to thank the Mayor's initial investment of $3.8 million in this current budget. Larger investments are crucial to continue the school-based mental health expansion program and to further spur DC's innovation around mental health for our students. The Mayor's investments include:

- **Funding additional clinicians** - which we welcome, but we must provide additional support and stabilized grants to our existing clinicians to ensure they can do their important work with our students.
- **Additional positions at DBH to support program infrastructure, data oversight, and program evaluation** - Parents, providers, and community members have advocated for data oversight and continuous program evaluation to ensure this model can meet the needs of our students. While we are excited about these positions to support oversight and evaluation, parents, students, and providers must be meaningfully included in these conversations.
- **Wraparound services to support 6-7 schools** - wraparound services are the backbone of a healthy school community, but we must ensure we are funding the professionals who are implementing these crucial services.
- **Strengthening the SBBH program workforce pipeline** - While we welcome the investment into the workforce pipeline, we cannot attract the talent our students need without adequate and stabilized grants to our CBO mental health clinicians and professionals.

We need to ensure our investments at a system level directly impact and improve on our students' and families' experiences with school-based mental health at the school-level and the Mayor's current investments miss the mark on what parents, providers, and community members have all collectively asked for. Currently, many schools have vacancies for a mental health clinician or professional and some schools have yet to even be matched with a community-based organization.

Still, we've learned that when this model is funded *well* and *implemented well*, it WORKS. However, the Mayor's current investments do not address many of our schools' and CBO's challenges and needs to implement this program WELL.

And that's what I have come to share today: how we can advance the school-based mental health program investments to ensure this program WORKS for every DC kid. In partnership with the Strengthening Schools through Behavioral Health Coalition, PAVE parents have identified the following three steps to support the mental wellness of all of our children.

1. **Right-size the grant amounts for our CBO clinicians with an investment of $2.4 million.**
    a. Thank you for advocating and leading the charge to increase grant sizes for CBO clinicians to $78,000 in FY22's budget; however, in the Mayor's current budget, CBOs are experiencing cuts.
    b. In the Mayor's current budget, our CBO clinicians are receiving grants from the 2016 estimate, which does not account for inflation nor does it account for our students' outsized need and increased costs of care for mental health services

the pandemic has caused. That's why we are asking to increase grant sizes to at least $80,000, for a total of $2.4 million. Let's keep the providers we have whole by stabilizing their funding so we do not ask them to do more with less.

2. **Provide at least $300,000 to fund a cost study to determine the correct cost of the school-based mental health program now and in the future to best support the crucial work of our clinicians.**
    a. This includes determining how the needs of individual schools, providers, and communities impact program costs.
    b. This is the epitome of a "work smarter not harder" strategy. It is well worth this investment so we can make targeted, high-impact, and long term investments and plans.
3. **Create a strong accountability system**
    a. The Deputy Mayor of Education (DME) and the Department of Behavioral Health (DBH) should develop clear, publicly transparent, and strong accountability systems for any agency/organization providing mental health supports in schools in partnership with families and youth.
    b. This accountability system should be fostered and supported by the DC Council and the Committee on Health to ensure the DME and DBH do not continue to work in silos and in separate rooms from school leaders, parents, and students.

Our communities are in crisis. Experts have declared a national state of emergency in child and adolescent mental health, and parents/caregivers, educators, and mental health professionals alike are overwhelmed and on the verge of burnout. While there have been strong steps taken to improve access to mental health supports at school in DC, far too many families are not aware or able to receive the support that they need.

There has never been a more important time to have a laser focus on supporting students' mental health. These supports are foundational to their learning, to reaching their potential, and to achieving their dreams. It is essential to promote public safety, and to give young people the tools to cope and heal from the myriad of challenges and trauma they face.

This work is only possible with leaders on the Council and in DBH who also believe in the power and promise of community voice. Thank you so much for the opportunity to testify today, I hope that we can count on your leadership.

In service,

Kerry Savage
Director of Policy
PAVE (Parents Amplifying Voices in Education)

Committee on Health's Budget Oversight Hearing: Department of Behavioral Health

Joshua Hodge
Policy and Communications Manager
Education Reform Now DC

March 21, 2022

Hello, and good morning Chairperson Gray and the Committee on Health. My name is Joshua Hodge. I am the Policy and Communications Manager at Education Reform Now DC (ERN DC), a Ward 6 resident, and a member of the Strengthening Families Coalition. ERN DC is a non-profit organization that fights for a just and equitable public education system for all students in the District of Columbia. I am pleased to provide testimony at the Department of Behavioral Health's budget oversight hearing. We are asking for the Committee on Health and the D.C. Council to increase community based organization clinicians grants to $80,000 and to fund a cost study of the school-based behavioral health (SBBH) program so that D.C. can finally right-size the cost of the program.

First, we are very grateful for the Mayor's continued investment in the SBBH program. The Mayor proposed $3.8 million to support the SBBH program. The $3.8 million includes: $1.76 million to fund additional clinicians; $908,000 to fund 8 FTEs at DBH to support program infrastructure, data oversight, and program evaluation; $829,000 to fund high fidelity wraparound services to support 6-7 schools; and $281,000 to strengthen the SBBH program workforce pipeline. These are crucial investments, and if withheld many students would not have the support they need.

We are asking for the D.C. Committee on Health and DC Council to raise CBO clinician grant amounts from the Mayor's proposed $70,000 to $80,000 so that CBOs are able to provide needed services in schools. Without additional funding to permanently stabilize CBO grants, it will be difficult to retain the clinician workforce we have and fill additional open positions. The District should maintain grant levels from the current fiscal year for the next three years and include increases to cover the cost of inflation. The difference in funding from the Mayor's proposed investment in the program and what is needed is $2.4 million. The D.C. Committee on Health and D.C. Council should also fund a cost study, which is estimated to be $300,000 so that D.C. can finally right-size the cost of the SBBH program.

Behavioral health services have always been crucial for a student's success in school, but these needs have been exacerbated by the pandemic. These needs will continue to persist as we are not headed towards a post-pandemic world, but instead, we are in a new covid era of life that directly affects schools and students well-being. Since the start of the pandemic, emergency department visits for children with mental health emergencies have risen sharply. Tens of thousands of children have experienced a pandemic-related death of a primary caregiver across the world, country, and right here in D.C. In October of 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a national state of emergency in child and adolescent mental health.[1]

As we know, the pandemic has not impacted communities the same, with more Black, Brown, and low-income households being affected more severely by the effects of Covid-19, ways include; financial losses, housing instabilities, long-term health repercussions, physical sickness, loss of family members, and decreased overall mental health. Increased access to behavioral health services is proven to be transformative for students and their families and can boost the long-term overall health and productivity of communities as evidenced by school outcomes, overall health and well-being, and reduced crime rates. Behavioral health is foundational to the District's long-term recovery from the impacts of the pandemic. Currently, only about 80% of public schools here in D.C. have a mental health services provider on-site and this needs to change to 100%, as all students have the right to, and need access to a mental health provider. [1]

In closing, District leaders have an opportunity to deepen investments and focus on students to continue to address some of the most severe issues facing our youth. Presenting the chance to create a behavioral healthcare system that is more just and equitable for DC children, students, and families. Thank you for allowing me to testify today.

[1]American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association

Declaration of a National Emergency in Child and Adolescent Mental Health, October 19, 2021, available at:

https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/

Testimony Submitted to the Committee on Health

By D.C. Long-Term Care Ombudsman For the District of Columbia

Budget Oversight Hearing for the

D.C. Department of Behavioral Health

March 21, 2022

Greetings Chairman Gray and Members of the Committee on Health. I am Mark Miller, D.C. Long-Term Care Ombudsman with Legal Counsel for the Elderly (LCE). Thank you for the opportunity to provide this testimony on behalf of the 9,000 District residents receiving long-term care services and supports (LTCSS) in nursing homes, assisted living residences, community residence facilities, and in their homes through the District's Elderly and Persons with Physical Disabilities (EPD) Medicaid Waiver Program.

The Office of DC Long-Term Care Ombudsman advocates for the rights of some of the District's most vulnerable citizens through its federal and local mandates, including accountability as one of the D.C. Department of Aging and Community Living's Senior Service Network providers. Our mission is to promote and help ensure the highest quality of life and quality of care for these individuals.

This past year, our office handled over 270 complaints, resolving 76% of those issues to the satisfaction of the care recipients or complainants. This resolution rate is above the national average. Issues involved quality of life, quality of care and residents' rights.

I am providing testimony today on the Department of Behavioral Health's (DBH) budget. DBH monitors and licenses about 90 community residence facilities (CRFs) for adults with primary diagnoses of mental illness and is responsible for ensuring the provision of mental health support for these residents through contracts with Core Services Agencies (CSAs) and Assertive Treatment (ACT) Teams.

My testimony today will focus on four areas that require DBH to have sufficient funds to fulfill their mission on behalf of residents living in CRFs.

- Ensuring sufficient DBH staff to monitor CRFs
- Ensuring sufficient transitional housing opportunities
- Ensuring adequate training for CRF staff
- Reducing inappropriate discharges

Ensure Sufficient Staff for Oversight of Community Residence Facilities

We support a budget that allows DBH to adequately oversee these homes, ensure compliance with regulations that protect residents, and that quickly and effectively identify and address problems impacting residents' quality of care and their rights. Responding quickly to situations is important to protecting residents' rights and addressing sub-standard care and mental health issues. If this requires additional staff, we recommend a budget that includes funds to accomplish this essential monitoring and oversight.

Ensure Transitional Housing and Services to Assist with Helping Residents Live Independently

CRFs were originally conceived as temporary housing and support for residents to transition to independent housing. Therefore, discharge planning for residents should be

ongoing, assisting residents who can, to transition to more independent living. This means that the resident, their community support worker and/or ACT Team, and the provider must all work together starting at the day of admission.

Transition to a more independent setting requires an adequate supply of transitional residential beds. These "transitional beds" are often a necessary step for residents who are seeking and working toward a more independent life in the community. We applaud and support the City's proposed budget which provides an increase for the number of housing vouchers that will be made available to help these residents make the move to greater independence.

In addition, our Office recommends funding for a study of the effectiveness of transitioning residents to less restrictive placements. This study could identify the number of residents who have successfully moved to more independent settings, as well as identifying any additional supports which are needed to maintain and increase these moves, which are the primary goal of the CRFs.

Ensure Adequate Mental Health Training for CRF Staff

For staff in all of the various types of CRFs, we urge that the budget include sufficient funds for needed training. Providers and their front-line staff must have access to on-going mental health training. Training is not only necessary to ensure that staff can effectively intervene and de-escalate a situation in the CRF, but also provide day-to-day services for residents with a wide range of mental health diagnoses.

Reducing Inappropriate Discharges

While we support efforts to transition CRF residents to the least restrictive setting, our Office continues to advocate against provider-initiated discharges which are unsafe

and do comply with DC law. Per recent testimony, our office has been working with DBH to revise a model discharge plan which would ensure that all parties including providers, and ACT teams provide consistent and appropriate support to the resident throughout this discharge process. Our Office can inform the Council today that DBH is close to finalizing this Plan and we look forward to working with them to implement it on behalf of all CRF residents.

My Office meets with DBH staff on a regular basis to discuss issues of concern and to collaboratively work to ensure CRF residents receive the services they need and are entitled to under the law.

Thank you for the opportunity to testify. I am happy to answer any questions the Committee may have.

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Testimony before the
Council of the District of Columbia
Committee on Health
FY23 Budget Oversight Hearing
for the
Department of Behavioral Health

* * *

Presented by

Justin Palmer, MPA

Vice President, Public Policy & External Affairs

March 21, 2022

Greetings Chairman Gray and members of the Committee on Health, my name is Justin Palmer, and I am the Vice President for Public Policy & External Affairs at the District of Columbia Hospital Association (DCHA). I appreciate the opportunity to present testimony at the Department of Behavioral Health's FY23 Budget Oversight Hearing. DCHA is the unifying voice of the District's hospitals and represents the interests of our members who provide care to residents from all eight wards, our neighbors in Maryland & Virginia, and patients from around the world.

Ensuring the District is meeting the behavioral health needs of its residents is essential to ensuring that individuals are able to thrive in our city. The pandemic has highlighted the importance of continued investment in behavioral health services. This includes ensuring providers are properly and

sustainably compensated for their services and building/maintaining the necessary capacity of outpatient services to prevent patients from going into crisis and to support them in a timely manner should they need stabilization. The District's hospitals provide vital stabilization services to those that need them, but it is in the patient's best interest to receive the needed supports in their community.

The Mayor is making significant investments in the Department to improve the resources available to residents of the District of Columbia. The continued investment in the school-based resources and wrap-around services is essential to improving the supports for students as well their successes in and out of the classroom.

We are in support of the continued investment in the sobering and stabilization center. As I have testified before, this

resource will keep individuals in the right level of care to support them without unneeded trips to the hospital.

The budget books indicate a reduction in local funds for mobile crisis services for children and youth as well as stabilization beds. It is critical that any reduction in local funds to mobile crisis or crisis stabilization beds is met with investment from other funding sources. Our pediatric providers have seen an immense increase in pediatric hospitalizations over the last two years and we must ensure that services are available when they are needed. We have seen increased boarding in the emergency departments because pediatric behavioral health beds are not available due to the increased demand.

In this same vein, the District and the Department must continue to expand the capacity and availability of CPEP

resources. Thanks to the Department's reopening of additional beds last year, we have seen a decreased number of diversions from CPEP. This investment was an important start but investing in additional locations and beds will be critical as we increase capacity for stabilization outside the hospitals.

We also support the one-time operational and capital investments at Saint Elizabeths Hospital. The District's public psychiatric hospital plays an essential role in the behavioral health system within the District, and we need to ensure investments are being made to safeguard the hospital's ability to continue to meet the needs of its patients. This includes its ability to care and treat our forensically involved patients as well as those in need of civil commitment.

Thank you for allowing me to testify today, and I am happy to answer any questions you may have.

TESTIMONY FOR BUDGET HEARING REGARDING THE PROPOSED FISCAL YEAR 2023 BUDGET FOR THE DEPARTMENT OF BEHAVIORAL HEALTH (DBH)
COMMITTEE ON HEALTH

Jaclyn Verner, Staff Attorney

April 1, 2022

Disability Rights DC at University Legal Services ("DRDC") appreciates the opportunity to submit written testimony regarding the Department of Behavioral Health's proposed budget for FY23. DRDC is the designated protection and advocacy program for people with disabilities in the District of Columbia. Pursuant to our federal mandate, DRDC advocates for hundreds of DC residents with mental illness each year. I would also like to thank the DC Bar Foundation for supporting DRDC's efforts to address housing barriers experienced by District residents living with mental illness.

My testimony is focused on 1) DBH's continued failure to allocate adequate housing resources for individuals who are housing unstable or experiencing homelessness and living with serious and persistent mental illness, 2) DBH's failure to hold its certified providers accountable, and 3) the continued gap in Medicaid services for individuals living with traumatic brain injury.

First, DBH is continuing to fail in allocating adequate housing resources for individuals who are housing unstable or experiencing homelessness and living with serious and persistent mental illness. We have testified about this before, and it continues to present a significant challenge for our clients. Mayor Bowser has again made a historic investment in housing in the District by investing $31 million in Homeward DC, $41 million for project-sponsored vouchers

for deeply affordable housing, and $500,000 toward the Housing Production Trust Fund (HPTF).[1] We are thankful for this and encouraged by it. However, we continue to have concerns that a significant portion of this money will not go to housing those with the greatest need, particularly those individuals living with serious mental illness and other disabilities who rely on Supplemental Security Income (SSI) to meet their basic needs. As we have testified before, we know from our clients' experiences that many DBH consumers and other people with disabilities are not eligible for the Coordinated Assessment and Housing Placement (CAHP) system, because many of these individuals need housing, but do not necessarily meet the narrow criteria of being chronically homeless. Also, those individuals who do meet these criteria often have difficulty connecting to and remaining in the CAHP system. We continuously see our clients' community support workers and Assertive Community Treatment (ACT) caseworkers be unfamiliar with local housing resources and fail to understand their obligations to connect their behavioral health consumers with housing resources under DC regulations and DBH policy.[2] It is well understood that in order for anyone to be able to focus on their mental wellbeing, they must first be safely housed. We continue to urge DBH to hold its providers accountable in doing this. We also continue to urge DBH to expand its housing continuum for its consumers, rather than

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[1] Mayor Bowser Presents Fair Shot Budget Proposal, https://mayor.dc.gov/release/mayor-bowser-presents-fiscal-year-2023-budget-proposal, (March 16, 2022).

[2] D.C. Mun. Reg. tit. 22-A §2201.1 requires Core Service Agencies to "assess consumers for supported housing needs as part of the treatment plan process." D.C. Mun. Reg. tit. 22-A §2201.3 further requires that when a consumer is assessed as needing housing, "the mental health provider shall assist the consumer in applying for any… housing assistance program for which the consumer is eligible, including but not limited to the District of Columbia Housing Authority (DCHA) Housing Choice Voucher Program and other supported housing services provided by or through the Department." DBH Policy 511.1 §5c mandates that all certified providers "shall…provide and/or arrange all housing supports needed to assist the consumer in obtaining housing." DBH Policy 511.1 §8a(6) further requires certified providers to "make a concerted effort to assist the consumers in identifying other housing options not provided by [DBH] when none are readily available through [DBH]."

[2] DBH Policy 511.1 §5c requires all certified providers to "designate a Housing Liaison for the CSA to serve as the central point of contact with the [DBH] Housing Division and as coordinator of CSA housing resources, requests and compliance."

narrowing it, as it did for example, but ending its contract with Supported Independent Living (SIL) programs last year.

Second, and related to above, we would be remiss if we did not share with you our dismay at the poor quality of services in the District's behavioral health arena at present. Our office receives a stream of phone calls from behavioral health consumers who complain that their Core Service Agencies (CSAs) provide few to no community supports. Every week we see evidence of lost housing applications, case workers who simply disappear and do not alert their clients, medication that is not renewed, under-performing ACT teams that insist that clients go into the office, a failure to coordinate with other agencies, and a neglect of medical needs. It is our view that DBH has an obligation to set and enforce values and practices to ensure that the agencies actually provide the services for which they contract. Yet, we find that our complaints, grievances, and concerns to DBH are only given lip service. We suggest that DBH invest in its Accountability Division. These types of investments would include commitments to regularly monitor and to train providers on implementing behavioral health services and supports with fidelity to ensure that the budget is well spent and building an infrastructure to enforce its contracts with providers to ensure that District residents with behavioral health needs are not neglected.

Finally, DRDC would again like to bring to your attention the District's continued lack of targeted services for individuals living with traumatic brain injury (TBI). In addition to representing individuals with severe and persistent mental illness, DRDC also represents a number of individuals with TBI each year. What continues to remain clear is that there is a gap in community-based services for individuals living with TBI.

As we have testified before, currently, TBI is still not a Medicaid-billable diagnosis in DC. Thus, CSAs cannot bill for services provided to consumers who have a primary diagnosis of

TBI. Because CSAs cannot bill for this diagnosis, they ultimately have not invested resources into training staff to assess for, treat, and accommodate TBI. TBI is prevalent among District residents experiencing homelessness, with a 2010 survey of 199 DC residents experiencing homelessness showing that nearly two-thirds had a TBI.[3] Thus, this gap in community-based services is another way in which the District is failing to adequately address the needs of residents experiencing homelessness through community-based supports.

We were encouraged last year to see that the FY22 proposed budget included $698,000 to allow some outpatient providers to offer enhanced services for brain injuries, as well as for autism spectrum disorders. We do not see a cut to this funding in the proposed DHCF budget for FY23. We appreciate this investment and want to be sure that DBH-certified provider organizations are also able to offer these enhanced services. We urge DBH and DHCF to work together to include evaluation of any changes needed for DBH-certified provider organizations to offer these enhanced services.

Thank you for the opportunity to submit testimony on these important issues.

For further information:

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[3] *Findings from the District of Columbia Traumatic Brain Injury Needs and Resources Assessment of Homeless Adult Individuals, Homeless Shelter Providers, TBI Survivors and Family Focus Group, TBI Service Agency/Organizations*, DC Department of Health, revised August 2010, http://www.nchv.org/images/uploads/DC_TBI_Report.pdf.

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Testimony of Tammy Seltzer, Director Jail and Prison Advocacy Project
Disability Rights DC at University Legal Services
Before the Council of the District of Columbia
Committee on Health
DBH Budget Hearing
March 21, 2022

Good morning, Chairman Gray and members of the committee. I am Tammy Seltzer, Director of the Jail and Prison Advocacy Project (JPAP), Disability Rights DC (DRDC), at University Legal Services, the federally mandated Protection and Advocacy agency for people with disabilities in the District of Columbia. JPAP supports the recommendations and testimony of the District Task Force on Jails and Justice (submitted by the Council for Court Excellence) but emphasizes these increased resources must come with increased accountability and transparency.

As formerly incarcerated individual and DRDC client Donald Hines will testify, significant, targeted community investments are essential to breaking the District's trauma-to-prison pipeline. We must both support people already in the system AND prevent individuals from ever entering the system. Most necessary community investments are the responsibility of DC agencies <u>other</u> than the Department of Corrections (DOC). Although DOC runs the jail, DOC is not responsible for the egregious overrepresentation of Black individuals, people diagnosed with psychiatric and intellectual disabilities, and those who struggle with substance use disorders. Nor is DOC responsible for how many of our city's residents are caught in the criminal legal

system's web due to significant trauma that is usually unaddressed at any point in their lives.

Every city agency should have measurable goals and specific funding to decrease the likelihood of someone becoming involved in the criminal legal system. DBH plays a particularly important role in prevention and early intervention.

We must start before children are born, such as investing in pregnant residents diagnosed with mental illness and/or substance use disorders (SUDs) and supporting families where caregivers have a mental illness and/or SUD, two of the 10 Adverse Childhood Experiences (ACEs) that increase the risk of violent behavior and incarceration.[1] The New York DOC is using TAMAR, the trauma program DBH has wisely contracted to use on the DC Jail's Mental Health Step Down Unit and the Acute Mental Health Unit. In a video about the program, *Healing From Inside Out,* one individual likens trauma to plumbing, observing that "pressure breaks pipes."[2] Unaddressed trauma, which affects close to 90% of all people incarcerated and 100% of all incarcerated people with psychiatric disabilities, breaks people. There is a direct link between childhood abuse and neglect and involvement in the criminal legal system.[3] We can, with the right investments, break the cycle and build resilience.

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[1] See, e.g., Moore and Tatman, *Adverse Childhood Experiences and Offender Risk to Re-offend in the United States: A Quantitative Examination*, international Journal of Criminal Justice Sciences (2016), https://www.sascv.org/ijcjs/pdfs/moore&tatmanijcjs2016vol11issu2.pdf.

[2] See https://www.youtube.com/watch?v=uAdcYBUc4qY

[3] National Institute of Justice, "Pathways Between Child Maltreatment and Adult Criminal Involvement," October 11, 2017, nij.ojp.gov: https://nij.ojp.gov/topics/articles/pathways-between-child-maltreatment-and-adult-criminal-involvement.

How do we know if we are making the right investments? DBH must track and share outcomes so we can see which interventions and providers are effective and which are not, which can be improved and which should be scrapped. Service quality varies widely, from excellent to negligent. DC's most vulnerable residents should not depend on the lottery to determine which kind of services they will receive.

Thank you for your time.

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Statement of Donald Hines
before the Committee on Health
of the Council of the District of Columbia

Budget Hearing for the
Department of Behavioral Health

March 21, 2022

Introduction

Good morning, Chairman Gray and members of the committee. My name is Donald Hines. I am a returning citizen and client of Disability Rights DC at University Legal Services (DRDC) and a resident of Ward 5. I thank Mayor Bowser for the money she added to the Department of Behavioral Health's (DBH's) proposed FY23 budget. While I am thankful for the increased funding, the needs of the District's community are many, and this does not yet come close to meeting them. I am here today to emphasize the importance of investing early in our community's youth and the massive impact that DBH's programs can have on minimizing and preventing trauma, incarceration, and other negative life experiences.

I was first incarcerated when I was 11 years old. Since then, I've spent much of my life in and out of prison and was just released 10 months ago. I want to tell you about my childhood and the circumstances that led me down this path. I grew up in a low-income household. My dad was an alcoholic and frequently beat my mom. As the oldest of three children, I beared the brunt of my family situation. I

felt unsafe in my own home. Even though I liked school and received good grades, I soon lost interest in my education and dropped out.

At this time, my 15-year-old cousin was living with us and introduced me to alcohol, marijuana, and heroin. I soon found myself heavily consuming these substances. This lifestyle eventually landed me in prison and began a cycle of incarceration. When reflecting on this period of my life, I believe that if I had more community support and resources to navigate my family situation, I would have found myself taking a much different life path. A path that would not have placed me behind bars for years of my life.

I experienced several Adverse Childhood Experiences (ACEs). I lived with a parent who abused substances. I also experienced, firsthand, violence against my mother. I believe my dad also experienced similar ACEs when growing up. This upbringing caused him to develop mental health issues and exhibit abusive behavior in *my* childhood household. He didn't have the resources or programs necessary to prevent his own trauma from affecting his behavior around his own children. The generations of trauma that have perpetuated in my family, along with other individuals in similar situations, needs to be stopped. DBH can implement programs that can shatter this cycle. If these services had been provided during my own formative years, I strongly believe that I would not have dropped out of school, heavily consumed drugs and other substances, or spent much of my life in

prison. I don’t want to see other young children and adults go through these same experiences.

Thank you for your time today. I welcome any questions you may have.

2021-2022

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Council for Court Excellence
Improving Justice for the Community

Statement of the Council for Court Excellence
Before the Committee on Health
Council of the District of Columbia

FY 23 Budget Hearing for the
Department of Behavioral Health

March 21, 2022

Good morning, Chairman Gray and members of the Committee on Health, thank you for the opportunity to testify today. My name is Jennifer Ubiera and I am a Senior Policy Counsel at Council for Court Excellence. CCE is a 40-year-old nonpartisan, nonprofit organization with the mission to enhance justice in the District of Columbia. Please note that per our policy, no judicial member of CCE participated in the formulation or approval of this testimony. I am also a member of the Strengthening Families Through Behavioral Health Coalition (SFC) and CCE facilitated the District Task Force on Jails & Justice (Task Force). I am here today to discuss several budget investments that will serve D.C.'s most vulnerable residents, and help ensure that people with behavioral health needs have access to the services necessary to thrive.

School Based Mental Health

I would like to affirm earlier requests to the Council to invest $2.4 million in additional recurring local funds for the School Based Behavioral Health Expansion program to stabilize Community-Based Organization (CBO) grant funding and $300,000 to fund a cost study that will determine appropriate

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grant amounts to sustain the longevity of the SBMH program. The Mayor's current budget proposal suggests lowering current grant amounts from $80,000 to about $70,000 which is unsustainable for current CBOs to perform this critical work in our schools. DC has provided one-time supplements to address the financial strain of the pandemic on providers. These supplements should be made permanent, and the CBO grant amount should cover inflationary cost increases over the next three years while a cost study is conducted. To fund this cost study, we urge the committee to invest $300,000 in one-time local funds. The cost study will determine the appropriate grant amounts for participating CBOs. As stated earlier, the current grant amount for participating CBOs is set at $80,000 and the Mayor's budget proposal recommends decreasing this amount to $70,000. This amount undermines the longevity and any potential success of the program because $70,000 is not financially sufficient. Further, the current grants were formulated in 2016[1] before the pandemic and all of the additional mental health service needs it created for youth. Grant amounts must remain at $80,000 and maintained for the next three years, including the costs of inflation, to fully realize the benefits of this program and sustain its success.

Ensuring behavioral health clinicians are in every public school compliments services already offered to students and families. Their presence provides supportive services for school teachers and staff such as professional development on a variety of behavioral health topics, classroom management techniques, and case management. In addition, having mental health clinicians on hand as we navigate the COVID-19 pandemic is essential. Since the start of the

[1] Based on estimates and data gathered in 2016. https://test-dcfpi.pantheonsite.io/wp-content/uploads/2021/12/Strengthening-Families-Coalition-Letter-to-Mayor-Bowser.pdf

pandemic, emergency department visits for children with mental health emergencies have risen sharply[2] and tens of thousands of children have experienced the pandemic-related death of a primary caregiver[3]. The Center for Disease Control and Prevention (CDC) reports one in every five children and adolescents experience the signs and symptoms of a diagnosable behavioral disorder each year, resulting in significant disruptions of school classrooms, increased truancy, increased risk for alcohol and drug abuse and decreased graduation rates[4]. As students continue to return to a standard, in-person education, it is vital that they have full access to the resources that SBMH services provide to ensure their mental health does not degrade to a level requiring a need for emergency response. These children are facing significant behavioral health needs and the failure to meet these needs will have long-lasting negative impacts on the health, education, and future well-being for children in the District.

I would like to thank both the Mayor and D.C. Council for their support so far on School-Based Mental Health, however, the mental health needs of youth have increased a significant amount since the programs were first instituted. Because of this, these programs require stabilization of current funding to ensure they remain effective.

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[2] CDC data indicates that the mental health-related emergency department visits increased by 31% among 12-to-17-year-olds from January to October of 2020, we can see that the pandemic had a significant toll on youth, especially when they were not present in schools with the necessary resources at their disposal.

[3] Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020 https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm

[4] Mental Health and Morbidity Weekly Report: Mental Health Surveillance Among Children — United States, 2005–2011 https://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm

Community-Based Mental Health and Housing

Secondly, CCE supports DC Behavioral Health Association's (DCBHA) asks to increase funding for community-based behavioral health services and housing by $12 million. In addition, we ask for a $2 million increase to expand the use of the housing-first model among reentry housing providers, as recommended by the District Task Force on Jails & Justice. This investment will fund new housing and case management services for 55 more residents in FY23 returning to D.C. from prison or jail.

Community Response Team

I would also like to call your attention today to DBH's Community Response Team's (CRT) Pre-Arrest Diversion (PAD) and 911 Diversion projects, both of which were recommendations of the Task Force. Specifically, I am here today to urge the committee to increase funding to DBH's Community Response Team overall by $15 million to provide for enhanced provider and MPD training, workforce development, and worker recruiting and retention.

As this committee is aware, in 2019, DBH merged the PAD pilot program into its CRT to provide alternatives to the criminal justice system by diverting people facing arrest for non-violent offenses into programs that help address their behavioral health and other needs. Data from the pilot's evaluation showed success. However, despite being better suited to connect people to the supports needed to prevent future unlawful behavior, CRT's current operational capacity does not

allow the team to respond in a timely manner to all cases that might be – and should be – eligible for PAD's alternative intervention model, or to support the law enforcement trainings and collaborations that are critical to making the program a success.

CCE also requests continuation of the pilot program that allows the Office of Unified Communications to divert 911 calls from law enforcement to behavioral health first-responders. Ensuring the District has a high-quality, multi-intercept, comprehensive screening mechanism helps steer people with acute and chronic behavioral health issues away from the criminal legal system could have significant impacts at many different stages of the criminal process – not to mention improve connections to needed health care. For example, in 2018, roughly 62% of all people booked in D.C. jail had an identified behavioral health need,[1] and in D.C., individuals with serious mental health issues are 16 times more likely than others to be killed during a police encounter.[2] During the 911 Diversion pilot, from June-September 2021, OUC never diverted more than 28 calls per week to DBH, and some weeks diverted as few as 5 calls[5]. An advanced screening mechanism, in conjunction with a fully staffed and funded CRT provides a chance to help these individuals before circumstances escalate, before more serious crimes are committed, and they end up in jail, or worse, killed.

We encourage this Committee to allocate DBH an additional $15M to enable CRT to scale up appropriately. Reaching the majority of eligible PAD and 911 diversion cases – a goal shared by CCE, the District Task Force on Jails & Justice, and DBH, too – would require 1) an expansion of the CRT's capacity, 2) DBH's ability to track high-quality data about the impacts of its

[5] Department of Behavioral Health, *911 Behavioral Health Call Diversion Pilot*, October 14, 2021. On file with CCE.

interventions, and 3) its capacity to develop a successful partnership with MPD. Given the severe workforce shortages in D.C.'S behavioral health sector, CCE recommends that much of this funding be allocated to training opportunities for community members who seek to join CRT but do not have the means to participate in the necessary trainings or certificate courses. D.C. should be standing up a career pipeline for non-law enforcement responders, like Peer Specialists and Violence Interrupters in the same way we do through the MPD Cadet Corps.

Services for Justice-Involved People with SUDs

Finally, CCE recommends increased local dollar funding to increase non-Medicaid billable services to support justice-involved consumers. Between 2015 and 2019, almost 48% of people in Dept. of Corrections (DOC) custody had a documented substance use disorder (SUD) and of those, people who received SUD care after their release from DOC custody had a 36% lower chance of being rearrested or reincarcerated within 90 days. Based on our research and recommendations in "Everything is Scattered… The Intersection of Substance Use Disorders and Incarcerations in the District," CCE requests a $10 million total investment in services for justice-involved people with SUDs in FY23. This includes a $5 million increase to local dollar support of non-Medicaid billable services to support justice-involved consumers; a $2.5m increase to electronic medical records systems to increase technological capability and ease of sharing released records with DOC and CSAs; and a $2.5 million increase to boost connection to care services at DOC jail facilities, DC Superior Court, and the soon-to-be-opened Stabilization and Sobering Center.

In closing, I ask that the Committee fund CCE's asks, in addition to those of the Strengthening Families Through Behavioral Health Coalition, the DC Behavioral Health Association and the recommendations from the District Jails & Justice Task Force. Specifically, we ask that the Committee budget $2.4 million in additional recurring local funds for the School-Based Behavioral Health Expansion program and $300,000 in one-time local funds for the School-Based Behavioral Health Expansion program to fund a cost study for CBOs. We also affirm the DCBHA's asks to increase funding to over inflation costs for community-based behavioral health services and organizations that house individuals with mental illness enrolled in DBH services. Finally, we ask that the Committee fund the recommendations of the District Task Force on Jails & Justice formulated by a broad spectrum of justice service providers and advocates across the District.

Thank you for this opportunity to testify. I look forward to continued work with the Council on these budget asks nd I am available for questions.

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Testimony to the Committee on Health
For the FY2023 Budget Oversight Hearing for the Department of Behavioral Health
Nadia Gold-Moritz
Executive Director, Young Women's Project
March 21, 2022

Good afternoon Chair Gray and members of the Committee. Thank you for this opportunity to testify. My name is Nadia Gold-Moritz. I am the Executive Director of the Young Women's Project (YWP). I'm also a Ward 4 resident and have two kids in DCPS high schools. YWP builds the leadership and power of DC youth so that they can transform institutions to expand rights and opportunities. Our youth leaders work on three fronts – as organizers (educating, engaging, mobilizing their peers, working as teams to make decisions), as advocates (presenting testimony to city Council, convening accountability meetings of Agency leaders, developing and passing policies) and as system rebuilders (developing programs, creating new peer-led systems, integrating youth into decision making). *We advocate from the bottom up with an eye toward implementation. And we focus only on DC public high schools. Right now, YWP has 110 youth leaders working in 20 DC public schools and has trained and engaged 175 so far this year,* mostly Black and brown youth and women. Half of our youth live or go to school in wards 5, 7 and 8. As if 9.20.2021, our programs are back in person. YWP has a staff of 5 and manages two offices: (Connecticut Ave NW (W1) and Benning Rd NE (W7***).***

YWP's work is organized into two programs—*The Youth Justice Campaign (YJC)* develops youth as advocates and organizers to advance a bold agenda based on the real-life issues, and leverage their power through collective action to improve rights, resources, and accountability. *Our 2021-22 YJC Team includes 60 youth in 16 schools (bios here) working together to build a city-wide school-based peer-led mental health & wellness system.* Youth leaders work 4-6 hours a week, develop a portfolio of products, build cross-neighborhood friendships, earn $10-15/hr and receive more than 70 hours of training. **The *Youth Health Educator Program (YHEP)*** *– which you have supported for years* -- develops youth as sexual health advocates who work to reduce DC's unintended teenage pregnancy and STI rates through peer education, resource provision, and clinic referral initiation. Last year we engaged 121 youth advocates who reached 11,000 peers. *During the seven years of YHEP, we employed 1,225 youth who reached 40,381 of their peers, distributed 529,053 condoms and made 14,208 clinic referrals. We have 50 youth on the ground in 20 schools during the 2021-22 school year.*

My testimony today focuses on the School-Based Behavioral Health expansion. We are grateful for the Mayor's continued support in the School-Based Behavioral Health program including the increase to $33.6 million for the FY2023 budget. We also support additional funding to restore CBO grants to $80K per clinician to stabilize CBO grants. However, in order to ensure that this investment is actually reaching the children and youth who need the services – we are asking Council to require that some basic infrastructure in place as part of this investment:

1. **Contact Information:** DBH Clinicians and CBO providers should share information on their office hours, the specific services they offer and how to access them, and insurance requirements. Although DBH shares the emails of clinicians on their website (which we appreciate), there is no information on office hours, services offered, or appointment links. The only way for youth to seek services is to somehow find the Clinician PDF on the DBH website and send an email.

2. **Data:** We need to know the numbers of children and youth being served, what interventions are being provided, and what the impact has been. Although Child Trends is collecting data for DBH, the data is based on surveys and focus groups and does not capture what is actually happening in the schools in terms of youth needs, assessments completed, or services administered. It is vital to expand the data

collection and sharing to include a monthly dashboard that provides school-based and system wide information on needs and interventions.

3. **Tier 1 and 2 services:** DBH clinician positions are designed to operate on 3 levels: 3 Tier level (Tier 1 (reaching 100% of children and youth) includes Promotion and Primary Prevention Services, Tier 2 (reaching 10% - 15%) includes group interventions and skills building, and Tier 3 (reaching 1-5%) includes Intensive Support including individualized treatment to assist the child/youth to improve functioning in school, home and community. However, in most high schools, clinicians are doing only Tier 3 interventions which are reaching less than 6% of the high school population. Therefore, we are asking that the Committee provide additional funds for a new, third tier of school-based mental wellness services & support that is youth development based, resilience building focused. In order to avoid overtaxing clinicians and counselors who are leading the crisis intervention side of the mental health, this work would be run out of the Deputy Mayor for Education's Office as part of their Learn24 Initiative.

YWP has 50 youth educators in 16 schools working to educate their peers on mental health – and – connect them to counselors and clinicians. And so we've seen close up how the expansion is working in public high schools**.** Driven by the Covid-19 emergency and rising rates of already high depression and suicide among DC youth, YJC youth staff launched the **Mental Health Campaign (MHC)** in 2019 to strengthen school-based mental health programming, connect youth to services, and expand access to mental health education. YWP's mental health-wellness curriculum includes a deep examination of the causes and effects of stress, toxic stress, trauma, resilience-building, and the brain science behind it. Each youth educator will specialize in a range of wellness skills and strategies that will be shared through Virtual Wellness Centers and as part of school-based health education. **Since Spring 2020,** MHC youth leaders presented 23 testimonies to the DC Council Committees on Education and Health, completed a High School Website Assessment, created and distributed a 3.21 Youth Mental Health Survey: with more than 380 DC public school students from 29 schools, forged relationships with DCPS and DBH mental health leaders. We will have the results from the 2022 survey soon. Finally, student leaders researched school-based wellness models in other states and cities and developed a series of mental health solutions that were presented by youth leaders in DCPS and DBH hearings and meetings in early June.

In early April, YWP will launch Virtual Wellness Centers (VWC) in 16 DC high schools. Developed by youth for youth using the Google slides and Bitmoji application, VWCs will connect students to essential wellness educational resources and school-based mental health supports. VWC rooms provide interactive tools that support students to examine the impact of stress, toxic stress, and trauma and build resilience through relationship building, meditation, exercise, nutritional healing, self-care, self-agency, and other wellness practices. YWP youth leaders will share their VWC link via their Linktrees, social media posts, email, text message, and in classroom presentations. DCPS VWC sites will include Anacostia, Bard, Banneker, Cardozo, CHEC, Coolidge, Duke Ellington, Dunbar, and Eastern. McKinley, Ron Brown, Roosevelt, School Without Walls, Wilson, and Woodson. DCPCS sites will include BASIS, Thurgood Marshal Academy, Girls Global Academy, and KIPP. VWCs seek to connect youth to providers and fill existing mental health informational gaps. Click here to see sample rooms on stress, toxic stress, trauma, brain science, and resilience building and a draft of the **Bard High School VWC.**

DCPS, DBH and Charter Schools have been slow to develop virtual mental health and wellness resources that students can access. The majority of high school based websites still do not have mental health services detailed on their websites or highlighted on their home page. You have to search through the staff directory to find counselors or other staff who look like they might provide mental health. VWCs will include: 1) Provider background and contact information, appointment scheduling (including QSR codes), and school-based services offered; 2) A schedule of wellness activities for students and parents; 3) Videos and links that examine a range of

mental health issues (toxic stress, trauma, brain science, depression, suicide, etc), where to get support, and what students can do themselves to build resilience.

The VWC work is not officially endorsed by DC Public Schools or Department of Behavioral Health but they are working with us to participate in the project to ensure their services are included. Most notably, we are working with the DBH Community of Practice, run by CHHCS, we launch a Youth Adult Partnership Working Group that has been an invaluable resource to provide feedback and guidance for the VWC work. Thanks so much to Simone Sawyer, Olga Acosta Price, and Mariola Rosser for their commitment to youth partnership. We also appreciate the commitment of Kenya Coleman and Carla Hall on the DCPS Mental Health Team. We are hopeful that VWC will create an opportunity for cross system, cross generational collaboration that creates a venue to connect youth to providers and wellness development opportunities.

Everyone at this point has declared a national state of emergency on adolescent mental health. In October, the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children's Hospital Association (CHA), have declared a national state of emergency in child and adolescent mental health and called for urgent action. In December, the U.S. Surgeon General issued a new Surgeon General's Advisory to highlight the urgent need to address the nation's youth mental health crisis. Nationally, we are dealing with rising levels of mental health emergencies increased by 24% for children ages 5-11 and 31% for children ages 12-17[1]. Suicide attempts by girls ages 12-17 increased by more than 50% increase from 2019 to 2021.

Although very little recent data is available at the DC level, we do know that even in 2019, before the pandemic, our YRBS (Youth Behavioral Risk Survey) data was alarming: **40% of HS females and 25% of males felt sad or hopeless almost every day for 2 weeks in a row; 20% and 14% respectively had plans to kill themselves; 1**5% already attempted suicide –double the national average of 7.4%. Rates are significantly higher for middle school students, teen women of color, and LGBTQ students. Similar results surfaced in YWP's 3.21 Youth Mental Health Survey: youth are severely stressed (57% rank their stress as consistently high and unbearable in the past 3 months.). They are not sleeping (82% have difficulty sleeping including 26% who can't sleep most nights). They are so sad and hopeless that they stopped doing regular activities (55%); 24% have seriously considered suicide in the past 3 months. Most survey takers, at this time, had not received mental health information or services or mental health education, had not been assessed, and were not comfortable seeking help from counselors or clinicians. Further, 47% of children and youth in the DC public school system are considered "at-risk" based on the Office of the Superintendent (OSSE) definition[2] -- which means that they most likely have been exposed to significant instability and trauma in the past year.

In the three years since YWP has been doing advocacy and front line youth work on mental health, the crisis has grown and the school based response has not kept pace. Based on our calculations, given our YRBS data and with a school system of 94,000 children and youth – we've got 44,187 children and youth at risk of trauma. Considering our 20,000 public high school students – close to 10,000 are sad and depressed and 5,000 have considered suicide. There are many dedicated individual counselors, social workers, teachers, clinicians working very hard to identify and address youth mental health needs. But the systems we have in place right now are by design, reaching a fraction of the youth who need support.

On the DCPS side, we have seen improvements in a number of high schools. Many of our students have benefitted from lunch time support groups, mental health check ins during class time, and additional wellness-focused skills building sessions on time management. Counselors and teachers are doing their best but they are

[1] https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm?s_cid=mm6945a3_w
[2] . https://osse.dc.gov/page/data-and-reports-

also managing a heavy academically focused workload -- tied up test coordination, college recommendations, supporting Individual Education Plans (IEPs) and are not always available for mental health interventions.

On the DBH (Department of Behavioral Health) side -- a central goal of the school-based behavioral health expansion is to place at least one behavioral health provider in each of 245 public schools. This school based clinician pipeline has been growing each year since 2018 and was funded at 100% last year ($32 million). According to Director Bazron's 2.22 testimony, out of the 245 schools who need clinicians, 155 have been placed in schools and **90 have been hired but not yet placed in a school and are somewhere in the pipeline.** So we are operating at 63% capacity. DBH clinician positions are designed to operate on 3 levels: 3 Tier level (Tier 1 (reaching 100% of children and youth) includes Promotion and Primary Prevention Services, Tier 2 (reaching 10% - 15%) includes group interventions and skills building, and Tier 3 (reaching 1-5%) includes Intensive Support including individualized treatment to assist the child/youth to improve functioning in school, home and community. This level of care is designed for students who have active mental health symptoms that meet diagnostic criteria. But we are only getting Tier 3. In the 26 public high schools we've assessed, Tier 1 and 2 activities are rare and we do not have any examples of ongoing social emotional skill development at the high school level.

So right now we are reaching 5% of the student population – and probably closer to 3% since its operating at 65%. Also, since DBH clinicians work with an average of 25 students per year, we are reaching about 4,000 students. There are 40,000 who need help. More than 50% of DC students, according to YRBS data and our own at-risk assessments, are struggling right now with depression, suicide, and significant exposure to toxic stress and trauma. They need Tier 1 and 2 interventions ASAP. Also – there is still no school based or cross system for sharing data, information, or services with students or parents. We are trying to address this at the high school level with the Virtual Wellness Centers but the same issue needs to be addressed in the lower grade bands.

Recommendations for Improving School-Based Mental Health:

In the three years since YWP has been doing advocacy and front line youth work on mental health, the crisis has grown and the school based response has not kept pace. The systems we have in place right now are by design, reaching a fraction of the youth who need support. The DBH clinician pipeline is slow moving and in seven years has not yet operated at more than 50% capacity. Right now we have 245 schools need clinicians, 155 are in schools, and 90 have been hired but not yet placed. This system is expensive ($32 million) and even when operating at its maximum potential – it will reach at most 6% of the student population. On the DCPS side, most counselors are tied up test coordination, college recommendations, supporting Individual Education Plans (IEPs) which can impact, and crisis intervention. Meanwhile -- more than 50% of DC students, according to YRBS data and our own at-risk assessments, are struggling right now with depression, suicide, and significant exposure to toxic stress. We have five recommendations:

1. **Fund a new, third tier of school-based mental wellness services & support** that is youth development based, resilience building focused, and does not rely on our already-maxed out clinicians and counselors who are leading the crisis intervention side of the mental health work. We believe the Deputy Mayor's Office is in the best position to create a cross-city a school-based Mental Wellness Initiative! This Initiative could support a new stream of wellness educators and practitioners into the schools who could lead the prevention and education work that is falling through the cracks of the current system. Grounded in young development and brain science, a Resilience Building approach embodies a more aggressive commitment to undoing the impact of toxic stress and trauma and providing a set of tools that will support continued development. Wellness opportunities should be offered at every school, every week. Youth respondents said they would participate in a range of mental wellness services including peer support groups (61%), talk therapy (74%), meditation and mindfulness (73%) and art therapy (75%). An investment of $5 million with minimum administrative costs could support a pilot that could engage 35 organizations, reaching 125 DC schools with mental health and wellness

activities and education DME already has the funding, data, and collaboration infrastructure in place and a whole set of OST organizational partners who are likely to overlap with the groups needed to do this work. ***Policy Recommendation:*** *Direct and fund DME to launch a school-based, system-wide wellness initiative that provides mental health-wellness education, support, and capacity building to 125 schools.*

2. **Assess Student Needs! Use the Adverse Childhood Experience (ACE) framework to assess and educate youth on trauma and resilience building.** Assessment is a critical first step in understanding the mental health needs of children and youth and informing targets and interventions. We do not have an assessment system in place. Several states including California[3] are using the ACE screening tool which evaluates children and adults for ACEs experienced by age 18: in three categories: 1) Abuse: physical, emotional, and sexual abuse; 2) Neglect: physical and emotional neglect; and 3) Household challenges: growing up in a household with incarceration, mental illness, substance dependence, absence due to separation or divorce, or intimate partner violence. ACE screening helps to identify individuals at increased risk of having a toxic stress response and target interventions early, when they are likely to be more effective and less expensive. An individual with four or more ACEs has a 70% higher risk of kidney disease, more than double the risk of heart disease, and triple the risk of chronic lung disease as someone without ACEs. All children and youth should be assessed when they return to school. This will require an all hands on deck effort that should include school based SEL and counselor staff as well as MH Team staff members in DCPS central administration, parent and community volunteers with health-mental health backgrounds. Our suggestion is to follow the **Resilience Roadmap** approach currently being implemented by California by Surgeon General Nadine Burke Harris who has integrated the ACE process into public education and health. ***Policy Recommendation:*** *Direct all public schools, DCPS and the DC Public Charters, to assess 85% of students within the first advisory, as they return to school. Assessment data should be compiled. Aggregated data should be shared with the public. Disaggregated data should be used by individual*

3. ***Compile and Share Data: Use Dashboards to Share Mental Health-Wellness Targets, Data, and Plans:*** *we Data collection and sharing is core to understanding mental health need, the quantity and depth of interventions, and whether we are making progress. Although a* tiered data collection plan is outlined by DBH as part of the Comprehensive Plan, it was never fully implemented. At this point, we know virtually nothing about what is actually happening in the field. Decisions are driven by process and not data. Collecting basic data at the school level would allow us to direct resources and education. *Essential* output data would include: 1) Assessment results; 2) The number of universal referral forms submitted, the availability of appointment scheduling; 3) The number of students receiving individual and group interventions; 4) The number of youth connected to DCPS, Charter, DBH and community services; 4) The number of mental health staff on the ground in each school (still not clear in the DCPS or Charter schools); 5) The content, frequency, hours of *mental health education*; 6) The content, frequency, hours of after *school wellness activities*; and 7) The content and availability of web-based information at the school and system level. This is all output level data and should be easy to collect, compile, share. Impact data will be more challenging but can be collected through school-based surveys on student self-reported stress and depression levels (compared to overall YRBS data) as well as school-level data on student engagement and safely-related behaviors. ***Budget Recommendation:*** *Direct OSSE (Division of Health & Wellness, Data and Strategic Initiatives) to compile and report on school-based mental health and wellness data for DC Public and Charter Schools. OSSE would collect a range of mental health data as listed above, compile, and share quarterly in aggregated and disaggregated formats. As part of this function, OSSE should convene a working group including relevant leadership and at least 4 youth members who are engaged in school-based mental health work. Funds to support this work could be included in the $*1 million OSSE Mayoral allocation to provide additional school-

[3] https://www.acesaware.org/events/roadmap-for-resilience-the-california-surgeon-generals-report-on-adverse-childhood-experiences-toxic-stress-and-aces/

side support for SBMH. *OSSE already assumes an effective cross system role in education data collection with the administration of the Health School Profiles and the Youth Behavioral Risk Survey. They effectively convene stakeholders, compile and share data in usable excel and slide formats.* (capacity-building, technical assistance)

4. **Establish System-Wide Goals and Targets, create plans use dashboards to Share Mental Health-Wellness Targets, Data, and Plans:** Although DCPS and DBH centralized staff and school-based practitioners are developing plans at the school-level (through the school strengthening tool), the results are not compiled and shared across the system and do not result in a common set of goals and target or shareable school-based or system-wide mental health-wellness plans. Such plans are a critical tool for engaging community resources, parents, youth leaders, peer educators, and others and ensuring everyone is working in concert to address the most pressing needs. ***Policy Recommendation:*** *Direct DCPS and the DC Public Charter Board to create and publicly share an annual mental health & wellness plan that includes goals and targets overall and by school and a timeline for delivery. Targets should reflect the needs and realities reflected in the 2019 YRBS data, School Climate Survey, OSSE student at-risk assessment data, and any other behavioral risk or economic data available to school leaders.*

5. **Teach Health Class:** The absence of mental health-wellness education for children and youth continues to be a serious blind spot. The vast majority of DC public school students receive no mental health education. Further, all of the educational interventions from DCPS SEL staff are focused on teachers and administrators Children and youth need the Resiliency Building skills, knowledge, tools and support to respond to the high levels of trauma, economic hardship, adversity, and stress that they face every day. Skills building requires human-led, hands-on, interactive, experiential, consistent, safe, supportive education interventions that meets youth where they are, challenges them to develop new capacities, and supports them in building new relationships and connections. In other words – health class! And even though health class is required by law implemented (Healthy Schools Act[4], Student Safety and Consent Education Act[5] and Suicide Prevention Act of 2017 and School Climate Survey Amendment Act of 2015.[6]) -- health classes and health teachers are rare in DC public schools. According to the 2019 Healthy Schools Profiles data on the OSSE website, out of the 212 schools who completed their OSSE Health Profiles, there were **2** health only teachers in the 60 Public and Charter Elementary Schools reporting data in the HSP, **zero** health-only teachers in the 28 middle schools reporting, and **10** health-only teachers in the 41 high schools reporting;[7] This is a long—term issue that needs to be addressed through health teacher hiring. Meeting the legal requirements for health class means hiring about 200 health teachers – which would add $20 million that needs to be repurposed to the front lines in DCPS and Charter School budgets. We recognize that this is a heavy budget lift – and -- we are in a budget scarcity environment. However. The immediate challenge of providing a minimal level of mental health-wellness education to children and youth for the 2021-22 school years can be addressed. Our recommendation is to engage DCPS Training and Learning Team to develop a 12 hour mental health-wellness curricula that can be adapted by grade and rolled out in the first advisory using the 45 minutes of homeroom

[4] The Healthy Schools Act requires that all DCPS and PCS provide an average of 75 minutes per week of health education for grades K-8. They must also provide 150 minutes of physical education for K-5 and 225 minutes per week for grades 6-8. The data for 2018 show progress but are still not meeting the legal requirement.

[5] **The Student Safety and Consent Education Act of 2018 requires** all DC schools to adopt and implement a policy to prevent and address sexual harassment, sexual assault, and dating violence among students and to amend the HAS to require age-appropriate instruction on consent, training for parents and staff. Based on anecdotal evidence, it seems that the teachers have been trained – but not the students.

[6] **Suicide Prevention Act of 2017 and School Climate Survey Amendment Act of 2015 (DC Law 21-120)** requires all teachers and principals in public schools and public charter schools to complete the youth behavioral health program once every 2 years and requires OSSE to develop and publish online written guidance to assist local education agencies in developing and adopting policies and procedures for handling aspects of mental and behavioral health, an on line catalogue of resources, and to pilot a school climate survey.

[7] https://osse.dc.gov/page/2018-19-school-year-dc-public-schools-health-profiles

time utilized by most schools. YWP youth and adult staff would be pleased to work alongside the Training and Learning Team to develop the high school curricula. **Policy *Recommendation:*** *The Committee directs DCPS and the Public Charter Schools to include a minimum of 12 hours of behavioral health and social emotional learning as part of health instruction. Instruction should include a focus on brain development, trauma, and resiliency building.*

Thank you again for the opportunity to testify today.

PARENTS AMPLIFYING VOICES in EDUCATION

Department of Behavioral Health
Budget Oversight Hearing Testimony
Committee on Health
Monday, March 21, 2022

To: Committee on Health, Councilmember Vincent Gray, Committee on Health members, and Committee on Health staff

From: Tara Brown, PAVE (Parents Amplifying Voices in Education) Ward 8 PLE Board Member and Citywide Board Member
Date: March 21, 2022

Hello Councilmember Gray, The Committee on Health, HBX and DBH. My name is Tara Brown. I am a Ward 8 resident, and a PAVE parent.

My child suffers from severe clinical depression and extreme social anxiety. Their mental health issues are treated with therapy and medication. Their ability to learn was significantly impaired by their condition. Once they received their diagnosis, it was even more important to understand the impact of their mental health on their learning process. We did a needs assessment and then tailored their education to fit their mental health needs. Now, they are managing both their mental health and their education better. We have over 94,000 more students that need the same assessments and customized plans for aligning their mental health needs with their education.

Today, I'm talking about trauma and learning. There is plenty of research compiled about what trauma does to the brain-especially developing brains, and how that stress and trauma can impede the learning process. I do not have to convince this group that there is a need for School Based Mental Health.

Considering that this pandemic is a collective traumatic experience, it is logical to assume that virtually every school-age child in DC has gone through trauma. When you also factor in violence, abuse, poverty and the unmet mental needs of some caregivers, this assumption has even more credibility.

Considering how adults have struggled with Covid, how does a child process it, while simultaneously getting an education that is integral to their life long success and develop into a fully functioning adult? DBH is integral to the success of our students operating under a cloud of trauma and this trauma existed before COVID and will continue beyond COVID. School Based Mental Health will always be foundational to the education of our students.

However, before you can determine where a student falls on the Multi-Tiered System of Support, you must understand what each school community needs to support their students. The first step towards addressing the problem is understanding it.

Our PAVE parent priorities around SBMH include:

- Assessing the mental health needs of each school. Generating a gap analysis to determine what is needed, compared to what each school has.

- Using this gap analysis to create a comprehensive and transparent plan for the future, inclusive of families and investing $300,000 to fund a cost study to determine the true cost of expanding the school-based mental health program now and into the future.

On behalf of the PAVE parents who were surveyed and collaborated to come up with our parent priorities around school based mental health, I urge you to listen to our recommendations. Figure out what you are doing, figure out what needs to be done, then work together to make it happen. DC invests billions in education. It is a colossal waste of money if we don't also invest in comprehensive school based mental health supports that will insure our children are equipped to benefit from that investment and can actually learn.

Thank you!

Tara Brown

PAVE (Parents Amplifying Voices in Education) Ward 8 PLE Board Member and Citywide Board Member

PARENTS AMPLIFYING VOICES in EDUCATION

Department of Behavioral Health
Budget Oversight Hearing Testimony
Committee on Health
Monday, March 21, 2022

To: Committee on Health, Councilmember Vincent Gray, Committee on Health members, and Committee on Health staff
From: Mary McCane
Date: March 21, 2022

Good morning Chairman Gray and members of the Committee On Health. My name is Mary Mccane and I am a proud grandma to Zhion Jones who is a Kindergartener at Boone Elementary in Ward 8. I also serve with Parents Amplifying Voices in Education (PAVE) on the Ward 8 PLE Board.

In the past, before the Pandemic, I testified in front of the Council to speak about my grandson Zhion and how important it was to fund the School Based Mental Health priorities, which gave him access to the service he needs to develop and learn! Today, I want to share where we are now, and why the Deputy Mayor of Education and the Department of Behavioral Health should create strong accountability systems for any agency or organization providing mental health support in schools in partnership with families and youth.

Zihon is a survivor of physical and emotional abuse and his resilience is one reason I'm so proud of him! Those traumatic events mean that his access to behavioral health specialists was important to his development during his pre-K years. But this year, when our family's home was caught in a fire, we lost everything! This only made mental health support more necessary and urgent for Zihon. Right now our family is working with the courts so that his parents and I can share custody. Yet at this time, when we need it the most, his services are not being offered as well as they should be!

Throughout this process of our custody hearings, we've had so many issues coordinating access to care with the court systems, DBH, and schools. No one is making sure that when he's at his other home, he's getting the same level of care and services as he does when he's home with me. Even more, in the transition from in-person learning to virtual and back to in-person, there was somehow a gap in time where he wasn't able to see his team for weeks. And then, when the custody changed from sole to joint custody, he needed a new evaluation and he wasn't able to get it for three months! That is not acceptable for a kindergartener! Kids develop so quickly and every day counts !I shouldn't have to call DBH multiple times per week to ask them to

update the status of his case or travel all the way to 35 K Street to do things in person that could just as easily be done over the phone or on the computer.

During the pandemic, Zhion transferred from Apple Tree Institute to Boone Elementary, moving from the charter sector to DCPS. He also transitioned from virtual learning to in-person and from being under my sole custody to being under joint custody with his parents. Lots of kids in the District are facing similar transitions, and through it all we need the city to recognize that there are different types of families and family situations. Our families need and deserve a strong accountability system so that every single agency that touches a student or family will be in communication with each other. They should be in better communication with their parents as well. In addition to this, we need to support clinicians and professionals from community based organizations in their work with our students. We must stabilize their grants to match the needs of our students . This means investing $80,000 per CBO clinician, for a total of $2.4 million. This will be good not just for Zihon, but all kids!

Thank you for allowing me to testify today!

Mary McCane

PAVE (Parents Amplifying Voices in Education) Ward 8 PLE Board Member

PARENTS AMPLIFYING VOICES in EDUCATION

Department of Behavioral Health
Budget Oversight Hearing Testimony
Committee on Health
Monday, March 21, 2022

To: Committee on Health, Councilmember Vincent Gray, Committee on Health members, and Committee on Health staff
From: Randee Grant
Date: March 21, 2022

Good afternoon Councilmember Gray and members of the Committee on Health. My name is Randee Grant and I am speaking out today with Parents Amplifying Voices in Education (PAVE). I have lived and worked in DC as an artist and educator for over 30 years, 10 of those years in Ward 7, and as a mother of two daughters, I know first hand the necessity for mental health services for youth and young adults. I want to begin by saying thank you! We are grateful to the Mayor for her $3.8 M investments in School Based Behavioral Health, as well as her record investments in OST which can help to support the social emotional learning and behavioral health needs of our kids. While we welcome Mayor Bowser's initial investments for SBMH to work on the workforce pipeline and the model's infrastructure, the investments do not address what our students, parents, and providers have collectively asked for - a comprehensive map of what mental health needs and supports currently exist in each school and funding stabilized grants to our CBO clinicians and professionals - the backbone of this program.

My youngest daughter's journey began at 11 years old when she was attacked by two teens on her way home from school. She had just gotten off of the U8 bus at Hillside RD and Chaplin St SE and was attacked from behind , thrown to the ground and her wallet was taken. This spun into her inability to go to school, a suicide attempt and CFSA being called. She was given a therapist for the upcoming school year, the 8th grade and continued to fall deeper into what I now know as agoraphobia, PTSD, anxiety and depression. At the time I didn't have Medicare, which left me unable to be added to the enormous waitlist for services and my learning curve kept me in the dark. My youngest daughter literally lost her High School years due to the inability to get the services due to her, and I continue to be subject to judgment and blame as a mother for this experience.

My daughter and students throughout the District experienced traumatic events like this before the pandemic, and now we know that the need they face is even more widespread. There are more behavioral issues in and out of the classroom than ever, and our kids are reporting being in distress!

When I think about how the city can address this issue – I know the first step is generating a comprehensive map of what mental health needs and supports currently exist in each school, including a corresponding gap analysis, and making it public to help create a comprehensive and long-term plan for the future! To do this we need to provide $300,000 to fund a cost study to determine the trust cost of expanding the school-based mental health program now and in the future. And to support our CBO clinicians and professionals in their important work with our students, we must stabilize their grants to address our students' outsized needs - this includes $80,000 per CBO clinician, for a total of $2.4 million.

Thank you for allowing me to testify and share what I want to see for our kids and our city. I hope you will take seriously the urgent need for mental health and social emotional learning support in our schools.

Randee Grant
Ward 7 Parent Leader

PARENTS AMPLIFYING VOICES in EDUCATION

Department of Behavioral Health
Budget Oversight Hearing Testimony
Committee on Health
Monday, March 21, 2022

To: Committee on Health, Councilmember Vincent Gray, Committee on Health members, and Committee on Health staff
From: Tyesha Andrews
Date: March 21, 2022

Good morning Councilmember Gray and members of the Committee on Health. My name is Tyesha Andrews. I am a Ward 8 resident and proud parent of a Kindergartener at Plummer Elementary School and a Seventh grader at Jefferson Middle Academy. I am also a Ward 8 PLE board member for PAVE.

I am testifying today to advocate for SBMH program funding. My advocacy for School-Based Mental Health (SBMH) supports stems from personal experience. Growing up, I felt high levels of stress and anxiousness, especially when I was in the classroom. Despite these feelings being so visually apparent, my family, teachers, and schools did nothing to help. This is why I fight for kids in the District as a PAVE parent leader; I want all our kids to receive the mental health support that I never did.

My advocacy only grew stronger following my oldest son's high-functioning autism diagnosis. When he was first diagnosed, specialists explained that he was reaching all his developmental milestones, but aspects of his behavior needed to be addressed with the help of mental health professionals. Approximately seven years later, I was told, yet again, that my second son also was a high-functioning autistic. While I'm fortunate that my husband and I are working alongside both my sons' teachers and school staff to manage their behaviors, the resources to do so are limited.

Mental health supports come in a wide variety of ways and all children's mental health issues are different which means that their reactions to similar situations would be different as well.

There are children that have lost parents and guardians due to COVID. Black and brown people, in general, have higher stressors due to our current situation in the U.S. #BlackLivesMatter. Those two things are separate mental health issues within themselves. In addition, some children are with mental health issues are looked at as troublemakers instead of children that need extra help.

As of now, both of my children's schools do not have enough mental health clinicians or support to meet my children's needs, and my sons are two of *many* students in their respective schools with a learning disability and an IEP. The SBMH supports my son's needs are WAY beyond what many of our schools can provide. This is why we need a change. One of the solutions to this that PAVE parents identified, is creating and distributing a citywide needs assessment that will help determine what mental health needs and supports currently exist in each school and what needs must be met. The design and implementation of this assessment, of course, must include the voices and support of parents and families. A needs assessment would help us learn directly from those whose voices are often lost or ignored in discussions about SBMH support. Additionally, to support the future of this program, we are asking for at least $300,000 for a cost study to determine the true cost of the program now and in the future is important. In addition, we need $2.4M ub grants for CBO providers, for a total of $3.8M in additional funding. This past Saturday, at the PAVE Budget Forum, we learned that $18M has been secured for D.C. Schools for the next two fiscal years. However, this funding is to be spit evenly amongst the D.C. public and D.C. Charter schools. This is unreasonable due to the fact that Charter schools also receive private funding. D.C. Public schools need the funding for more and better resources to compete with D.C. Charter schools. Our current funding levels are not addressing the impacts of the pandemic and our children's outsized mental health needs. We need to support our clinicians - the backbone of this program - and ensure we are funding their important work well.

From the results of our 2021 Fall Back to School Survey, I learned that 55% of parents with students with an IEP are not satisfied with the mental health and social-emotional supports they receive at school. I haven't seen many other surveys that ask about my son's IEPs with

them receiving SBMH support. This is why an assessment created WITH parents' input, just as we did in the PAVE survey, can ensure this representation is top of mind.

I want to know all the answers instead of wondering *how* I can provide my children SBMH support. This means knowing *where* I can find these supports in every school, being able to name *who* is providing these supports, and determining *what* supports will best serve them both. Parent leaders are ready to move forward and take steps towards real change. To our District leaders: I'm here to tell you that our hands are out – in this budget season and the next. Prioritize our solutions and take the step to walk with us.

Thank you for allowing me to share my vision for students and families in our District.

Tyesha Andrews
Ward 8 Parent Leader in Education Board Member

PARENTS AMPLIFYING VOICES in EDUCATION

Department of Behavioral Health
Budget Oversight Hearing Testimony
Committee on Health
Monday, March 21, 2022

To: Committee on Health, Councilmember Vincent Gray, Committee on Health members, and Committee on Health staff
From: Kelita Boyd
Date: March 21, 2022

Good morning Councilmember Gray and members of the Committee on Health. My name is Kelita Boyd and I am a Ward 8 resident and proud parent of three amazing children who have attended both DCPS and Charter schools. They have also graduated from The University of the District of Columbia. I am a Ward 8 Parent Leader in Education Board Member and Organizing Captain.

I want to start by thanking the Mayor for her continued investments in school based behavioral health in the FY23 budget. To support these investments of $3.8M in new SBBH dollars, I believe that the District should fund a $300,000 a cost analysis. This cost study would determine the true cost of the program now and in the future. The District should also develop a comprehensive map that would look at what supports exist in each school and what's missing!

Today I am testifying to advocate for even more support when it comes to school based mental health for our kids. We don't only need more dollars, but we need a stronger implementation and an accountability system. This calls for DBH and the DME to partner to develop a clear, publicly transparent, and strong accountability system, so that any agency or community based organization providing mental health supports in schools are working together to provide kids the services they need.

Mental health support encapsulates a lot .Although the comprehensive map and cost analysis will primarily benefit younger students, the positive effects of these investments will impact not only kids who attend K-12 schools, but also our UDC students. For many of these young adult students, the future seems unsure, considering the lasting effects of the pandemic on our economy and society. They need a strong foundation for resilience and tools to deal with their anxieties, which begins in their earlier years. The effectiveness of school based mental health interventions is also at least in part determined by what is happening in students homes and in the streets.We need to serve the whole child and whole family, providing wrap-around support for families. I hope that through improved implementation and accountability systems we will be on the right path to doing so.

PARENTS AMPLIFYING VOICES in EDUCATION

Thank you for the opportunity to testify today!

Kelita Boyd
Ward 8 PLE Board Member and Organizing Captain

PARENTS AMPLIFYING VOICES in EDUCATION

Department of Behavioral Health
Budget Oversight Hearing Testimony
Committee on Health
Monday, March 21, 2022

To: Committee on Health, Councilmember Vincent Gray, Committee on Health members, and Committee on Health staff
From: Ms. Latonya Graham
Date: March 21, 2022

Good morning Councilmember Gray and members of the Committee on Health. My name is Ms. LaTonya Graham, I am a Ward 7 resident and school bus driver for OSSE/DOT. My daughter Asia attends Kipp College Prep in Ward 5. I advocate with Parents Amplifying Voices in Education.

Thank you to the Mayor for your $ 3.8 M investment in school based behavioral health in the FY23 budget. I am testifying today because I want all kids, no matter what neighborhood they live in or what type of school they attend, charter or DCPS to have access to mental health support! The District can do this by committing $300,000 for a cost analysis, as part of a needs assessment, to better understand how to maximize those investments.

My daughter has always been an exemplary student making excellent grades and testing extremely high on Parcc and ANet tests. At KIPP Valor Academy during my daughter's 8th grade year, I sought an IEP to protect her because the 504 plan I had in place wasn't properly carried out by the school. On the academic evaluation of the IEP which was finalized December 2019, she tested on college ready level. She was referred to attend The Learning Center, a KIPP school geared toward social and emotional support.

My daughter was diagnosed with depression in 2018. She had faced multiple traumas, starting at age 7 she was inappropriately touched by a 7 yr old boy in school. This boy also threatened to stab her which led to her conducting a forensic interview at Safe Shores while shortly after, she was scared to sleep alone, would wet the bed, had bad dreams and so on. She was traumatized and went through counseling at Safe Shores. In September 2015 at age 8, had her right fibula broken during school recess and in November 2015, she was hospitalized with a concussion for 4 days by a student throwing 3 large rocks at her each striking her one on the side and the other two in the back of her head. Due to trauma symptoms from the concussion, in January 2016 she had to go through Neuropsychotherapy and was cleared In July 2016. The ultimate betrayal was the abandonment from her father in July 2017. Just months later, the signs of depression were obvious.

The Learning Center worked really well for her because the teachers, clinicians and staff are geared to support your child. They didn't see behavior issues during her tenure at TLC. She was respectable and engaged. They had to give her extra work because she completed her work so fast in each class, they had to keep her challenged. At TLC, they treat your child with respect, genuine concern for their well being and assures that their social and emotional needs are met. I truly believe in "it takes a village", and TLC was that village. I felt at ease and confident that my daughter was in safe, concerned and professional hands. I thank the entire TLC staff for the assurance and guarantee of meeting my daughter's needs

Now that Asia attends KCP, she continues to perform very well academically and get all A's and B's. My daughter isn't a trouble maker nor is she a bad child, she's healing from past hurts.I'm testifying today because I believe that parts of the approach that makes TLC so successful should be available at all schools!

Investing in the mental health expansion so that there would be at least one clinician available, is a good start, but what parents and families who have students like mine need is consistency, assurances and equality of SBMH support regardless if they have an IEP or not.

Initially I pursued an IEP for my daughter because I felt that If she had an IEP I could protect her. Prior to the 8th grade year she had been getting sent home for behavior issues a lot, I would have to go to work late or take off work. I wasn't and am not a stay at home mom who can run to the school every phone request. I couldn't keep taking off of work to attend reentry meetings every time she was sent home from school. Although the IEP has been beneficial, schools need to support the very clear goals set out especially when it comes to school based mental health and access to the help she needs.

She does have some good people on her team at KCP, in fact, they tell me she's a rock star who's intelligent, engaged, assists other students and helps them with work, but how do we make sure that they're supported? It doesn't seem as if PCS schools are able to support kids with IEPs to the same level as DCPS schools and that's not right! We want to see increased partnerships with community based organizations like Mary's Center and Wise center made more available!.

Asia deserves to attend a school that can support our kids BOTH academically and in terms of SBMH. When the school year started, she was excited and prepared to take her honors classes. In fact, I was more excited than she was. Due to behavior issues, and the lack of behavioral support in the honors classes, she was allowed to take one honors class which was seminar and the remainder of her class were taken in the BSR located on the lower level. In October 2021, she got into an altercation with a male student who confronted her during lunch and in November 2021 it ended with a physical altercation. Those incidents set her back from transitioning to take all of her honors classes.

PARENTS AMPLIFYING VOICES in EDUCATION

My daughter felt singled out in her seminar's honors class and completely withdrew from the honors program in mid February 2022. The decision not to pursue her academic goals was feeling like she was setting herself up for failure. Since then, she's been doing very well. Students shouldn't have to choose between their academics and SBMH.

We need there to be support for both DCPS and PCS. The majority of students who attend charters live in Ward 7 and Ward 8.. We need for there to be support for both!

I'm asking you today to assess the mental health needs of DC school communities. We can do this by generating a comprehensive map of what mental health needs and supports currently exist in each school, including a corresponding gap analysis, and make it public to help create a comprehensive and long-term plan for the future. This can be made possible by providing $300,000 to fund a cost study to determine the trust cost of expanding the school-based mental health program now and in the future. We must also support our CBO clinicians to sustainably do this important work with our children. The Mayor's initial investments decrease CBO grants. To ensure our clinicians and professionals are able to most effectively work with our children, we are asking for at least $80,000 grants for a total of $2.4 million.

Parents should be involved in community meetings and focus groups to get a deeper understanding of what this really is like in our community. Where I live in Parkside and we especially need the support East of the River. Oftentimes we speak broadly in terms of Wards, but there are differences in experiences from individual neighborhood to individual neighborhood.

Thank you for allowing me to testify and share what I want to see for our kids and our District!

Ms. Latonya Graham
Parents Amplifying Voices in Education

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Fiscal Year 2023 Budget Oversight Hearing

Testimony of
Barbara J. Bazron, Ph.D.
Director

Before the
Committee on Health
Council of the District of Columbia
The Honorable Vincent C. Gray, Chairperson

Remote Hearing by WebEx
March 21, 2022
10:00 a.m.

Good Morning, Chairperson Gray, Councilmembers, and Council staff.

I am Dr. Barbara J. Bazron, Director of the Department of Behavioral Health (DBH). I am pleased to testify before you today on Mayor Muriel Bowser's proposed Fiscal Year 2023 Budget and Financial Plan. Mayor Bowser's proposed FY 23 budget invests in building safer and stronger communities and in helping us emerge from the pandemic stronger and more ready to thrive than ever before. Under the Mayor's leadership, DBH supports these goals with a range of prevention, treatment and recovery services and supports that improve the health of individuals and the social and emotional well-being of our communities.

Like people across the country, the mental health of District residents has been impacted by the grief, loss, and physical isolation of the last two years. In a national survey, two out of five adults report symptoms of anxiety or depression. The U.S. Surgeon General issued an advisory to highlight the urgent need to address the impact of the pandemic on youth and families.

Studies show that people often turned to alcohol, opioids and other drugs to help them cope with the pandemic. For people already facing mental illness, opioid addiction or other substance use disorders, pandemic related disruptions in treatment regimes, social networks and daily routines challenge their recovery. Gun violence and safety concerns place additional stress for too many in our communities. Longstanding health disparities across populations were exacerbated by the COVID-19 pandemic with people of color disproportionately affected by severe illness, death and associated economic loss.

Mayor Bowser's proposed FY 23 budget for DBH ensures that residents can get connected to the care they need—by phone, at home, in school or in the community.

The FY 23 budget supports the work underway with the Department of Healthcare Finance to integrate behavioral health services into the Medicaid managed care program effective October 1, 2023. Whole person care recognizes that physical, behavioral, and social health are interdependent and must be treated together to achieve optimal health. Bringing these services into the managed care program supports better care coordination and alleviates the need for residents to navigate multiple systems. The promise of integrated care is healthier people living longer, more fulfilling lives.

The integration to managed care provides the opportunity for DBH to embrace its role as the behavioral health state authority and transform behavioral health in the District to be more holistic and equitable. DBH's role as a state authority includes establishing District-wide standards and policies for behavioral health care delivery, monitoring quality of care, promoting behavioral health education and disease prevention, and defining and measuring population health outcomes.

Let's take a moment to recall how far we have come in building a behavioral health system that residents need and deserve. Just 10 years ago, the District ended 37 years of federal oversight of our public mental health system during your administration, Chair Gray. A year later, the Department of Behavioral Health was established to bring together treatment and services for residents with mental health and substance use disorders to promote better health, prevent

behavioral health problems, and support better outcomes for individuals with co-occurring mental health and substance use disorders.

Today, the integration of behavioral health and primary care moves us to whole person care. To prepare providers for this transition, DBH and the Department of Health Care Finance are engaging in planning and readiness activities with providers to ensure the smooth transition of behavioral health services to managed care. We are surveying providers to identify their needs, providing multiple technical assistance opportunities, and providing grants to support IT development. We also are conducting a rate study to determine the appropriate payment for behavioral health services.

As we move toward the whole person health model of care DBH works to provide high quality care for residents who rely on the public behavioral healthcare system as well as for residents who may be experiencing common disorders such as depression and anxiety related to the pandemic.

In FY 21, the utilization of mental health services increased by 14 percent while the number of residents receiving substance use disorder services was essentially the same. The accelerated use of telehealth allowed for continuity of care as well as more frequent consumer engagement. Data from the first quarter of FY 2022 indicate that services are being delivered in a hybrid environment of in person and telehealth based on consumer preference. The proposed FY 23 budget anticipates that increased service utilization and increased use of telehealth will continue.

DBH has certified a robust number of providers across the District with particular attention to locations in Wards 7 and 8. However, research shows that less than half of people with mental health conditions receive treatment. Too often, people are misunderstood, blamed, or are embarrassed to get the help they need. We want to make it as easy as possible for people to get the help they need when they want it.

Under the direction of Deputy Mayor Wayne Turnage, DBH works with agencies within the Health and Human Services cluster and throughout government to integrate the work they are doing to support residents with behavioral health needs. DBH has partnerships with the Office of the Deputy Mayor for Planning and Economic Development, the Department of Human Services, the Department of Employment Services, and the Department of Corrections to co-locate staff to normalize behavioral health treatment as a resource just like housing or a job to support daily living.

We know that residents need varying levels of mental and emotional support. The proposed FY 23 includes a 24-hour Mental Health Hotline for people who may just need to talk or want help with problem solving and self-care techniques. Any resident can talk with a clinician for up to three sessions with no enrollment papers to fill out and no cost sharing.

The proposed FY 23 budget includes funds to promote broadly the availability of the supports for all District residents and to target communities most at risk of behavioral health challenges. The proposed budget includes $250,000 to fund prevention of opioid use disorders in the LGBTQ community.

DBH also supports residents to access behavioral health care through their insurance coverage. By law, insurance companies generally must offer behavioral health benefits at the same level of support as physical health care benefits. DBH supports the work of the Health Benefit Exchange Authority and DC Health Links to promote healthcare parity.

Support the mental well-being of our frontline health workers.

Through grant partnerships with the Wendt Center and Howard University, we have continued to provide support for frontline health workers including our own employees through promoting self-care and encouraging seeking help. About 70 percent of DBH employees continued to report onsite during the pandemic. I can't express my appreciation often enough so I want to take this opportunity to thank them again. They were there when we needed them the most.

I will now discuss in more detail various aspects of the proposed FY 2023 budget for DBH.

FY 23 Proposed Gross Budget

The proposed FY 23 gross budget is $369,419,870 million which is a 3.7 percent increase over the FY 22 approved budget. The increase includes a $10.7 million increase in local funds and a $16 million dollar increase in federal funds.

The proposed FY 23 capital budget is $12.7 million for information technology equipment upgrades and Saint Elizabeths Hospital facilities projects.

The FY 23 Proposed Budget by Funding Source

The largest source of funds is the local budget of $298 million—a 3.7 percent increase over the FY 22 budget. The second largest source of funds is $55 million in Federal Grants which includes funds through the federal American Rescue Plan Act and the State Opioid Response grant.

DBH Administrations

DBH is anchored by eight administrations including Saint Elizabeths Hospital, which together, oversee, manage, and deliver behavioral health services and supports to District residents and establish the policy and regulatory framework for behavioral health care for the District of Columbia.

FY 23 Budget Overview

The Mayor's proposed FY 23 budget for DBH funds a projected increase in utilization of services, continues investments that support our most vulnerable residents, and and enhances early intervention services and school-based supports for children and their families. The proposed budget also includes $1 million for facility maintenance at Saint Elizabeths Hospital which is now a 12-year-old facility.

The proposed budget includes:

- $36.5 million for mental health services which leverages $121.7 million in services
- $28.4 million to maintain supported housing for 1,700 residents
- $41 million for substance use disorder services
- $10.9 million for mental health services for uninsured residents
- $33.6 million to expand school-based services
- $18.3 million for crisis services
- $7.3 million for prevention and early identification services, and
- $104.4 million to support Saint Elizabeths Hospital

The proposed budget realizes $2.6 million in savings through maximizing the use of Medicaid for crisis services, aligning the supportive housing model to expand capacity and maintain clinical support, and contract efficiencies.

The proposed budget supports new and existing priority services, including:

- $8.9 million to support behavioral health transformation services and increased utilization by Medicaid eligible residents
- $3.7 million to expand school-based services
- $2.5 million for the Sobering and Stabilization Center
- $250,000 to prevent opioid abuse in the LGBTQ community, and
- $213,000 to support health promotion and public engagement

I've already talked about most of these initiatives so I'll focus on expanded school-based services.

Expansion of school-based services

Children and young people have been particularly impacted by the pandemic as disruptions in routines and relationships have led to increased social isolation, anxiety, and learning loss. Some research suggests that youth who have been exposed to multiple traumas, have a history of anxiety issues, or have experienced family adversity face a much higher risk of prolonged stress. As the Surgeon General's advisory notes, before the pandemic, an alarming number of young people struggled with feelings of helplessness, depression, and thoughts of suicide — and rates have increased over the past decade. Further, in one study, more than half of parents expressed concern over their children's mental well-being.

Studies show that half of all lifetime mental health disorders start by the age of 14 and school-based services have proven to be an effective, safe environment to reach students who need mental health support and their families. Our goal is to support the "conditions of learning" that have been shown by the research to be linked to students' academic success, graduation, and post-secondary success. The results of this strategy may contribute to decreasing the learning gap between Black and White students.

Through multi-year investments by Mayor Bowser and the Council, the proposed FY 23 budget funds a clinician in every public school. Behavioral health clinicians from DBH or contracted

community-based organizations (or CBOs) are now in 158 or 63 percent of public schools and we continue to expand in partnership with the DC Public Schools and the DC Public Charter School Board. In addition to a clinician in every public school, the proposed budget includes $1,758,341 to add clinicians in 25 schools with the most significant needs. DBH will collaborate with our education partners to select the schools.

New High Fidelity Wraparound Services

To support treatment, the proposed budget will allocate $829,000 to provide High Fidelity Wraparound in six schools. This service will be available to a total of 60 children and their families. Care Coordinators work closely with students and their families to remove barriers to learning, access needed behavioral health services and support academic abilities and improved functioning.

Strengthening Technical Assistance and Support

Like many fast-growing programs, the school-based program is experiencing challenges related to maintaining fidelity to the model, reporting quality data, supporting the workforce, and infusing youth and family voice. To help address these challenges, the proposed budget includes $907,978.00 for eight positions to work with CBOs to provide technical assistance, assist with data reporting and collection, and support fiscal and program integrity and accountability.

Using a public health model, school-based clinicians are expected to provide prevention, intervention, and treatment services. Along with funding supervisors, DBH provides $53,667 for each clinician to support the delivery of non-reimbursable services. The pandemic created unique challenges to reaching students, so we provided an additional $9,316 for each clinician in FY 21 and another $7,461 in FY 22.

Working through the Coordinating Council, we are examining closely conditions in each school to identify any barriers to providing services and the Community of Practice will focus individualized training and support. We also are ready to reexamine the service delivery model and will conduct a rate study to determine if the current funding is sufficient to support the program.

Support for Workforce Development

To complete our expansion to all public schools will require recruiting and retaining a significant number of licensed clinicians during the current national shortage of licensed clinicians. In fact, we are competing within DBH as we also are recruiting clinicians for our Community Response Team and other clinical services.

We recognize that recruiting more than 100 licensed clinicians is a challenge that will require focused effort, careful planning, and coordination with community-based organizations (CBOs) who contract with DBH to deliver services in our schools. I am encouraged by our ability to meet this challenge since funding has been allocated in the Mayor's budget to support our workforce development initiative to attract and retain licensed clinicians.

Full funding for supervisors. The proposed budget includes $100,000 to support supervisors at a ratio of one supervisor for six clinicians. In addition to providing appropriate guidance, this strategy aims to attract graduate social workers who can obtain the supervised hours required to advance to independent licensure.

Intern agreements with local universities. DBH has multi-year affiliation agreements with Howard University, the Catholic University of America, and the University of Maryland to host graduate-level interns. DBH is working to finalize agreements with Delaware State and Morgan State University.

The proposed budget allocates $281,000 to support the costs of licensure which can be burdensome to graduates. The funds will provide $1,000 for each CBO clinician and $500 for DBH clinicians who already are independently licensed clinicians. In addition, DBH is collaborating with DC Health to connect our CBO partners to the Health Professional Loan Repayment Program.

FY 23 Budget Advances Health Equity

The DBH is committed to addressing health equity for all District residents in need of behavioral health care. Health equity is achieved when every person has the opportunity to attain his or her full health potential and is not prevented from achieving this potential because of race, social position, or other social determinants of health. The Mayor's FY 23 budget provides resources for DBH to advance health equity as follows:

- Making substance use treatment easily accessible through the new Sobering and Stabilization Center.

Our proposed budget includes $2.2 million to continue operating the Sobering and Stabilization Center expected to open this summer. The Sobering Center is an important addition to our health care system to support individuals under the influence of alcohol or drugs who require stabilization services and support but do not need to be transported to hospital emergency departments. Induction in Buprenorphine will be offered to survivors of an opioid overdose. Peers also will remain engaged with them after they leave the Sobering Center to encourage care.

- Increasing the number of Community Response Teams to increase engagement of residents with behavioral health needs, connect them to care and address crisis.
- Ensuring that residents receive the right services from the right provider at the right time by working in collaboration with the Office of Unified Communications to respond to certain 911 calls to support individuals experiencing a behavioral health crisis.
- Offering behavioral health services to children and youth through the school-based program to address emotional or behavioral concerns that can negatively impact learning.
- Expanding the number of individuals with lived experience who can provide engagement and support to those facing from addiction and serious mental health issues.
- Providing housing to returning residents from incarceration, and

- Offering supported employment to assist residents with mental health and/or substance use disorders to get and keep a job.

Consumer and Family Voice.

The proposed FY 23 budget supports strong consumer voice and presence throughout our system of care. We know that peer support is effective in engaging individuals in treatment and helping them maintain recovery. Peer leaders model our conviction that treatment works, and sustained recovery is possible. Further, peer leadership is essential to our fight to reduce stigma that can prevent people from getting the help they need. DBH has strong partnerships with consumer leaders and advocates along with the Behavioral Health Planning Council who advise me on policy and strategic direction.

Peer specialists now work in the provider network as integral members of treatment teams, in community hospital emergency departments, our emergency facility, and Saint Elizabeths Hospital. DBH is working to adopt a national certified peer specialist certification program to standardize training and incentivize hiring of peers in the workforce.

Mayor Bowser's Fiscal Year 2023 budget provides new and ongoing investments that support whole person care and the opportunity for all residents to live longer, healthier lives.

Mr. Gray, this concludes my testimony. We appreciate our partnership and the work of the Committee and look forward to our continued work together. I am ready with my team to answer any questions. Thank you.

ATTACHMENT 3

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
WITNESS LIST – FY23 BUDGET OVERSIGHT HEARING
1350 PENNSYLVANIA AVE., N.W., WASHINGTON, D.C. 20004

COUNCILMEMBER VINCENT C. GRAY, CHAIRPERSON
THE COMMITTEE ON HEALTH

FY23 BUDGET OVERSIGHT HEARING ON

NOT-FOR-PROFIT HOSPITAL CORPORATION AND UNITED MEDICAL CENTER BOARD OF DIRECTORS

THE DEPARTMENT OF HEALTH CARE FINANCE

AND

THE OFFICE OF THE DEPUTY MAYOR FOR HEALTH AND HUMAN SERVICES

MONDAY, MARCH 28, 2022, 10:00 A.M.
REMOTE HEARING VIA WEBEX
STREAMED LIVE ON YOUTUBE AT TINYURL.COM/FISCAL23

WITNESS LIST

Not-for-Profit Hospital Corporation and UMC Board of Directors

Panel 1 – Public Witnesses

1. Wala Blegay — Staff Attorney, DC Nurses Association (DCNA)
2. Roberta LeNior, RN — President UMC-DCNA

Panel 2 - Executive Witnesses

3. Angell Jacobs — Chair, United Medical Center Board of Directors
4. Marcela Maamari — Interim CEO, United Medical Center

The Department of Health Care Finance

Panel 3 - Public Witnesses

5. Caroline Kenney	Managing Director of Public-Private Ventures, Urban Atlantic
6. Mary Procter	Public Witness
7. Tamara Smith	President and CEO, DC Primary Care Association
8. Luisa Furstenberg-Beckman, MPH	Produce Prescription Program Manager, DC Greens

Panel 4

9. Claudia Schlosberg	Chair, Workforce Development Subcommittee, DC Coalition on Long Term Care
10. Ian M. Paregol	DC Coalition of Disability Service Providers
11. Judith Levy	Coordinator, DC Coalition on Long Term Care
12. Claudia Balog	Lead Researcher, 1199SEIU United Healthcare Workers East - Maryland/DC Region

Panel 5

13. Mark LeVota	Executive Director, District of Columbia Behavioral Health Association
14. Damon King	Director of Policy Advocacy, Legal Aid Society of the District of Columbia
15. Mandar Bodas	Research Scientist at the Fitzhugh Mullan Institute for Health Workforce Equity, The George Washington University Milken Institute School of Public Health
16. Selene Lara	Community Health Worker, La Clínica del Pueblo

Panel 6

17. Mark C. Miller	State Ombudsman, Office of the D.C. Long-Term Care Ombudsman

18. Mary Cabriele	Director of Workforce Programs, Academy of Hope Adult PCS
19. Veronica Sharpe, MHSA	President, District of Columbia Health Care Association
20. Susan Hargreaves	Administrator, The Lisner-Louise-Dickson-Hurt Home; DCHCA Board Member
21. Samaria Washington	Director of Regional Operations, BridgePoint Healthcare

Panel 7

22. Rob Downing	Carding Group, LLC; Downing & Company
23. Kate Coventry	Senior Policy Analyst, DC Fiscal Policy Institute

The Office of the Deputy Mayor for Health and Human Services

Panel 8 - Public Witnesses

24. Kate Coventry	Senior Policy Analyst, DC Fiscal Policy Institute
25. Jesse Rabinowitz, MSW, LGSW	Senior Manager of Policy and Advocacy, Miriam's Kitchen

Panel 9 - Executive Witness

26. Wayne Turnage	Director, Department of Health Care Finance Deputy Mayor for Health and Human Services, Office of the Deputy Mayor for Health and Human Services

Testimony before the Committee on Health

Budget Oversight Hearing of the Deputy Mayor for Health and Human Services

Delivered by Jesse Rabinowitz, Senior Manager for Advocacy and Policy at Miriam's Kitchen

March 28, 2022

Councilmember Gray and Members of the Committee, thank you for the opportunity to provide feedback on behalf of Miriam's Kitchen regarding the Deputy Mayor for Health and Human Services' homeless encampment response. I want to start my testimony by thanking Mayor Bowser for fully funding the Permanent Supportive Housing asks recommended by The Way Home Campaign, our 110 partner organizations, and over 7,000 supporters. These investments, combined with the historic funding from Fiscal Year 22, will change the face of single adult homelessness in DC. However, this progress will be placed at risk if DC reverts to a policy of encampment evictions and no camping zones. To keep our foot on the gas, we must focus now on what works: housing first, without strings or sticks, without artificial timelines or displacement.

My testimony today, despite some claims to the contrary, is informed by my deep knowledge of homeless encampments in DC. This includes a year doing street outreach to homeless encampments and witnessing more encampment evictions than I can count. I have sat with people as their tents and other items were destroyed by city officials paid with DC tax dollars. And I have conducted multiple listening and feedback sessions with encampment residents (and previous Deputy Mayors), all while staying up to date with national best (and worst) practices for dealing with encampments.

<u>Evicting encampments is bad policy</u>

I won't dwell for long about the significant disagreements that exist. I think we can all agree that we want everybody living outside to move into their own housing as quickly as possible. Miriam's Kitchen, along with dozens of local and national organizations, believes that DC should focus on housing and stop displacing encampment residents through "full engagements," evictions, and no camping zones. Police officers and bulldozers should have no place in DC's encampment response and must not be used as tools to force our unhoused neighbors out of their chosen communities.

<u>Continued lack of clarity around encampment and outreach funding</u>

Since this is a budget oversight hearing, I will focus the remainder of my time on the budget implications of DC's current encampment approach. Budgets are moral documents that necessitate honesty and transparency. Yet despite repeated public calls for accountability from community members and Councilmembers, we still do not know how much money DC spends to clear encampments.

Despite claims to the contrary, we do know that a detailed cost breakdown of DM HHS encampment costs is possible, as illustrated by a 2015-16 breakdown, which I've included in my written testimony. This breakdown indicates that DC spent over $130,000 to close a single encampment, including over $7,000 for police presence.

A more current breakdown of spending on encampment engagements would enable the Council to evaluate whether the money allocated towards bulldozers, police, and no-tent zones is the best use of taxpayer dollars. As such, DM HHS must release a spending breakdown of all encampment clearings, evictions, and associated costs from FY 16 to the present.

<u>Questions remain about FY 23 outreach and encampment funding</u>

Mayor Bowser's proposed FY 23 budget contains $2 million in funding for street outreach. We are happy to see increased investments in this critical program and look forward to receiving additional information about the specific purpose of this appropriation. It is our hope that this funding will be used to make permanent the intensive outreach services that DC has deployed to encampments as part of the CARE Pilot. Still, we have significant questions about the CARE Pilot and encampment-specific funding in FY 23.

- Is DMHHS extending the CARE Pilot into FY23?
- If so, will the $2 million proposed for outreach in the mayor's budget be allocated for encampment outreach via DHS or instead be used for other outreach-related programs?
- How does DC's posture of encampments align with Homeward DC 2.0, DC's strategic plan for ending homelessness, especially the plans focus on housing as a solution to homelessness, the importance of using trauma-informed approaches, and the understanding that current shelters do not meet the needs of many unhoused people?
- If the CARE Pilot continues in FY23, will funding be maintained for the successful parts of the pilot, namely dedicated housing-focused street outreach to encampments and rapid housing? Additionally, how does this rapid housing intersect with DC's coordinated entry system? Where does the rapid housing funding come from?
- If the CARE Pilot continues, will funding also be maintained for harmful parts of the program such as forced evictions, no tent-zones, and artificial timelines?

<u>DM HHS must produce a detailed cost breakdown of FY 2022 CARE Pilot funding</u>

Just as DM HHS was able to provide a cost breakdown of encampment-related costs in 2015-2016, so too should they provide the same financial analysis for FY 2022. It was alarming to hear during the February 28th performance oversight hearing that DM HHS was unable to provide this breakdown. Knowing the full cost of the program is integral to evaluating its

efficacy. An updated breakdown will equip taxpayers and the Council with invaluable information to answer questions such as:

- How much was spent to station 30 MPD officers at the New Jersey and O encampment during a recent eviction?
- What is the cost of DDOT and DPW staffing at encampments?
- Who pays for the concrete barricades that displaced unhoused communities and still block all pedestrian access to L and M Streets in NoMa?

If DM HHS is unable to provide a breakdown similar to the 2015-16 iteration at today's hearing, we call on the DC Council to use their oversight prerogative to determine where and how monetary decisions are being made.

<u>Encampment evictions are costly, but monetarily and in other ways.</u>
My written testimony describes how the cost of evicting encampments extends beyond money. In brief, encampment evictions take up provider and client time that could be better spent connecting to housing and services. These evictions also have a high emotional and physical cost for parties involved. While those costs will not show up in a budget book, they are real and must be addressed.

While the monetary costs of DC's encampment posture are high, we must also consider the costs associated with the trauma and harm of encampment clearings and the capacity costs that clearings have on clients and providers.

Encampment evictions are traumatic. This trauma is most present for those being forced to relocate from their chosen spot, often as their communities are broken up. Evictions are also traumatic for outreach workers and those supporting encampment residents. This trauma further compounds clients' mistrust of government and service providers and makes it harder to accomplish our shared goal of ending homelessness.

Encampment evictions force clients and outreach workers to make costly sacrifices. I've talked to countless encampment residents who must take days off work to move their items before encampment clearings. It's hard to earn an income that will hopefully enable you to exit homelessness when you frequently need to take time off work.

Encampment evictions are also extremely emotionally and physically taxing for outreach workers and reduce their capacity to connect clients to housing. DC's team of dedicated outreach workers are overworked, under-compensated and underappreciated. They have been on the front lines of DC's COVID-19 response from day one, handing out PPE and meals to folks living outside. They worked to make sure our unhoused neighbors were safe during the insurrection and during the inauguration, during snowstorms and extreme heat. Most recently, they worked to inform their clients that a serial killer was targeting men experiencing homelessness in DC. DC's outreach workers go above and beyond and put their clients first. Encampment evictions place a significant time burden on top of their already full plates. In addition to often hours-long clearings that are emotionally and physically draining, outreach

workers must support clients ahead of time, as well as track them down and support them after they've been displaced. This eats up a significant portion of their time, which could be better spent building rapport and supporting clients move into housing. I've talked to several outreach workers who state that the time they spend with encampment evictions actively takes them away from meeting clients' housing and other urgent needs.

DC must fund restrooms and sanitation stations at encampments

Before I close, I must voice my significant concern that DHS, during a recent briefing on phasing out COVID protections, stated that they will cease providing sanitation stations and portable restrooms for encampments. While I deeply hope that one day soon all of our neighbors living in encampments and shelters will have the housing that meets their needs on their own timelines, sanitation stations and restrooms must remain until that is the case.

Encampment Cleanups: October 1, 2015 - January 8, 2016												
Location	Cleanup Date	Estimated Encampment Scouting Trip and Cleanup Length (30 minute increments)	Approximate Number of Residents Living on Site	Number of Residents Housed	Number of Residents Relocated	DMHHS total cost	DPW total cost	DBH total cost	DHS total cost	DDOT total cost	MPD total cost	
3rd and E Streets, NW (Behind 441 4th building)	October 2015[1]	1 hour	10	4	6	$28.16	$522.00	$413.40	$580.00	$2,830.00	$96.80	**$4,470.36**
4450 Wisconsin Ave, NW (Tenley-Friendship Library)	October- 2015	30 minutes	8	6	2	$14.08	$522.00	$175.60	$690.00	$230.00	$24.20	**$1,655.88**
26th and K Streets, NW (Whitehurst Freeway)	November 16, 2015 November 20, 2016 December 3, 2015	25 hours total	25	14	12	$704.00	$20,150.00	$3,064.71	$10,423.02	$90,732.87	$7,260.00	**$132,334.60**
Southwest Freeway (12th Street exit)	November 1, 2015	1 hour	0	0	0	$28.16	$522.00	$405.19	$470.00	$2,830.00	$96.80	**$4,352.15**
E Street, NW (towards the Kennedy Center)	November- 2015	1 hour	1	1	0	$28.16	$522.00	$368.54	$770.00	$2,830.00	$145.20	**$4,663.90**
Klingle Road, NW (Under 3200 Connecticut Ave Bridge)	November- 2015	5 hours	0	0	0	$140.80	$3,722.00	$162.10	$350.00	$2,830.00	$484.00	**$7,688.90**
295 overpass at Sousa Bridge	December- 2015	1 hour	1	0	1	$28.16	$522.00	$533.26	$250.00	$230.00	$48.40	**$1,611.82**
L and First Streets, NE (under the bridge)	December- 2015	30 minutes	4	1	3	$14.08	$522.00	$92.34	$935.00	$540.00	$48.40	**$2,151.82**
First Street along the H Street Bridge, NE	December- 2015	30 minutes	4	0	4	$14.08	$522.00	$174.67	$680.00	$3,095.00	$48.40	**$4,534.15**
3149 16th Street, NW (Old DPR headquarter)	December- 2015	1 hour	7	0	0	$28.16	$522.00	$115.43	$275.00	$230.00	$48.40	**$1,218.99**
1636 R Street, NW	December- 2015	1 hour	1	1	0	$28.16	$522.00	$259.29	$470.00	$230.00	$48.40	**$1,557.85**
320 Florida Ave, NE (behind Burger King)	December- 2015	3 hours	3	0	3	$84.48	$522.00	$92.34	$440.00	$2,830.00	$290.40	**$4,259.22**
600 Pennsylvania Ave, SE	January- 2016	1 hour	1	0	1	$28.16	$522.00	$340.71	$570.00	$230.00	$48.40	**$1,739.27**
Total:			**65**	**27**	**32**	**$1,168.64**	**$29,614.00**	**$6,157.56**	**$16,903.02**	**$109,667.87**	**$8,687.80**	**$172,238.89**

[1] Due to increase crime in the area the timeline of the encampment was advanced, only 13 days' notice was provided, residents were notified of this change.

[2] The $90,732.87 for DDOT costs at 26th and K Streets, NW (Whitehurst Freeway) includes erection of a fence.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Deputy Mayor for Health and Human Services

Fiscal Year 2023
Budget Oversight Hearing

Testimony of
Wayne Turnage
Deputy Mayor for Health and Human Services

Before the
Committee on Health
Council of the District of Columbia
The Honorable Vincent C. Gray, Chairperson

March 28, 2022
10:00 A.M.
Virtual Meeting Platform
The John A. Wilson Building
1350 Pennsylvania Avenue NW
Washington, DC 20004

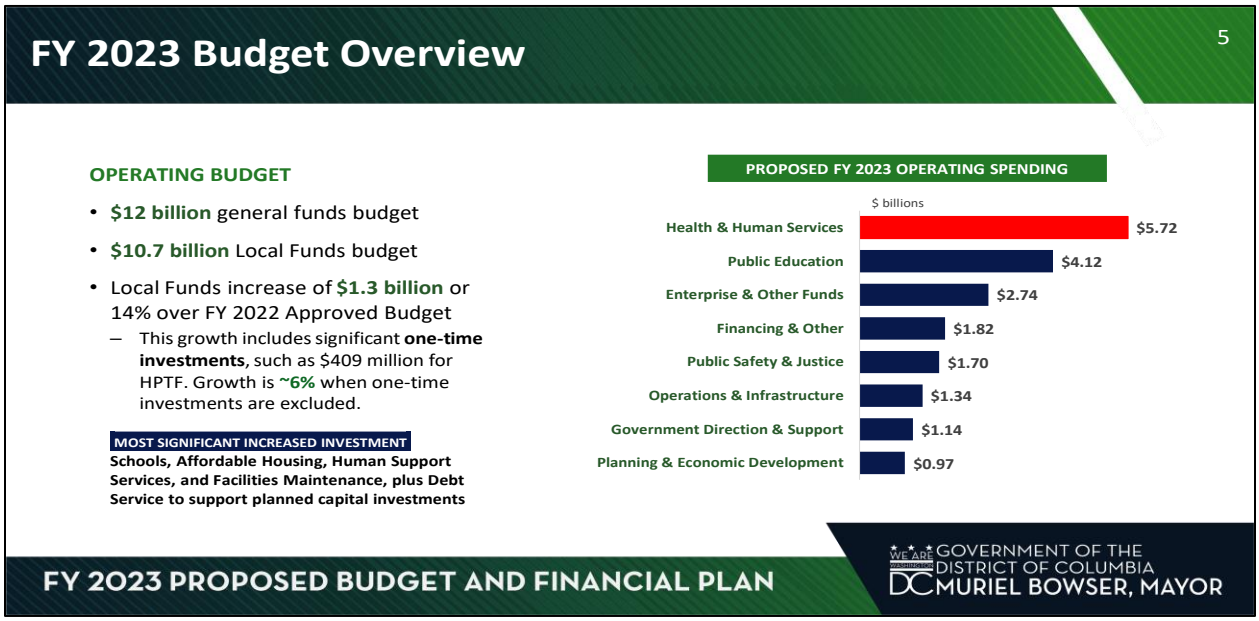
Introduction

Good morning, Chairman Gray, and members of the Committee on Health. My name is Wayne Turnage, and I am the Deputy Mayor for Health and Human Services (DMHHS) and the Director of the Department of Health Care Finance (DHCF). Thank you for inviting me to testify on behalf of the Bowser Administration. It is my pleasure today to report on Mayor Muriel Bowser's Fiscal Year 2023 (FY2023) Fair Shot Budget and Financial Plan for the Office of the Deputy Mayor for Health and Human Services.

As Mayor Muriel Bowser noted in her March 16, 2022, presentation to the Council, her FY2023 budget proposal is a "recovery budget"—one that offers a sweeping plan to fund initiatives that will allow the District to recover from a two-year pandemic that drained jurisdictions around the country of the resources necessary for sustained growth and prosperity. Now, the city is clearly perched on the precipice of a strong recovery. To wit, unemployment has declined to 5.8%, consumer spending is up by 7.3%, and the restaurant industry—always a leading indicator of the District's economic fortunes—has seen its revenue losses slow from -49% in the early days of the pandemic to -20% today. While the industry still has room to grow, the metrics are moving in a favorable direction.

So, with significant federal support and a surging DC economy, the Mayor has proposed a FY2023 budget that is built on a record $19.55 billion in total operating dollars. As was the case in 2021, rather than have the normal budget town halls across multiple wards, the Mayor led a virtual process where Deputy Mayors outlined their cluster agencies' mission and goals, and then community members provided input through online voting. This process afforded communities across the city a window into the formulation process and the opportunity to voice their beliefs of how money should be allocated in the budget.

The Mayor's commitment to funding the health and human services agencies at levels necessary to ensure that all District residents have a "fair shot" is unchanged from previous years. Comprising nearly 30% of the proposed operating budget, the Mayor has allocated $5.72 billion for FY2023 to a range of health and human services programs, the majority of which will fund health insurance coverage for more than 45%of District residents (see graphic below).



Office of the Deputy Mayor for Health and Human Services

The Office of the Deputy Mayor for Health and Human Services (DMHHS) supports 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. As most of the Health and Human Service (HHS) cluster investments are detailed in the relevant agency hearings, I will only briefly highlight a few of the Mayor's enhancements proposed in the FY2023 budget.

The HHS agencies have been at the forefront of leading the response to the pandemic. The Mayor's FY2023 proposed budget provides $2.8 million in funding for the DMHHS budget to continue to support this important work while we actively work to recover and emerge from the

pandemic healthier and with more supports than what we had available before it began. DMHHS' budget includes funding for nearly 14.8 full-time staff who support and provide oversight to the seven executive agencies under our strategic purview and oversight, including:

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

In addition to their work with these agencies, DMHHS staff coordinate interagency teams; work closely with our two independent agencies, the Health Benefit Exchange Authority and the Not-for-Profit Hospital Corporation (i.e., United Medical Center); lead and manage the work of the Interagency Council on Homelessness, and Age-Friendly DC; and facilitate the District's Encampment Protocol Engagements and C.A.R.E (Coordinated Assistance and Resources for Encampments) Pilot.

Key Investments Within HHS Cluster Agencies

Within our cluster, there are several pillars that serve as the structure for which investments and policies are made. When achieved, they result in a population that is healthier, happier, and set up for long-term success. Those pillars include ensuring access to healthcare; expediting the housing process for residents experiencing homelessness; making homelessness rare, brief, and nonrecurring; and making DC an easier place to grow older. The FY2023 budget continues our commitment to these goals.

Ensuring Access to Healthcare. Access to healthcare has always been a priority of this administration, but over the last year, all of us have become acutely aware to just how important this service is to the prevention and management of disease. An important aspect of healthcare is meeting people where they are. This is why the proposed budget includes $2.2 million to continue operating the Department of Behavioral Health's Sobering and Stabilization Center slated to open this summer. The Sobering Center is an important addition to our health care system to support individuals under the influence of alcohol or drugs who require stabilization services and support but do not need to be transported to hospital emergency departments. The Sobering and Stabilization Center will decrease demands on our area hospitals.

Speaking of new hospitals, Chairman Gray, I know we both share in the excitement for another key and monumental addition to our health system: the new Cedar Hill Hospital – GW Health. Cedar Hill is vital to ensuring all residents, especially those living in Wards 7 and 8, have excellent healthcare in close proximity to where they live. The Mayor's FY2023 proposed budget includes an additional $15 million to cover the pandemic-driven rising cost of construction for the new hospital.

The FY2023 budget also aims at fostering an environment for DC residents of all backgrounds to have access to services they need to live fruitful lives. This includes $4.5 million to expand school nursing services at public and public charter schools; $4.2 million to extend Alliance enrollment to 12 months and end the required in-person 6-month recertification for good; $500,000 to expand eligibility for individuals living with developmental disabilities to provide the same services as individuals with intellectual disabilities; and $1 million to expand the Connector Card Program. These hallmark investments will set up our residents of all ages and ability levels to have access to services to promote health.

Make Homelessness Rare, Brief, and Nonrecurring. This year's investments to address homelessness can be seen across the spectrum from $2.4 million for the new 801 East Men's Shelter to the $31 million for Homeward DC that will support housing vouchers for 500 individuals, 260 families, and 10 more youth, with $20 million of these funds being dedicated to investments for individuals experiencing homelessness.

As it directly relates to DMHHS, our ability to conduct the C.A.R.E. Pilot will be enhanced by the proposed $4.2 million in the DHS budget for housing subsidies, staffing costs, client costs, and outreach. The outreach services are critical to allow residents to engage with trained professionals to assist them in navigating and expediting the housing process. So far, we have an 81% engagement rate of residents on the "By Name List"—the list based on the census of the sites in the weeks prior to the initiation of pilot services—and these critical investments will help us maintain and improve these engagement numbers.

While we have been implementing the pilot at encampment sites that meet eligibility criteria, a proliferation of concerns at other locations have simultaneously emerged. Of note are the encampments located on National Park Service (NPS) land. In a meeting with my office last week, NPS indicated that it would begin to reclaim, clean, and return its parks to their intended use. In doing so, NPS officials have expressed a desire to coordinate with District Government to ensure we are acting in concert to minimize disruption to residents living on NPS property. Accordingly, we are now making plans to work closely with NPS to assist residents living in the parks who will be impacted by their closure to encampments. We fully anticipate that this effort will invite additional public attention to our encampment work, especially as NPS adjusts their posture. The hope is that we will be able to engage and place these residents into housing, using the housing first method to create stability and then address other problem areas in their lives.

Making DC an Easier Place to Grow Older. Not only has the pandemic exacerbated health disparities that disproportionately impact residents of color, but the pandemic has also further highlighted the challenges seniors have aging in the District. The city has the highest rate of senior hunger in the nation with 13.5% of seniors reporting they are food insecure. In FY2023, the Mayor is committing an additional $750,000 towards a new grocery gift card pilot program aimed at addressing senior food insecurity. With this investment, we are prioritizing choice, independence, and dignity. We also know that social connection, amid two years dominated by isolation, is an essential factor to staying healthy. This is why we support the proposed $2.6 million for the purchase of 1,000 wireless enabled tablets designed to encourage connection and wellness among our seniors.

DMHHS Budget

Arguably, no other cluster has been impacted by COVID-19 more than the HHS cluster. Our agencies quickly adjusted operations to deliver key services virtually and rapidly implemented in-person services for some of our most vulnerable residents amid social distancing and office closures. In response to the pandemic, we have given careful attention to what challenges were presented, and how we can harness those lessons to accelerate health systems change and adjust service delivery going forward.

While the DMHHS team is small, formulating and managing our budget requires significant stewardship to enable us to serve HHS cluster agencies and DC residents to the best of our capacity. The proposed operating budget for DMHHS is $2.8 million, comprised solely of local funds. The FY2023 proposed budget includes a reduction of $50,000 to account for the removal of one-time funding appropriated in FY2022 to support a new hospital contract for consulting services.

DMHHS' proposed local funds budget includes a net increase of $1,665 across multiple programs to reflect costs associated with salary, fringe benefits, and other personal services adjustments. Additionally, the budget includes an increase of $155,721 in nonpersonal services across multiple programs, primarily for professional service fees. This includes $36,000 for supplies to support encampment outreach. This funding goes toward meeting residents where they are with sleeping bags in winter months, and water in summer months, among other items provided.

Lastly, the proposed local budget reflects the transfer of $168,711 and 1.0 Full-Time Equivalent to the Executive Office of the Mayor to support the Office of Woman's Policy and Initiatives. This was done to better align the scope of work with a placement that will be the most conducive to collaboration.

Conclusion

Mayor Bowser's FY2022 Fair Shot Budget continues to embrace our shared DC values and provide District residents with the opportunity to live happy and healthy lives. We have made tremendous strides over the past year to respond to the pandemic and the FY2023 budget will set us up well to recover and emerge healthier. I am continually proud of the HHS cluster and their ability to adjust swiftly to ever-changing COVID guidelines all the while delivering outstanding care to District residents.

In closing, I'd like to thank you for the opportunity to testify before you today. This concludes my testimony and I look forward to working with the Committee as you finalize the District's FY2023 budget. My staff and I are happy to answer any questions you and the Committee may have at this time.

Deputy Mayor for Health and Human Services (DMHHS) and Department of Health Care Finance (DHCF) Fiscal Year 2023 Budget Presentation

Presentation Before the
Committee on Health
Council of the District of Columbia
The Honorable Vincent Gray, Chairperson

March 28, 2022
Washington, DC

WE ARE WASHINGTON GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

Presentation Outline

- ☑ **Rebounding Economy and General Budget Overview**
- ☐ Funding and Functions of Office of Deputy Mayor for Health and Human Services
- ☐ DHCF and Important Medicaid and Alliance Program Trends
- ☐ Key Budget Proposals For DHCF
- ☐ Status of New Hospital

The District's Economy Is Rebounding

	Pre-COVID	Early COVID	Mid-COVID	Today
DISTRICT REVENUES	$8.7B	$7.9B	$8.5B	$9.4B
UNEMPLOYMENT RATE	5.0%	11.1%	7.2%	5.8%
RESIDENTIAL VACANCY (Multi-Family)	7.7%	11.4%	12.7%	9.0%
COMMERCIAL VACANCY	11.1%	11.9%	12.5%	14.3%
DC RESIDENTS VACCINATED	-	0%	49%	72%
CONSUMER SPENDING	-	-41%	-17%	+7.3%
RESTAURANT SPENDING	-	-49%	-26%	-20%
PUBLIC HEALTH RESTRICTIONS	NONE	MANY	SOME	FEW

This budget will give District residents a “Fair Shot” by ……

investing $19.5 billion in helping us emerge from the pandemic stronger and more ready to thrive than ever

The Operating Budget is Funded With More Than $12 Billion

OPERATING BUDGET

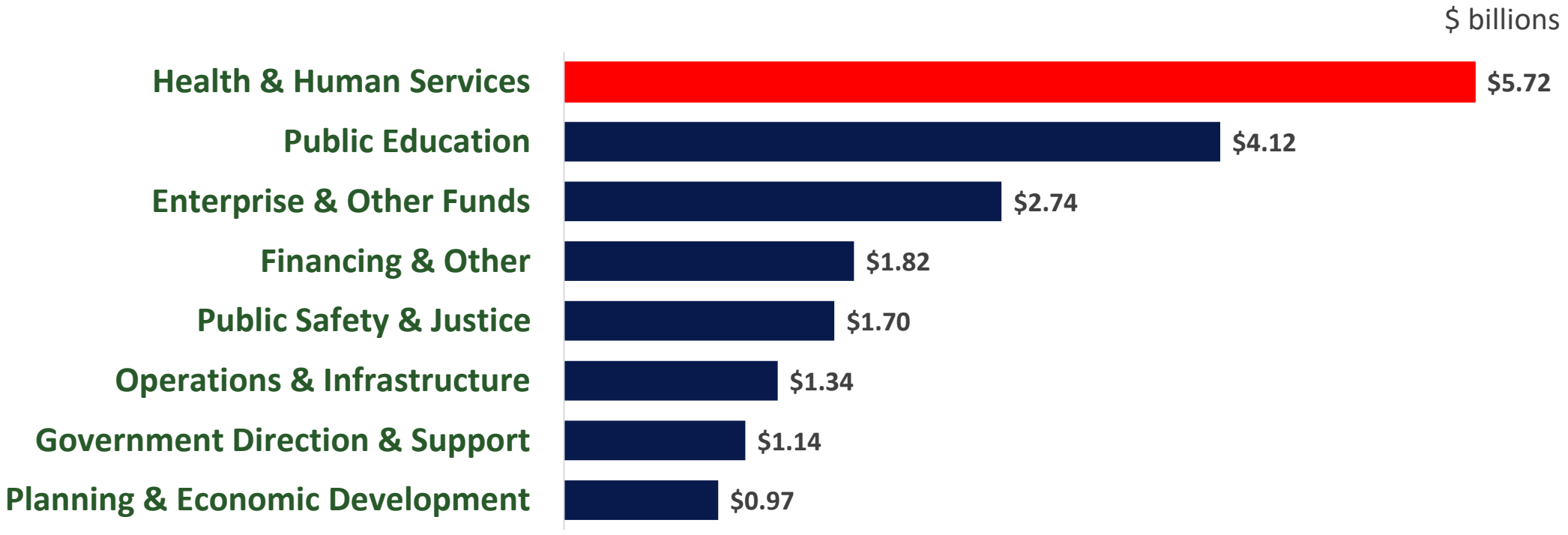
- **$12 billion** general funds budget
- **$10.7 billion** Local Funds budget
- Local Funds increase of **$1.3 billion** or 14% over FY 2022 Approved Budget
  - ❖ This growth includes significant **one-time investments**, such as $409 million for HPTF
  - ❖ Growth is **~6%** when one-time investments are excluded

Key Investments

- ➢ Schools
- ➢ Affordable Housing
- ➢ Health and Human Support Services, and
- ➢ Facilities Maintenance, plus Debt Service to support planned capital investments

Health And Human Services Account For Largest Portion Of Mayor Bowser's FY 2023 Budget

Proposed FY2023 Operating Budget



Total $19.55 Billion

Presentation Outline

- ☐ Rebounding Economy and General Budget Overview
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DMHHS Office Has $2.86 Million Budget To Support 15 Staff Who Perform A Range Of Key Oversight And Programmatic Activities

Key functions of the office:

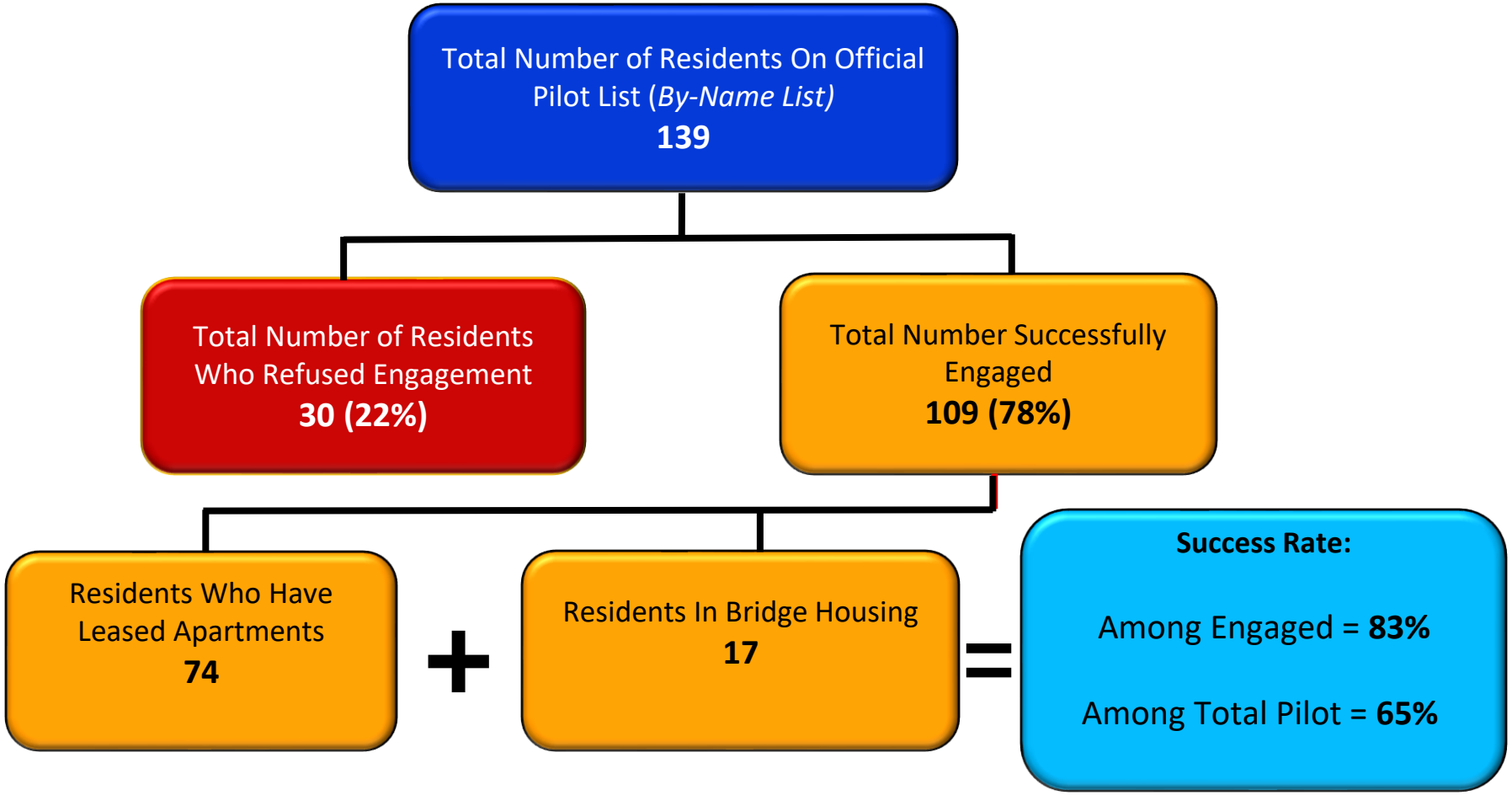
- Coordinate the work of interagency teams including Short-term Family Housing programs, Opioid Crisis, Commission on Health Care Systems Transformation, and the Coordinating Council on School Behavioral Health
- **Lead coordination of Encampment Response and Implement CARE Pilot**
- Provide oversight of interagency crisis response, including the COVID-19 response and recovery along with pressing issue of elevated opioid overdoses across the city
- **Facilitate our internally-directed programs – The Interagency Council on Homelessness, Encampment Protocol Engagements, and Age-Friendly DC**
- Partner with agencies to promote policy, legislative, and budget changes

Executing A Response To Encampments Is A Major Aspect Of Our Work

DMHHS leads Encampment Response and Engagement and Implements CARE Pilot.

- The Encampment Team conducts welfare checks and provides services to over 280 encampment sites in the District
- Mayor Bowser's CARE Pilot Program is a "Housing First" model for persons living in encampments. The goal is to establish permanent housing as the platform from which all other needs of those experiencing homelessness can be addressed.
  - Cross agency coordination with DBH, DPW, DHS, and the federal government through NPS along with CBOs (Pathways to Housing and Miriam's Kitchen).
  - **FY22 Budget of $3.9M**
  - **$4.2M** for **DHS** for expanded outreach, housing subsidies, staffing costs, and client costs which will assist in continuing services provided through the CARE pilot'
  - Coordinate with National Park Service which is planning to close several encampment sites
  - Report to Mayor this Spring with recommendations for next steps

Outcomes To Date Support Plans For Citywide Program



Key Investments Designed To Make DC an Easier Place to Grow Older

The Mayor's FY23 budget continues to invest in the District's older adults. It includes:

- **$500K** for free dental services
- **$2.6M** towards greater community connection and wellness through technology by distributing personal tablets
  - Approximately **1000** wireless enabled iPads in FY23. **500** distributed in FY21
- **$1M** to continue expanding city-wide mobility via the ***Connector Card Program***
- **$750K** towards a new ***grocery gift card*** pilot program

Presentation Outline

- ☐ Rebounding Economy and General Budget Overview
- ☐ Funding and Functions of Office of Deputy Mayor for Health and Human Services
- ☑ **DHCF and Important Medicaid and Alliance Program Trends**
- ☐ Key Budget Proposals For DHCF
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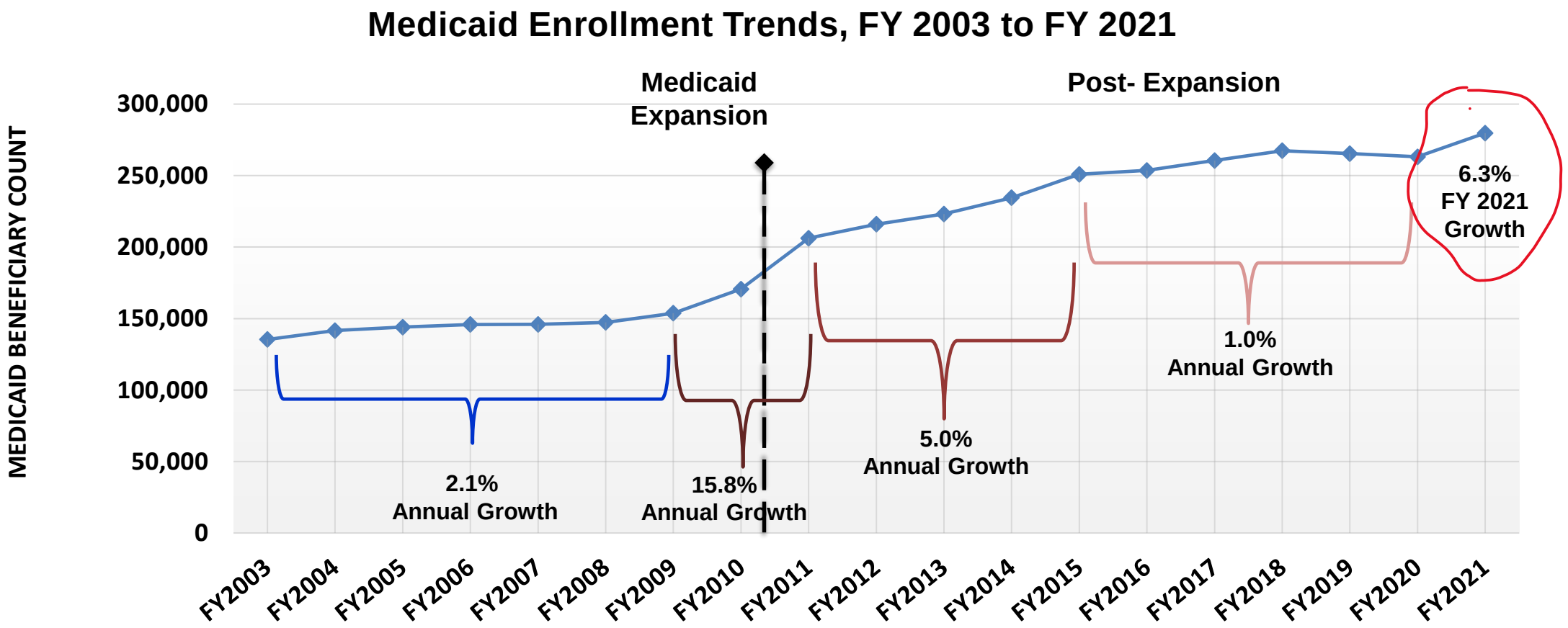
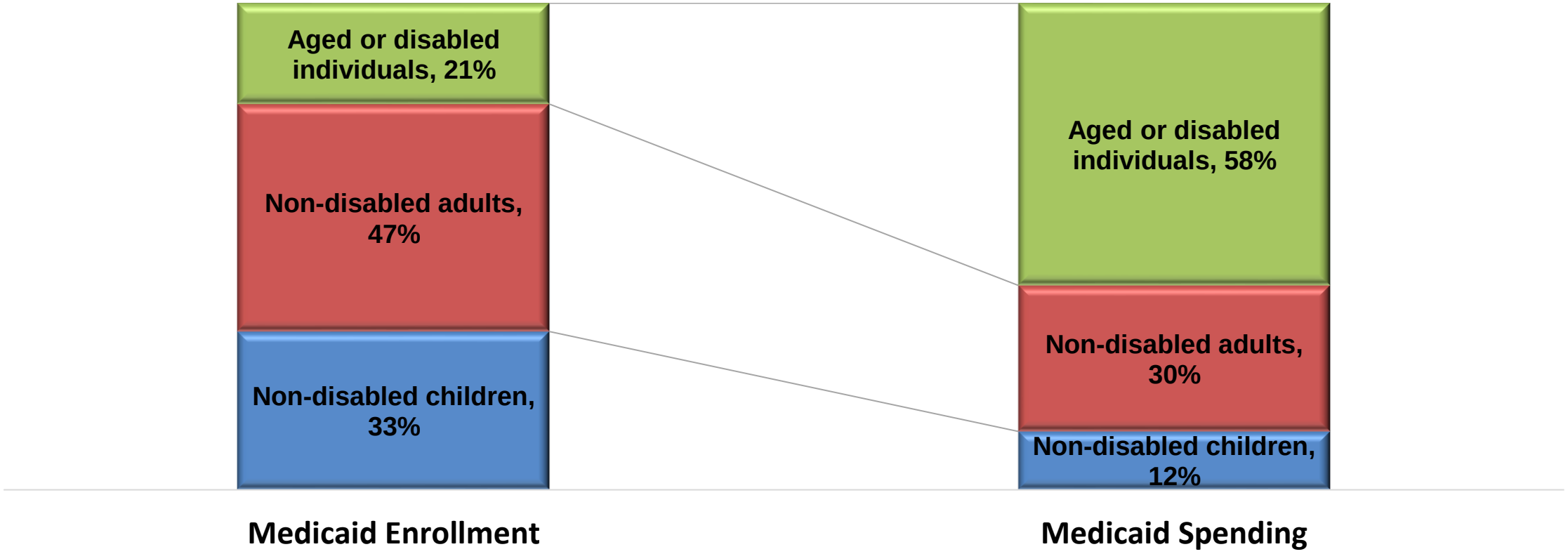
Medicaid Enrollment Spiked During The Pandemic



Source: Data for FYs 2000-2009 extracted by Xerox from tape back-ups in January 2010. Data for FYs 2010-2020 from DHCF's Medicaid Management Information System as of March 2022. Figures are average monthly.

Aged and Disabled Beneficiaries Account for About 20 Percent of Enrollment, But Nearly 60 Percent of Spending

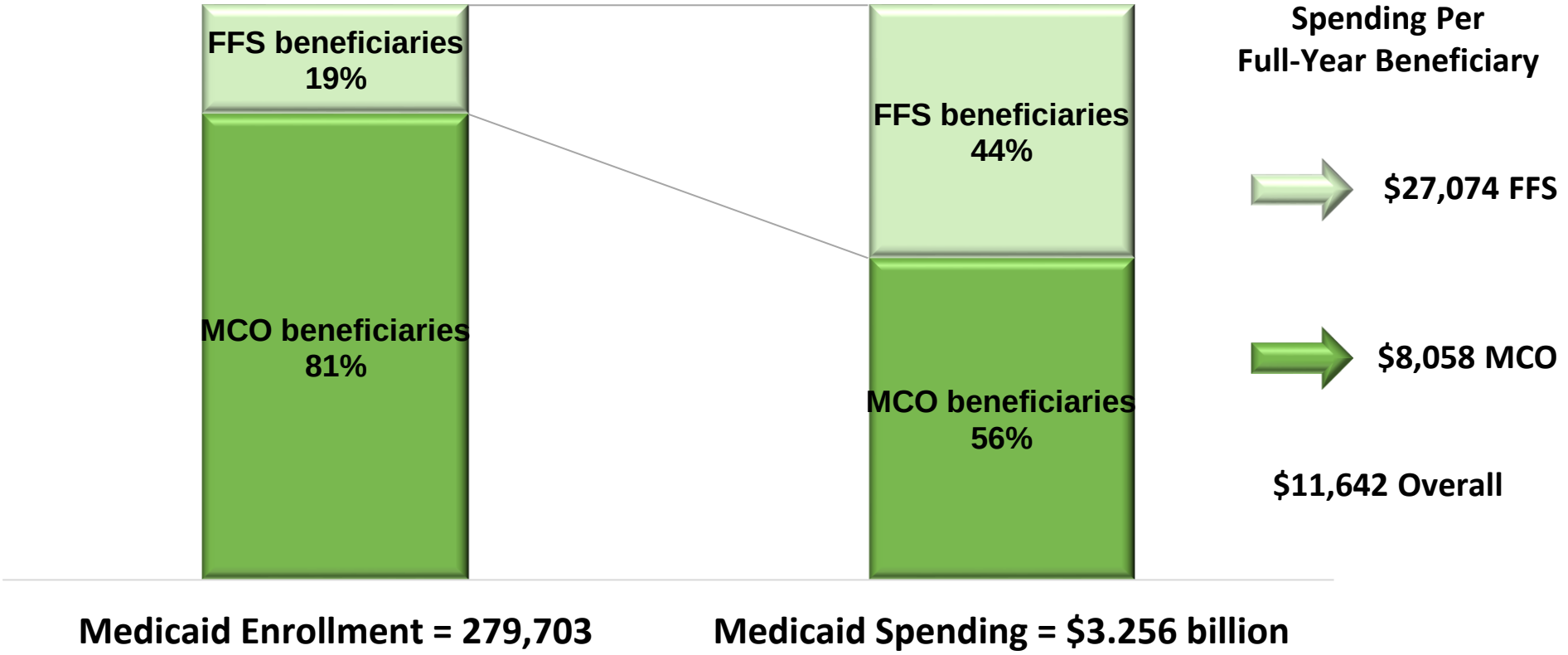
Medicaid Enrollment and Spending by Eligibility Group, FY 2021



Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for eligibility in FY 2021 and claims with dates of service in FY 2021.
Note: Reflects eligibility group at the time of payment. Disabled includes individuals eligible for long-term services and supports an institutional level of care. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

Most Beneficiaries Are In Managed Care But Spending Is Disproportionately Greater For Those Remaining In Fee-For-Service

Medicaid Enrollment and Spending by Service Delivery Type, FY 2021



Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for eligibility in FY 2021 and claims with dates of service in FY 2021.

Note: Enrollment reflects average monthly and spending per full-year beneficiary reflects the average cost over 12 months. Spending reflects DHCF payments for both capitation and any fee-for-service utilization. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

The Reason – A Lower Incidence of Chronic Disease in Managed Care Compared to FFS

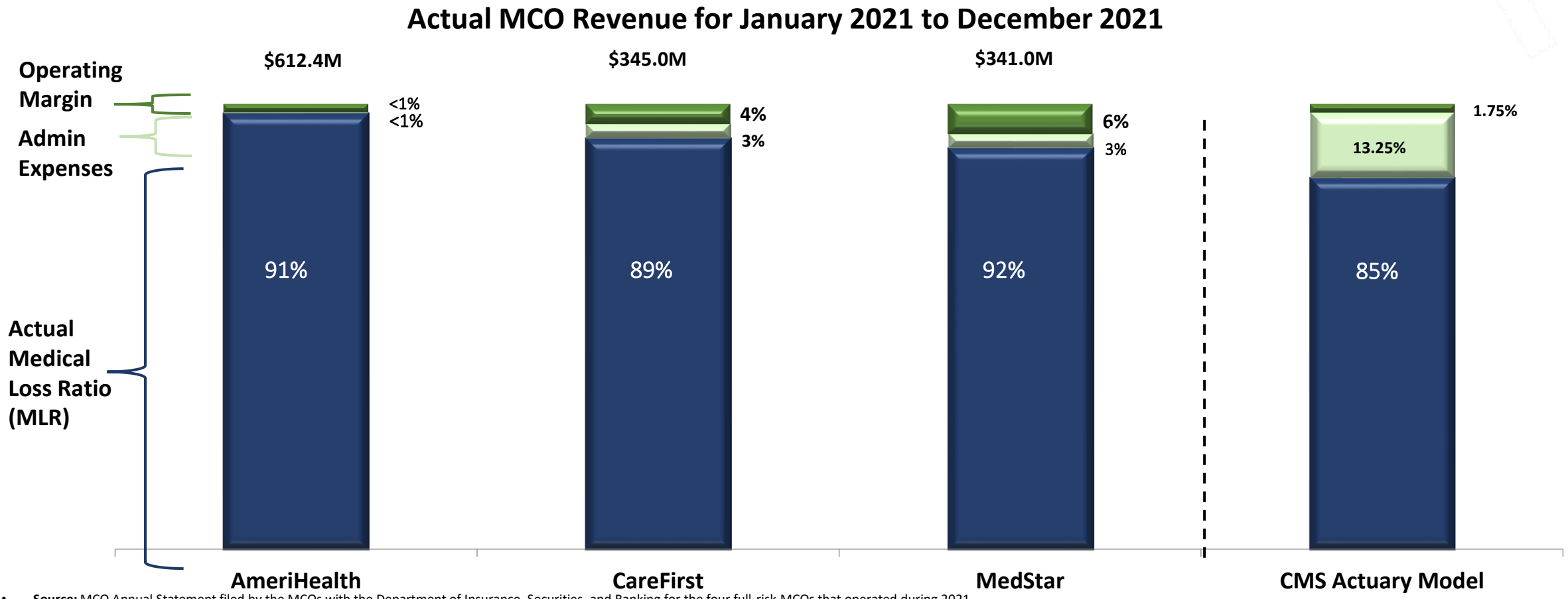
Medicaid FFS Population

- **FFS Medicaid-enrolled adults were most likely to have the following chronic conditions**:
  - Hypertension (48%)
  - Diabetes (27%)
  - Hyperlipidemia (27%)
  - Rheumatoid Arthritis/Osteoarthritis (19%)
  - Chronic Kidney Disease (18%)
- **FFS Medicaid-enrolled children were less likely than adults to have a chronic condition and were more likely to have different conditions affecting them:**
  - Asthma (8%)
  - Depression (3%)
  - Anemia (2%)

Medicaid Managed Care Population

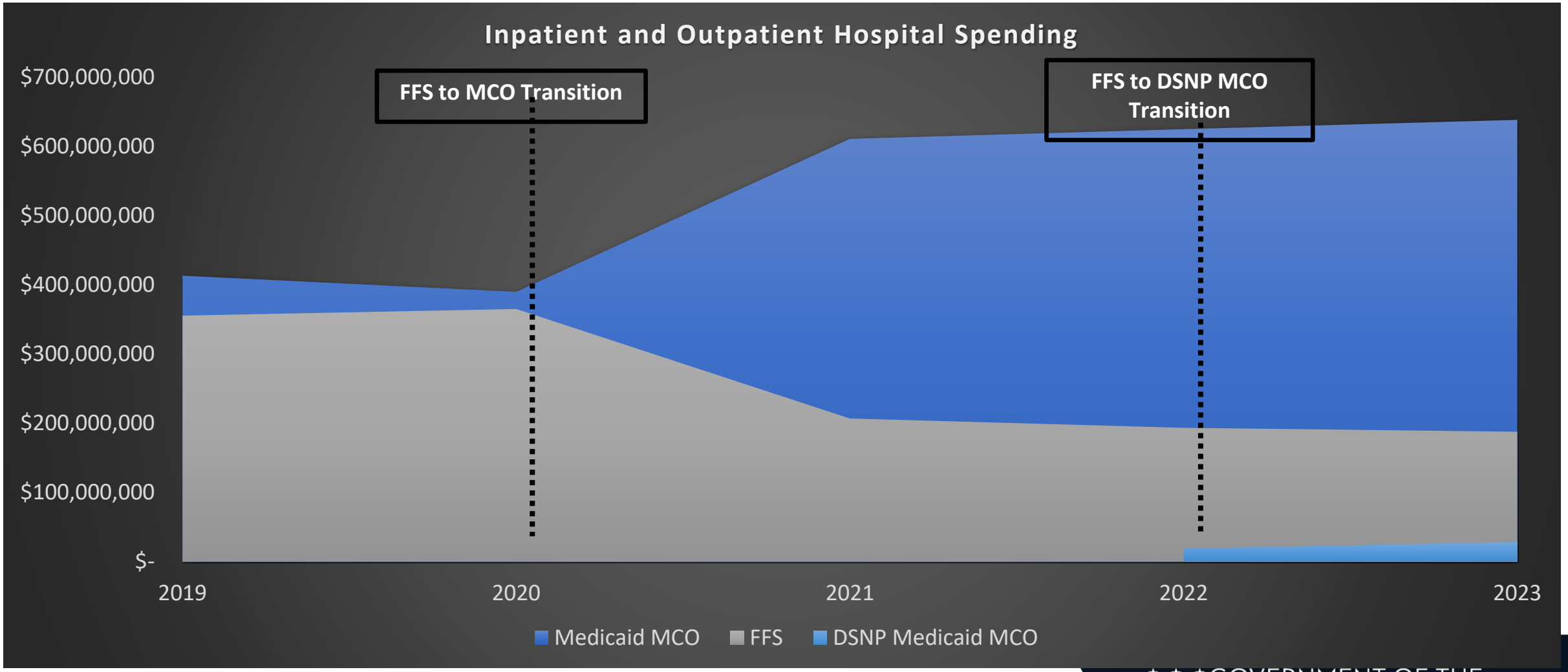
- **MCO Medicaid-enrolled adults were most likely to have the following chronic conditions:**
  - Hypertension (19%)
  - Hyperlipidemia (11%)
  - Depression (9%)
  - Diabetes (9%)
  - Asthma (9%)
- **MCO Medicaid-enrolled children were less likely than adults to have a chronic condition and were more likely to have different conditions affecting them:**
  - Asthma (10%)
  - Depression (3%)
  - Anemia (2%)

The Unquestioned Value Of Universal Contracting In The Managed Care Program



- **Source:** MCO Annual Statement filed by the MCOs with the Department of Insurance, Securities, and Banking for the four full-risk MCOs that operated during 2021
- **Note:** MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings and self reported quarterly filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes as reported in MLR report/calculation provided by the MCOs. MLR numerator is medical expenses – i.e., total annual incurred claims (including incurred but not reported (IBNR)) and cost containment expenses as of December 31, 2021, net of reinsurance recoveries. DHCF requires through its managed care contracts that all full-risk MCOs maintain a minimum MLR of 85%. *MCO reported reserve estimates included in DISB filings impact reported medical expenses and MLR amounts, and actual claims expense may differ from estimated reserves.

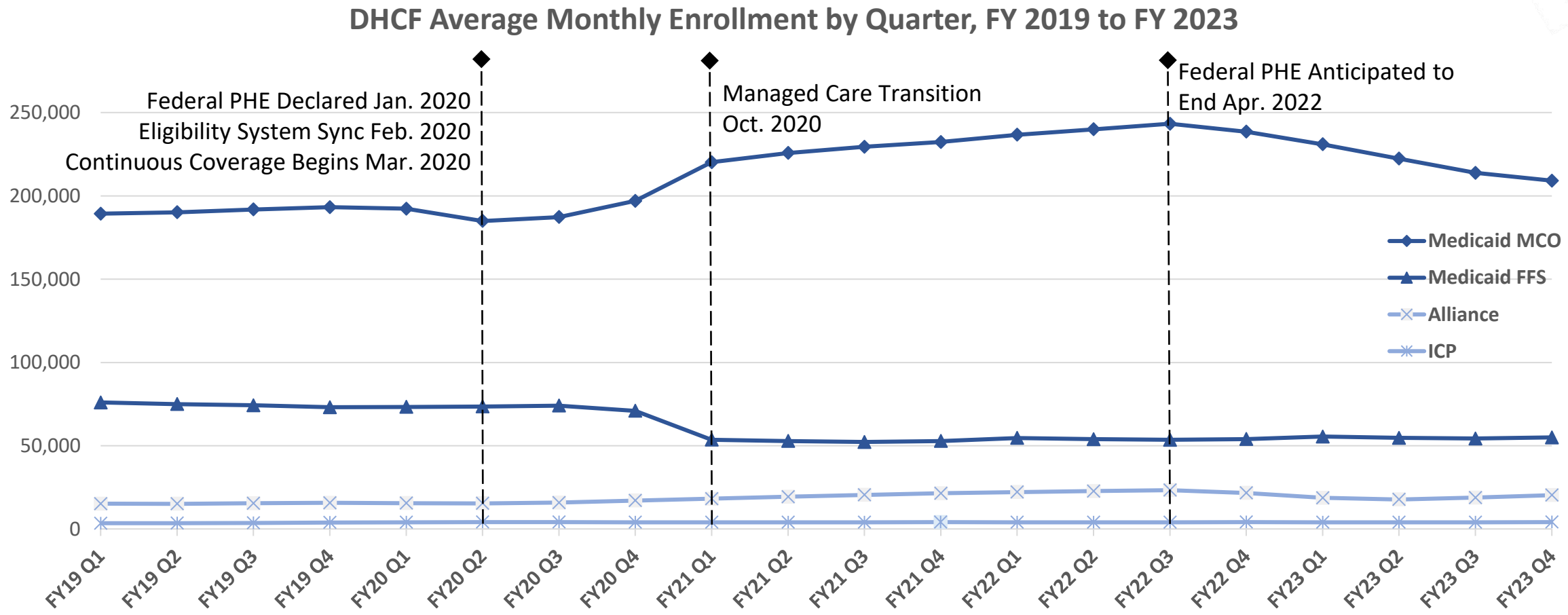
As the District Moves Toward More Coordinated Care For Medicaid And Alliance Beneficiaries, More Hospital Costs are Captured Under Managed Care



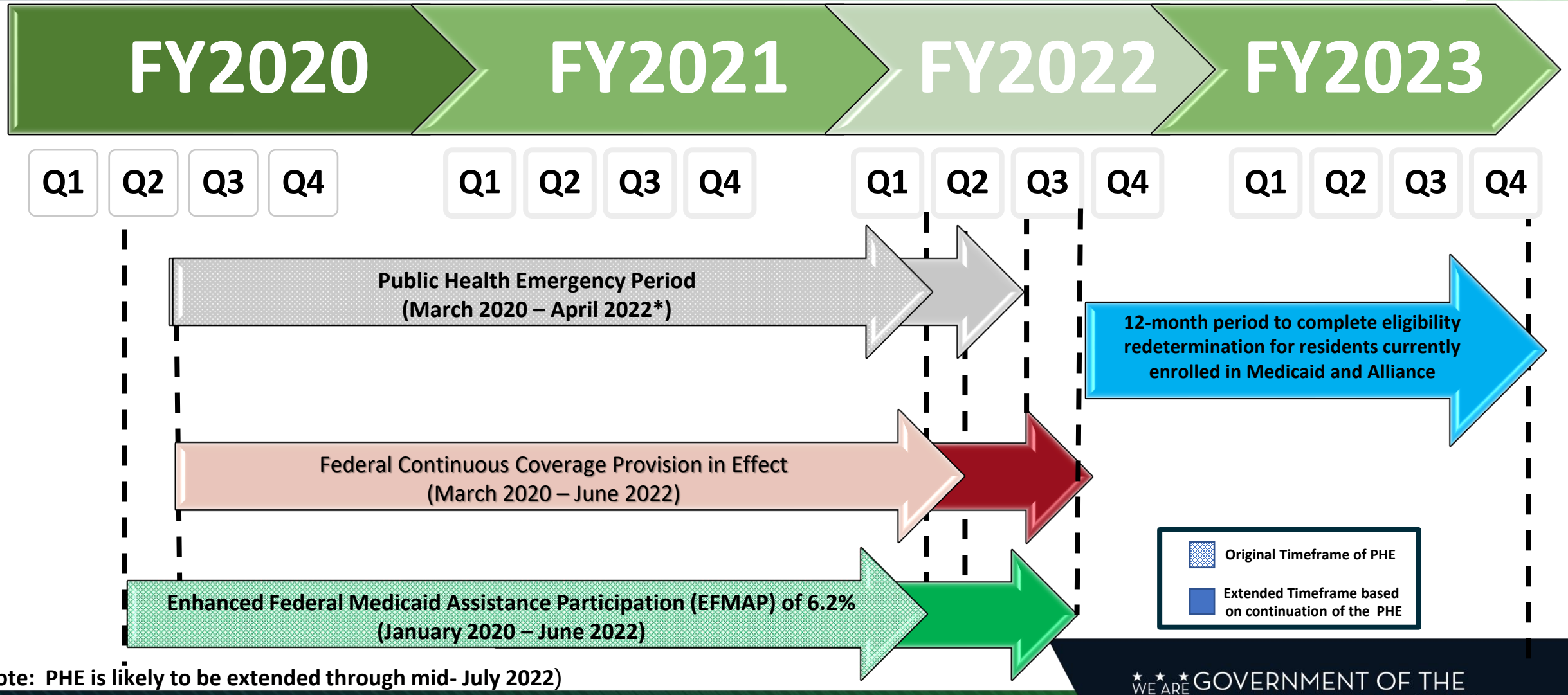
Presentation Outline

- ☐ Rebounding Economy and General Budget Overview
- ☐ Funding and Functions of Office of Deputy Mayor for Health and Human Services
- ☐ DHCF and Important Medicaid and Alliance Program Trends
- ☑ **Key Budget Proposals For DHCF**
- ☐ Status of New Hospital

Enrollment Projections – The Foundation For DHCF's FY2023 Budget Proposal – Are Especially Challenging During the Public Health Emergency



The Full Resumption Of Medicaid and Alliance Eligibility Will Not Be Complete Until 12 Months Following The End Of The Public Health Emergency



Note: PHE is likely to be extended through mid- July 2022)

How DHCF's Local Funds Budget Reached More Than $927 Million

In millions

FY22 Recurring Budget	**814,646,705**
Adjustments Made During MARC Formulation	52,826,742
2% Reduction	(16,480,565)
FY2023 Revised Baseline	**850,992,882**
Budget Adjustments:	
Restoration of Agency Budget Reductions to Meet MARC	37,773,425
Additional Vacancy Savings	(930,581)
Total Restored of Proposed Budget Savings Initiatives	**36,842,844**
Mayor's Enhancements:	39,343,141
Final FY2023 Local DHCF Budget	**927,178,867**

DHCF's Budget Details As Proposed For FY2023

In millions

Local- $927.7M*

Budget Adjustments: $81.3M

($1.4M): 9.2% in Vacancy Savings

(3.9M): Efficiencies in maximizing participation

$48.8M: Restore local funding due to the end of the enhanced federal match available in FY22, Fund Postpartum Bill, elimination of face-to-face recertification for Alliance and other changes

$37.8M Restoration of budget adjustments to meet the agency MARC

Enhancements $39.3M:

$490k: One Time funding for Cedar Hill Medical Center planning support including a PMO and training for potential hospital staff

$26.7M: One Time funding to support increase in utilization related to the continued extension of the PHE and continued coverage

$4.2M: Support cost associated with extending the recertification process for Alliance beneficiaries from 6-months to 12-months

Continuation of ARPA Funding $480K

$480k to support non-emergency transportation cost for Alliance beneficiaries to attend medical visits

*** Local budget is $927.1M plus Revenue replacement ARPA funds $480k Totals $927.7**

Federal Payments- $2M

Continuation of District ARPA Funding:

$1.5M to support Practice Transformation to ensure an adequate provider network exists to support whole person care by establishing value-based care systems

$500k to support Produce Rx initiatives that give health care providers nutritional tools to better manage and coordinate care for Medicaid residents with chronic illnesses

Dedicated Taxes- $105M

Continuation of support for Provider Payments, Administrative cost and Quality. Budget based on anticipated revenue collection

$17.7M 0110- Nursing Home Quality of Care Fund

$66.9M 0111- Healthy DC Fund (MCO)

$6.5M 0112- Stevie Sellow's Fund (ICF)

$8.5M 0114- Hospital Assessment Tax (Inpatient)

$5.5M 0115- Hospital Provider Fee (Outpatient)

O Type Revenue- $5.6M

Continuation of support for Provider Payments and Administrative cost. Budget based on anticipated revenue collection

$2.5M 0631- Third Party Liability- Medicaid Collections

$2.5M 0632- Health Care Bill of Rights

$600K 0635- Indiv. Insurance Mkt Affordable and Stability*

* New fund that will support navigation and assistance to qualified District residents to complete the application process to maintain health care coverage

DHCF Will Utilize HCBS ARPA Funds To Support Providers In Paying Direct Support Professionals An Average of 117.6% of Living Wage/Minimum Wage By FY2025

In response to the recent workforce shortage in Direct Support Professional (DSP) Workforce, DHCF will use HCBS ARPA funding in FY2023 and March 2024 and the District will support with local funds for fiscal years forward.

Mayor's Proposal

- Support HCBS providers, through the Medicaid rate; the ability to pay DSP's a wage above the living and minimum wages (whichever is greater). The current proposal aligns the concept of the original Bill (B23-214) to pay DSP's an average of 117.6% of LW or MW but expands it to cover the following DSP's: PCA's, Participant Direct Care Workers (PDW's in Services My Way an EPD Waiver service), DD DSP's, Certified Addiction Counselors (in MHRS- Mental Health Rehab Services and ASARS- Adult Substance Abuse Residential Services) that provide services to Medicaid participants in home and community-based settings. Providers will determine the rates they pay their DSP workers; however, they are required to pay an average of 117.6% of the LW/MW.
- This concept establishes a career ladder and promotes longevity by offering a range of pay from living wage (entry level) to $4 more for a tenured DSP

How Will Funds Be Allocated?

- DHCF will allot funds in FY2023 and FY2024 in a lump sum allotment to each Provider based on DSP data provide- due October 1st including Schedule of DSP's, salaries, date of hire and vacancy rate
- The allotment will be issued in December and the requirement for Providers to pay qualifying DSP's new rate will be aligned with regular living wage adjustments on January 1st
- DHCF will complete a reconciliation at the end of the period to determine the increase in DSP wages over the year and the impact it had on the vacancy rate
- In FY2025, DHCF will amend the State Plan and Waivers to increase the rate methodology for the respective provider to support the impact of achieving the average of 117.6% for the DSP workforce

What Will the Allotment Cover?

- The increase will cover the cost of paying an average of 117.6% of living/minimum wage (whichever is greater)
- Fringe
- Administrative rate

Example: The example assumes that living wage continues to increase annually

	Living Wage	Mid Level	Higher Level
FY2023	$16.10	$18.93	$22.37
FY2024	$16.45	$19.35	$23.20
FY2025	$16.82	$19.78	$24.05

The Mandatory And Optional Benefits Funded in The Mayor's FY2023 Budget Are Comprehensive And Extensive

Mandatory Service Benefits

- Inpatient hospital services
- Outpatient hospital svcs. (incl. Emergency Room)
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Service Benefits

- Prescription Drugs
- Clinic services
- Physical therapy and Occupational therapy
- Speech, hearing and language disorder services
- Other diagnostic, screening, preventive and rehab. svcs
- Podiatry svcs, Optometry svcs & Other practitioner svcs
- Dental Services and Dentures
- Prosthetics, Eyeglasses
- Private duty nursing services
- Personal Care
- Hospice
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Intermediate care facility for Individuals with IDD
- Adult Day Health Program
- Inpatient psychiatric services for individuals under age 21
- Health Homes Programs

For Several Reasons, Proposed FY2023 Provider Payments Vary Significantly From Those Approved In The FY2022 Budget

Provider Payment Category	FY2021 Expenditures	FY2022 Approved Budget	FY2023 Proposed Budget*	YoY Variance		Variance Explanation
Hospital	253,726,006	191,495,044	220,699,190	29,204,146	15%	Alignment with anticipated utilization post pandemic in Inpatient and a decrease in DSH as a result of the cahnges in DSH requirements
Hospital Support Funding	9,900,000	8,000,000	8,000,000	-	0%	
ICF/IID	98,625,562	109,758,823	92,556,719	(17,202,104)	-16%	Based on anticipated enrollment (XXX), FY23 includes funding to pay increased DSP wages for FY21 and FY23 does not include enhanced rate but assumes rebasing
Skilled Nursing Facility	303,898,273	280,101,143	286,081,727	5,980,584	2%	
Primary Care (Physicians, Clinics and FQHC)	96,373,867	99,627,598	69,156,102	(30,471,496)	-31%	Assumes end of enhanced rates and "normal" utilization for FFS population post transition
Other (Medicare Part A, B, etc)	123,232,012	136,125,533	154,916,714	18,791,182	14%	
DME	15,289,893	18,155,075	24,990,621	6,835,546	38%	Includes assumptions in utilization and updates in Fee Schedule adjustments
Behavioral Health (Inc. BH Waiver)	152,854,816	165,838,412	158,235,140	(7,603,273)	-5%	
Skilled Care	25,941,841	20,449,326	29,432,902	8,983,576	44%	Alignment of Nursing Rates including inflation
LTCS (incl PCA and PACE)	181,910,430	166,808,814	87,793,560	(79,015,254)	-47%	Assumes end of enhanced rates for PCA and ADHP, and a full year of PACE
DSNP	-	-	123,215,268	123,215,268		
EPD Waiver	170,957,106	203,578,632	210,349,699	6,771,068	3%	
DD Waiver	308,558,556	294,924,043	313,866,978	18,942,935	6%	
IFS Waiver	1,548	4,114,601	5,975,703	1,861,102	45%	Assumes increase in enrollment in the waiver
Emergency Medicaid	30,027,240	34,995,382	31,855,709	(3,139,673)	-9%	
MCO	1,598,723,474	1,475,732,863	1,516,854,052	41,121,188	3%	
Permanent Supportive Housing	-	10,667,822	70,575,546	59,907,724	562%	FY23 assumes a full year of implementation and increased enrollment
Total	**3,370,020,624**	**3,220,373,110**	**3,404,555,630**	**184,182,519**		
Note: FY23 Budget includes funds interagency funding that supports the provider payment category						

FY2021
- Full Year of PHE
- Enhanced Provider Rates
- First Year of FFS Transition

FY2022
- 1 Qtr. of PHE Enhanced Provider Rates

FY2023
- Post Enhanced Rates
- Return to Regular Provider Rates
- New Utilization Trends
- Adjusted Enrollment

* Transition Population represents the FFS Populations that shifted to MCO in FY21 (including SSI adults and Beneficiaries eligible for MCO but opted out).

DHCF is Collaborating with DBH On A Comprehensive Review of DC's Medicaid Behavioral Health Provider Reimbursement Rates

Goal: to establish rate methodologies that will support the behavioral health provider network's ability to achieve the goals and expectations set forth by DBH and ensure qualifying District residents have access to quality behavioral health care.

Milestones: DHCF's contractor has completed a cost survey of District BH providers and has begun analyzing survey and claims data. Work will be completed in phases to allow for simultaneous District review and feedback.

Timeline: The contractor will finalize its recommendations by September 30, 2022. Implementation of new rates is scheduled for October 1, 2023.

- Define BH Service Delivery and Expectation
- Conduct Research, Administer Provider Survey and Analyze Claims Data
- Review Findings and Receive Feedback from Stakeholders
- Establish Recommendations for New Rate Methodologies/Structures and Updates

Presentation Outline

- ☐ Rebounding Economy and General Budget Overview
- ☐ Funding and Functions of Office of Deputy Mayor for Health and Human Services
- ☐ DHCF and Important Medicaid and Alliance Program Trends
- ☐ Key Budget Proposals For DHCF
- ☑ **Status of New Hospital**

Cedar Hill Regional Medical Center GW Health

Committee on Health – FY23 Budget Update, March 28, 2022

Status Update March 2022

https://newhospitals.dc.gov/

CEDAR HILL
REGIONAL MEDICAL CENTER

GW HEALTH | WASHINGTON, DC

UHS

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DC MURIEL BOWSER, MAYOR

GW Medical Faculty Associates

Children's National

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

WE ARE WASHINGTON GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

Mayor's Budget Includes $15 Million Allocation For Increased Cost For The New Hospital in Ward 8

- Hospital construction cost have increased due to three factors –

  1. The hospital was designed and budgeted for before COVID-19, in late 2019. The partners incorporated lessons learned during COVID into the design – for example the use of 100% outdoor air HVAC systems.
  2. Inflation, global and national supply chain shortages, and market conditions have increased the cost of non-residential construction and new health construction by 12% from October 2020 to 2021 – with no expected end in sight.
  3. The hospital partners made a strategic decision to build a larger diagnostic and treatment area to accommodate future growth and potential health emergencies.

- Universal Health Services will contribute $5.5 million to assist with the additional costs associated with the larger diagnostic and treatment center, part of their $75M investment in agreement with the District.

- Workforce training and project management funds are also included in the budget.

  - $250,000 for the District to establish voluntary training courses for any United Medical Center staff who are interested in working at the new hospital and need to upskill or reskill to meet the new hospital's hiring requirements. This is a requirement of the Council passed legislation and associated agreements.
  - $240,000 to support the project's overall implementation, specifically these funds would be used for a 3rd party construction project manager to be overseen by DHCF.

Work on the new hospital has begun…

- Removal of former 801 East Men's Shelter
- Removal of former steam tunnels

CEDAR HILL
REGIONAL MEDICAL CENTER

GW HEALTH | WASHINGTON, DC

UHS

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MURIEL BOWSER, MAYOR

GW Medical Faculty Associates

Children's National

FY 2023 PROPOSED B

Cedar Hill Memorial Health Center Will Be A Full-Service Community Hospital with Verified Trauma Center

- 136 inpatient beds (can expand to 196 in the future)
- Verified Trauma Center
- ICU, Surgery and Operating Rooms
- Newborn Delivery and Women's Services w/ Level II Neonatal Intensive Care Unit
- Behavioral Health
- Adult and Children's Emergency Department
- The solar panels on the garage will provide energy assistance to over 200 households in the adjacent community.
- The hospital must comply with the District's CBE, First Source and Project Labor Agreement Requirements.
- Staffed by the George Washington Medical Faculty Associates, George Washington School of Medicine and Health Sciences and by Children's National
- Helipad if FAA Approves

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GOVERNMENT OF THE
DISTRICT OF COLUMBIA

MURIEL BOWSER, MAYOR

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

A Fair Shot

ATTACHMENT 4

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
WITNESS LIST – FY23 BUDGET OVERSIGHT HEARING
1350 PENNSYLVANIA AVE., N.W., WASHINGTON, D.C. 20004

COUNCILMEMBER VINCENT C. GRAY, CHAIRPERSON
THE COMMITTEE ON HEALTH

FY23 BUDGET OVERSIGHT HEARING ON

NOT-FOR-PROFIT HOSPITAL CORPORATION AND UNITED MEDICAL CENTER BOARD OF DIRECTORS

THE DEPARTMENT OF HEALTH CARE FINANCE

AND

THE OFFICE OF THE DEPUTY MAYOR FOR HEALTH AND HUMAN SERVICES

MONDAY, MARCH 28, 2022, 10:00 A.M.
REMOTE HEARING VIA WEBEX
STREAMED LIVE ON YOUTUBE AT TINYURL.COM/FISCAL23

WITNESS LIST

Not-for-Profit Hospital Corporation and UMC Board of Directors

Panel 1 – Public Witnesses

1. Wala Blegay — Staff Attorney, DC Nurses Association (DCNA)
2. Roberta LeNior, RN — President UMC-DCNA

Panel 2 - Executive Witnesses

3. Angell Jacobs — Chair, United Medical Center Board of Directors
4. Marcela Maamari — Interim CEO, United Medical Center

The Department of Health Care Finance

Panel 3 - Public Witnesses

5. Caroline Kenney	Managing Director of Public-Private Ventures, Urban Atlantic
6. Mary Procter	Public Witness
7. Tamara Smith	President and CEO, DC Primary Care Association
8. Luisa Furstenberg-Beckman, MPH	Produce Prescription Program Manager, DC Greens

Panel 4

9. Claudia Schlosberg	Chair, Workforce Development Subcommittee, DC Coalition on Long Term Care
10. Ian M. Paregol	DC Coalition of Disability Service Providers
11. Judith Levy	Coordinator, DC Coalition on Long Term Care
12. Claudia Balog	Lead Researcher, 1199SEIU United Healthcare Workers East - Maryland/DC Region

Panel 5

13. Mark LeVota	Executive Director, District of Columbia Behavioral Health Association
14. Damon King	Director of Policy Advocacy, Legal Aid Society of the District of Columbia
15. Mandar Bodas	Research Scientist at the Fitzhugh Mullan Institute for Health Workforce Equity, The George Washington University Milken Institute School of Public Health
16. Selene Lara	Community Health Worker, La Clínica del Pueblo

Panel 6

17. Mark C. Miller	State Ombudsman, Office of the D.C. Long-Term Care Ombudsman

18. Mary Cabriele	Director of Workforce Programs, Academy of Hope Adult PCS
19. Veronica Sharpe, MHSA	President, District of Columbia Health Care Association
20. Susan Hargreaves	Administrator, The Lisner-Louise-Dickson-Hurt Home; DCHCA Board Member
21. Samaria Washington	Director of Regional Operations, BridgePoint Healthcare

Panel 7

22. Rob Downing	Carding Group, LLC; Downing & Company
23. Kate Coventry	Senior Policy Analyst, DC Fiscal Policy Institute

The Office of the Deputy Mayor for Health and Human Services

Panel 8 - Public Witnesses

24. Kate Coventry	Senior Policy Analyst, DC Fiscal Policy Institute
25. Jesse Rabinowitz, MSW, LGSW	Senior Manager of Policy and Advocacy, Miriam's Kitchen

Panel 9 - Executive Witness

26. Wayne Turnage	Director, Department of Health Care Finance Deputy Mayor for Health and Human Services, Office of the Deputy Mayor for Health and Human Services

Caroline Kenney
Managing Director of Public-Private Ventures
Urban Atlantic

Testimony Before the
Council of the District of Columbia Committee on Health (COH)
March 28, 2022

Thank you, Councilmember Gray, and members of The Committee on Health for this opportunity to testify at today's budget hearing.

My name is Caroline Kenney. I am Managing Director of Public-Private Ventures for Urban Atlantic, a local firm that develops and invests in commercial real estate projects that serve as catalysts for vibrant, inclusive neighborhood development. Since 1998, we have developed nearly 10,000 resident units, with a focus on mixed-income housing.

Today, I am speaking as a representative of Abrams Hall Assisted Living, also known as "Building 14 North," an affordable seniors assisted living community within the Parks at Walter Reed. The Parks is one of the District's largest new master planned communities, a 3.1 million square foot mixed-use, mixed-income public-private partnership with the District at the historic Walter Reed Army Medical campus in Ward 4.

Overlooking The Parks' Great Lawn, today Abrams Hall provides housing for 77 low-income veterans and 80 low-income seniors. This summer, Urban Atlantic and our partners Housing Up and Triden Development Company will open the northern portion of the building – Abrams Hall Assisted Living – providing both housing and assisted living services for 54 low-income seniors. The project is financed by DHCD and DCHA and we are working closely with multiple District agencies including DHCD, DCHA, DHS and DACL to connect seniors experiencing homelessness to the new community.

Leveraging the District's innovative EPD waiver program, and working closely with DOH and DHCF, Abrams Hall Assisted Living will serve seniors who could not otherwise afford to live in an assisted living facility and who historically were likely to be housed in nursing homes or hospitals, both inappropriate for the seniors and at a high cost to the District. We are one of the first affordable housing communities to utilize the EPD waiver at scale.

I am here today to voice support for maintaining the increase in the EPD Reimbursement Rate that was passed in March 2020 as a response to the COVID-19 pandemic. While we know that the intention of the increase was to cover a temporary spike in costs, now in year three of the pandemic, these cost impacts are anticipated to endure beyond the public health emergency.

Here are 3 concrete examples:

1. Labor Costs: Between 2020 and 2022, labor costs have increased industry wide. Our service provider – Grand Senior Living – has increased Licensed Nurse Aid wages by 20%.
2. Personal Protective Equipment: The cost of obtaining PPE has increased. All direct care workers are required to use proper PPE especially when caring for a vulnerable population. We don't foresee any drop in demand for these materials.

3. Insurance Costs: Few insurance liability policies are being written without a COVID-19 rider, which adds 10 to 20% to already very expensive insurance rates.

Based on these and similar increases, our overall costs to provide assisted living services at Abrams Hall Assisted Living have increased approximately 15 to 20% over pre-pandemic budgets. At the current increased rates, we can maintain the integrity and original intent of our program, which is to address the needs of this vulnerable District population and at costs below other inappropriate, higher care environments.

We strongly recommend that this Committee keep the enhanced rates in place. Thank you for considering our recommendation.

Testimony before the Committee on Health
Oversight of the Department of Health Care Finance Budget

March 28, 2022

Mary Procter
Capitol Hill Village
Advocacy Team

Good Afternoon, Chairman Gray and members of the Committee on Health. My name is Mary Procter and I am a co-leader of the Capitol Hill Village Advocacy Team.

In the next panel you will hear from four impressive witnesses from the Long Term Care Coalition subcommittee on the direct care workforce shortage. There are over 50 members of this Coalition subcommittee including three of us from the Capitol Hill Village

I am here to tell you how disappointed we are that the Mayor's budget has failed to use abundant Federal grants and ample DC revenues to fix the problem of ominous shortages of direct care health workers that are critical to good functioning of the entire health system. Home health workers and aides to disabled adults ensure that these people do not end up in hospitals and nursing homes because there is no one to take care of them. Certified nursing assistants are critical to care for patients so that physicians and registered nurses can pay attention to their medical issues.

We are concerned that Medicaid reimbursements that dominate the wage range for home health aides are so low that the whole job category has a reputation for poor pay. We are told by the private pay agencies that employ home health aides for the many senior village members who wish to age in their homes, that these agencies **cannot find home health aides from DC to employ. These jobs pay too little to allow home health aides to live in high-cost DC.**

We are most disappointed that the work of the Coalition to put the pieces together for a robust apprenticeship program in DC is not viable with direct care worker wages as low as they now are. Health care organizations including affordable assisted living and adult day centers are eager to

participate in an apprenticeship program with increasing skills and responsibility, along with increasing wages.

There is one hitch. Many sources of training funding will not consider funding a program to train workers that are not earning at least 120% of minimum wage. Right now **the living wage** that is supposed to be paid in Medicaid reimbursements to direct care workers is **exactly the same as the minimum wage.** Witnesses in Panel 4 will tell you that ten years ago the living wage was significantly higher than the minimum wage.

The ARPA (American Rescue Plan Act) funding from the Federal government gives the DC government funding to raise the wages for direct care workers. Witnesses in Panel 4 will talk about the details to make this a lasting improvement beyond FY 23 and 24.

Unfortunately, in the Mayor's Budget, ARPA money is being used to grant signing and retention bonuses to "solve" the direct care workforce shortage. Witnesses later in this hearing will testify from their own experience that **bonuses don't work to attract more workers.** This is wasted money that does not get at the real cause of the difficulty in hiring direct care workers—**the pay is too low for a difficult job with expense for certification, significant responsibility and significant risk of injury,**

There are also workforce shortages in other states, but health and budget officials are thinking ahead and using ARPA funds to raise wages to a level that will attract and retain workers. You will hear about these states from SEIU's Claudia Balog on Panel 4.

Our Ask. Designate the funding in ARPA to increase direct care worker pay by using the funds for bonuses.

Thank you for allowing me to testify on this critical and disturbing issue.

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

To: The Honorable Vincent Gray, Chair, DC Council Committee on Health
Members of the Committee on Health
From: Tamara Smith, President and CEO, DC Primary Care Association
Re: Budget Oversight Hearing for DC Department of Health Care Finance
Date: March 28, 2022

The DC Primary Care Association (DCPCA) works to build a healthier DC by sustaining community health centers, transforming DC care delivery, and advancing racial and health equity. Our strategic focus areas include:

- Value-based reimbursement
- HIT innovation for health centers
- Cross-continuum stakeholder relationships
- Equity-oriented programs and innovations
- Health center infrastructure and operations

Our collaborators in this work include community health centers, serving almost 1 in 4 District residents in every ward of the city; District government agencies including the Department of Health Care Finance (DHCF), DC Department of Behavioral Health and DC Health; as well as other providers in the DC health ecosystem. Thank you for the opportunity to provide testimony regarding the FY23 budget of the District of Columbia Department of Health Care Finance (DHCF.)

As health centers deal with continued uncertainty related to the COVID pandemic and associated volatility in staffing, the role of DHCF in the stability of the District's health care system is ever more important. DCPCA remains grateful for our partnership with DHCF to establish a fee-for-service per member per month rate methodology that continues to provide critical ballast for the Federally Qualified Health Centers (FQHCs.) As we near the expected end to the Public Health Emergency (PHE) that allowed such payment flexibilities, DCPCA is focused on ensuring that the DHCF budget will adequately cover FQHCs' "new-normal" costs. Those include significantly higher staffing, technology, and infection control expenses.

DCPCA shares DHCF's concern about access to care, both in regard to Medicaid beneficiaries reporting delays in needed services, and in measures of preventative care that have yet to fully rebound to pre-pandemic levels. Staffing challenges across all levels of the system contribute to these issues. In addition to our primary focus on health centers, we support increases for all direct support workers, and for behavioral health providers in dire need of sustainability. DCPCA welcomes cross-system efforts to insure pathways to advancement for those entering health careers.

DCPCA particularly thanks the Mayor and the Deputy Mayor for funding the transition to 12-month recertification for the Alliance program. Along with our partners in safety net health and the Council Committee on Health, DCPCA has long sought to achieve this parity for Alliance beneficiaries. Especially as DHCF prepares to initiate re-enrollments that have been paused during the PHE, this change will minimize disruption for Alliance enrollees. DCPCA and our member health centers looks forward to partnership with DHCF to ensure that District residents maintain health insurance even as the continuous coverage protections under the PHE sunset. With the expectation of new managed care contracts to begin in October 2022, DCPCA is paying close attention to impacts on beneficiaries, and impacts on FQHC payments. For beneficiaries, we urge the path of most stability, minimizing changes not specifically requested by enrollees.

DCPCA also applauds DHCF's commitment to improve maternal health outcomes in the District by funding postpartum coverage for a full 12 months, resourcing non-emergency transportation for Alliance beneficiaries, and by working to include doula services as a Medicaid benefit. DC Network for Expectant and Parenting Teens DC NEXT!,) an innovation network facilitated by DCPCA in conjunction with Howard University and Children's National, is testing a postpartum doula intervention for teen parents, and we look forward to bringing our findings to DHCF in the months ahead.

DHCF's investment in the business transformation health care providers must achieve in order to participate and thrive in value-based contracting is most welcome. Our health centers are eager to enhance their financial, operational, and clinical practices to improve health outcomes, enhance patient-centeredness, and achieve cost-savings. Additionally, we celebrate the ground-breaking investment in Cedar Hill Regional Medical Center GW Health and look forward to presenting recommendations to DHCF and GW for vertical integrations that will make a difference in the well-being of District residents East of the River.

Mayor Bowser's efforts to end chronic homelessness and invest in housing affordability highlight the importance of meeting critical social needs with significant impact on health and well-being. DCPCA has long known that housing *is* health care. We look forward to partnership with DHCF to build a health system that holds itself accountable for individual and community well-being. We seek further opportunity to work across sectors through DHCF's Community Resource Information Exchange (CoRIE) project to address social drivers of health and give every District resident a fair shot at a full health life.

Testimony of Claudia Schlosberg, Castle Hill Consulting, LLC
Chair, DC Coalition for Long-Term Care
Workforce Development Subcommittee
before the
Committee on Health
Regarding the FY 23 Proposed Budget
or the
Department of Health Care Finance

March 28, 2022

Thank you, Chairman Gray and members of the Committee on Health for the opportunity to testify regarding Mayor Bowser's proposed FY 23 budget for the Department of Health Care Finance. I am the Founder of Castle Hill Consulting and the Chair of the DC Coalition on Long Term Care Coalition's Workforce Development Subcommittee.

For at least the past 18 months, our Coalition has engaged with the Department of Health Care Finance to raise awareness of the critical shortage of workers to provide direct care to a growing population of older adults and people with disabilities and to work collaboratively toward solutions. Long-term Care providers across the spectrum of both institutional and home and community-based service providers are struggling to recruit and retain sufficient workers to meet current needs. And the shortage will only get worse as the demand for services increases. According to the District's Workforce Incentive Council, the District will need over three thousand Certified Nursing Assistants (CNAs) and Home Health Aides (HHAs) every year for the next 7 years.[1] Yet, interest in pursuing the training and certifications needed for these critical entry level health sector jobs is waning and retention of incumbent workers is falling, because the current labor market in DC offers many more opportunities for jobs that require little or no training, less stress and responsibility and pay significantly more.

In late summer, at your request, DHCF convened a work group of provider representatives (of which I participated) to develop proposals to address this crisis. At the outset, DHCF acknowledged that the workforce shortage affected all sectors and all direct care professionals including Certified Nursing Assistants, Personal Care Aides, and Direct Support Professionals. There was also agreement that proposed solutions had to promote parity across all provider types to avoid creating imbalances that could favor one sector while exacerbating workforce

[1] *See* 2015-2018 jobs and wage data from the Bureau of Labor Statistic Occupational Employment Statistics. Projections and annual openings are from the DC Department of Employment Services, DC WIOA Unified State Plan, July 2020 – June 2024, p. 261-262, available at: https://dcworks.dc.gov/sites/default/files/dc/sites/dcworks/publication/attachments/DC-WIOA-Unified-State-Plan-2020.pdf

shortages in another. We consistently informed DHCF that one time recruitment and retention bonus payments not only will not resolve the workforce shortage but based upon employer experience, such bonuses could increase turnover rates. Rather, we urged DHCF and the Mayor to $88 million in available federal ARPA dollars to fund a meaningful increase in wages for all direct care workers across the LTSS spectrum. Using the funding to increase wages could generate additional federal match. But more importantly, the ARPA funding represents an unprecedented opportunity to raise the wages of direct care professionals that would rectify historic discrimination and underpayment of these workers and establish a foundation for the implementation of effective workforce development strategies – strategies that would ensure that District residents, especially those living East of the River, had a fair shot of participating in and benefitting from the fastest growing sector of our economy – health care-- and to ensure that seniors and people with disabilities could be assured of getting the care they need. Based upon a comparison of wages in other sectors and the cost of living in the District, we determined that a meaningful increase would be to raise wage rates to $22/hour.

While we appreciate the work that the Department has done and especially want to recognize the efforts of Angelique Martin, Deputy Mayor for Finance, unfortunately, we believe the Mayor's proposed budget falls short of the mark.

First, contrary to the shared goals we agreed to last summer, the proposed wage increase does not apply across the spectrum of direct care professionals. Rather, Certified Nursing Assistants (CNAs) are excluded from the definition of direct support professional and are ineligible for the proposed wage increase. There is no rational basis for treating CNAs differently than other direct care professionals. The training, certification standards and scope of work for Home Health Aides and CNAs are nearly identify. CNAs also work in a variety of home and community-based setting including Assisted Living Residences and Adult Day Health Centers. CNAs also work for home care agencies and care for clients in their own private homes.[2] By excluding CNA's, DHCF is creating the very imbalance that we warned could make workforce shortages worse if certain sectors were favored over others.

Second, the Mayor's proposal wage increase is simply too little and too late, will be very burdensome to administer and difficult to monitor for compliance. As described by DHCF, the proposal is to pay certain providers a supplemental payment that is sufficient to pay direct care professionals a wage, that on average, is equal to at least 117.6% of the District minimum wage or the District living wage, whichever is greater, by Fiscal Year 2025. This means some workers must still be paid an entry level wage that is effectively the greater of the minimum or living

[2] On August 23, 2019, Chapter 96 (Certified Nursing Assistants) of Title 17 of the DCMR (Chapter 96) became effective. The definition of a Certified Nursing Assistant under this chapter is "nursing assistive personnel who are certified to assist with the delivery of direct nursing care to patients, and work under the supervision of a nurse or other health professional." According to this definition, as well as the relevant provisions in this chapter, CNAs are not restricted to working only in a nursing facility.

wage, or $15.50/hour. While more experienced workers could receive more, the entry level salaries (in today's dollars) would still be $1.50 less than what Panda Gourmet is advertising for counter help, $3.50 less than what Amazon is offering entry-level warehouse workers and $5.50/hour less than what banks are offering new tellers. (Notably, to qualify for job training grants, the District's own Workforce Investment Council requires employers to pay at least 120% of the minimum or living wage for newly trained employees).[3] Not only is the contemplated wage increase too little, it is not fully effective for another 2.5 years. It is simply unrealistic to think that new workers will be attracted to entry level positions in health care that pay less than retail starting salaries or that incumbent workers will wait another 2.5 years to ultimately make less than a warehouse worker at Amazon.

Finally, DHCF is rolling back the enhanced provider payment rates that were put in place during the Public Health Emergency effective September 30, 2022. According to Deputy Mayor Turnage, "the budget assumes a return to the normal, pre-pandemic rate structure." For providers, however, there is no return to a "pre-pandemic normal." Instead, across the entire long-term care spectrum, providers have experienced significant increases in costs for labor, energy, supplies, insurance, etc. Inflation alone last year hit a 40 year high of 7.9 percent and forecasters predict that the war in Ukraine, coupled with ongoing supply chain constraints, strong demand, and labor shortages will keep inflation elevated for longer. Yet, beginning October 1, 2022, Medicaid Assisted Living Providers, in addition to being ineligible for the proposed rate increase to improve wages of direct care staff, will need to absorb a 15% reduction in their per diem rate beginning October 1, 2022. Other providers that will experience rate reductions include Home Health Care providers and IDD waiver providers. These rate reductions, without regard to providers costs, will put further financial pressure on providers, many of whom are already struggling to meet their costs based upon the rates paid today.

The Mayor's budget makes significant capital investments in infrastructure and amenities for District residents including recreational facilities and a luxury dog park. We believe these

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[3] The Request for Applications for 2022 Employer Partnership Training Grants issued by the DC Workforce Investment Council on December 10, 2021 states that**: "It is expected that all Training Participants will earn at least 120% of minimum wage upon successful completion of training.** Applicants may request consideration of Projects that do not meet this requirement but must submit evidence regarding why this wage threshold cannot be met, how investment in these skills and occupations support continued opportunities for worker career or wage advancement, and any additional information regarding non-wage benefits, supports or economic mobility opportunities available to Training Participants." The goal is that 80% of trainee's will be making at least $120% of the minimum wage. Available at:
https://dcworks.dc.gov/sites/default/files/dc/sites/dcworks/page_content/attachments/2021%20Employer%20Partnership%20Grant_RFA_FINAL.pdf,
In the recently released RFA for IT and Health Sector Training Grants, the DC Workforce Investment Council is requiring that: "At least 50% of Training Participants that successfully complete training will be placed in unsubsidized jobs at or above 120% of DC's current minimum wage level of $15.20 or $18.24 per hour and are retained for at least six months after being hired." Available at:
https://dcworks.dc.gov/sites/default/files/dc/sites/dcworks/page_content/attachments/IT%20and%20Healthcare%20Sector%20Training%20Grant_Final_3.22.pdf

investments reflect misplaced priorities and urge the Council to redirect funding to ensure that all direct care professionals receive a meaningful increase in wages, providers are paid their costs and that the care needs of seniors and people with disabilities are met.

Thank you for the opportunity to submit this testimony. I am happy to answer any questions.

DC Council - Committee on Health
FY23 Budget Hearing - Department of Health Care Finance
& Deputy Mayor for Health & Human Services
March 28, 2022

Good morning, Chairman Gray, and members of the Health Committee. My name is Ian Paregol, and I serve as the Executive Director of the DC Coalition of Disability Service Providers. The DC Coalition represents 50+ provider agencies, supporting over 2,000 persons with intellectual and developmental disabilities and employing over 4,700 staff, most of whom are residents of the District of Columbia. Member organizations provide residential, day, employment, in-home and other waiver services as well as Intermediate Care Facility ("ICF") supports to residents of the District with intellectual and developmental disabilities ("IDD").

The District's human service system is underwater. Overtime is crippling the industry. Average vacancies exceed 20% in the intellectual and developmental disability ("IDD") world with some providers reporting 38% in DSP vacancies. And a life raft - thrown in FY25 - is not going to save them.

Who will be the workforce for these jobs: the direct support workers, direct support professionals, home health aides, and personal care assistants? All of these front-line workers are dedicated, hard-working, severely under-funded (and thus, under-paid) staff who require extensive training (much of it also unfunded). This workforce is entrusted with the care and support of our loved ones while under immense pressure, risking personal and professional exposure every time they cover a shift. This is not a minimum wage job… but sadly, that is how these workers are funded by DHCF in the District.

Today, you will hear the governmental witnesses state that the Mayor's budget includes an allocation of $11.5M for FY23 - sometime between October and December 2022 - which will be infused into the industry, and that money is supposed to be used by service providers to calculate what can be paid for the remainder of the fiscal year. However, those monies will, on average, amount to about a 6% DSP wage increase above the $16.10/hr Living Wage that will be in effect at the beginning of the fiscal year. That yields an average wage of $17.05/hr. Mr. Chairman, that is a mighty long way from the 17.6% (and $18.93/hr) that the law requires - and has required since 2020 - for DSPs. The human service providers have waited three (3) years to address a crisis that existed well before COVID-19 decimated the industry with illnesses, death, and resignations. And yet, the District's remedy is 1/3 of the amount of the unanimously supported legislation authorized by this body.

Providers cannot fill their skyrocketing vacancy gap with the $17.80/hr that they are being allocated as a result of enhanced rates from the public health emergency. One of our very large provider-members is currently paying in excess of $18/hr to recruit new, untrained DSPs and not only is that not working, it is causing the longer tenured DSPs and supervisors to resign because of the inequity in their wages. This is the death spiral for an entire industry.

I am sure this body is well-versed in the *Bowser v Evans* litigation which concluded in 2017. The systematic inattention to an entire industry when the warning lights are flashing and countless persons within the advocacy community have publicly voiced the grave concerns about service sustainability will result in future litigation if the administration does not address this crisis with proper funding for services.

How is a reduction to an averaged hourly rate of $17.05/hr in January 2023 going to solve this crisis? The Public Health Emergency is going to end. And by DHCF's own budget submission, the enhanced funding rate for direct support wages will revert to the Living Wage of $16.10/hr on October 1, 2022. How is this limited amount of funding going to change the trajectory of this work exodus and provide a "Fair Shot" for not only the low income, historically marginalized, largely immigrant DC resident workforce, but also our elderly, vulnerable citizens who require a highly skilled, trained, and present workforce?

DHCF's plan is to allocate about $11.5M in FY 23, another $23M in FY24 and another $35M in FY25 from the ARPA monies. This money is accessible now! Why is the District suggesting this phased-in approach? There will be another excuse in FY24 and FY25 as why DSPs cannot escape from the poverty cycle. We will hear: "revenues are down," "unexpected miscalculations," "we just cannot afford it." When will human service be a priority for the administration?

This workforce has already waited three (3) years. It is unconscionable to think that they will wait another three (3) just to get to the pre-COVID funding need of 117.6% of the Living Wage. For years, the Coalition warned that there would be a direct care workforce crisis, and now - in conjunction with the public health crisis - we need action from the Mayor to raise the District's funding of wages of these workers to $22/hour… not in FY25, but in this budget cycle.

Further Analysis

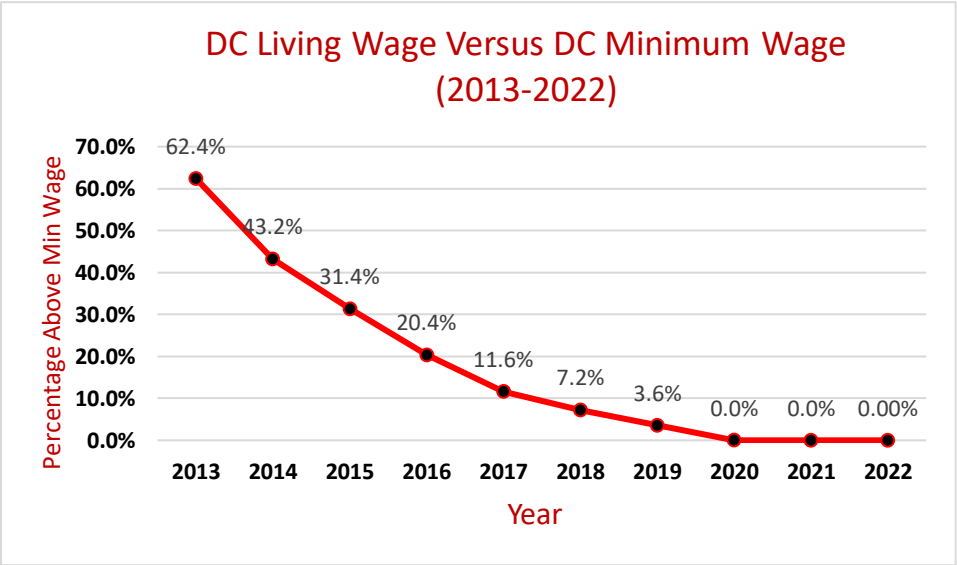
The Direct Support Professional Rate Payment Act of 2019 ("DSP Wage Act") legislation was unanimously supported by the Council when it was passed in February 2020. The DSP Wage Act provided, in part, that the District would adjust the funding formula for provider rates to account for a continuing budgetary allocation of a 117.6% factor[1] above the DC Living Wage for all rate models under the District's Medicaid Home and Community-Based Services ("HCBS") Waiver for Persons with Intellectual and Developmental Disabilities program ("Waiver") and the Intermediate Care Facilities for Individuals with Intellectual Disabilities program ("ICF").[2]

A major factor that is contributing to this crisis is the District's provider funding structure which uses the DC Living Wage rate to fund the wages for direct care workers. Unlike the private sector where wage rates are set and have risen with the marketplace, wages for direct care workers are largely driven by Medicaid reimbursement rates as Medicaid is the largest payor for long-term care services and supports.

[1] This 117.6% factor would be added to not only the wage elements of DHCF's funding models, but also the additional fringe components that are impacted and correspond to direct support worker wage funding, including but not limited to: payroll taxes, insurance, FICA, worker's compensation rates, etc.

[2] Pursuant to this legislation, Developmental Disability ("DD") service providers were authorized to pay individual direct support professionals more or less than 117.6% of the District Living Wage if that service provider created a tiered compensation schedule that considers the direct support professional's qualified experience in the field and their demonstrated competency and resulted in an average provider pay rate of at least 117.6% of the Living Wage. From a practical perspective, DHCF would adjust funding rates consistent with the expectations noted above and provide a budget that yields, on average, an increase of 117.6% of the DC Living Wage to all impacted wage-based elements and the provider would create its own market-based pay structure that resulted in redistributing the entirety of the increase to the class of direct support professionals defined in the legislation.

When setting provider payment rates for long-term care services and supports, the Department of Health Care Finance (DHCF) calculates wages using the District's Living Wage. In 2013, the DC Living Wage at $13.40/hour was 62% higher than the DC Minimum Wage of $8.25/hour. As of this January, the DC Living Wage increased to $15.50/hour only 30 cents an hour more than the DC Minimum Wage and effective July, 2022, the Living Wage and minimum wage will once again be exactly the same. This extraordinary reduction in the value of the Living Wage is graphically presented below.



With wage rates at or close to the District's minimum wage, current workers are leaving their jobs for higher pay and less demanding work. For example, jobs for Community Health Workers (who do not need to take Board of Nursing approved training program or pass a certification exam) are being advertised for $26.12/hour. Bank teller positions are paying $21 an hour; Amazon warehouse workers start at $19 an hour. Even dog walkers are being paid at over $18/hour.

As a result of the COVID health emergency and the minimum wage funding that currently serves as the basis of DSP wages, recruitment of staff is more difficult than it has ever been. Given the lack of meaningful FY21 and FY22 funding designated for implementation, we are now **well behind** the recruitment needs for the industry.

Recommendations

Beginning of FY23 – 10/1/22 – the District must shift resources to DHCF funding 117.6% of the projected Living Wage as a starting point **and then include an add-on to the increased wage funding factor to include ARPA monies** which project to be unused for FY23 and the first six (6) months of FY24 so that the averaged front-line worker's wage reaches the $22/hr target. It should be noted that the Living Wage would likely increase again on January 1, 2023 and then again on July 1, 2023, so the funding rate should be readjusted to reflect both of those increases or again the industry will lose ground.

In order to reach these targets, the DC Coalition has requested that the District consider the **reallocation of ARPA resources** which remain either unspent (or unlikely to be spent) and that those undeveloped funds be braided into any prospective wage factor as a means to increases wages as well. Thus, the

Coalition encourages DHCF to convene a meeting which describes the planned use of the existing ARPA funds and addresses comments from the community on possible reallocations.

The ARPA funds that DHCF secured last Fall are the lifeline for a properly-funded Medicaid waiver-funded services program in the District, but the window in which they may be spent closes in 25 months (March 31, 2024). The DC Coalition maintains that the best use of the ARPA funding remains shifting all possible allocations to the direct care/ direct support workforce by way of an immediate meaningful funding increase targeting front-line wages.

Moving forward, we anticipate that future rate setting based upon the audited wage expenses of the targeted programs would justify the continuing need to maintain a proper economic incentive so as to lessen the likelihood of a future District-wide human services industry crisis.

The heightened rate of COVID-19 incidence among the provider workforce speaks for itself. The industry is now saddled with **a minimum wage job** where a **prospective direct support applicant is more likely to contract COVID-19 than in virtually any other industry** coupled with a continually ticking clock of **attrition**. Based upon the workforce exodus that human service providers experienced and documented to DMHHS even before the PHE - and now, the continuing lack of direct support applicants because there is **no economic advantage whatsoever to accepting a demanding and COVID-exposure heightened role of working as a DSP** – the DC Government should not be surprised that a service crisis now exists.

We are calling for action from the Mayor to raise the District's funding of wages of these workers **PLUS** we urge the use of any and all funding available under the District's ARPA Plan so that the workforce can receive an averaged hourly wage rate of at least $22/hour.

And if not the Mayor, **we need the DC Council to recognize the need to address this crisis** and **allocate the resources necessary to stabilize these industries** and/or **redirect existing budget preferences** toward the funding for direct support workers, direct support professionals, home health aides, and personal care assistants.

On behalf of the DC Coalition of Disability Service Providers, I thank you for the opportunity to provide this testimony.

Respectfully submitted,

Ian Paregol,
Executive Director, DC Coalition of Disability Service Providers

2022Before the District of Columbia City Council
Committee on Health and Human Services
Budget Oversight Hearing for FY23
Chairperson Vincent Gray
March 28, 2022
Presented by Judith Levy, MHSA, BSN, RN
Coordinator
District of Columbia Coalition on Long Term Care

Good-Morning Council member Gray. My name is Judith Levy Coordinator of the District of Columbia Long Term Care Coalition.

The DC Coalition on Long Term Care has worked with the DC government for over 25 years to develop and implement home and community care options for low-income DC residents with chronic care needs. Its consumers, advocates and health care providers have assisted in the development and implementation of expanded Medicaid home care, the regulations of assisted living residences and home care agencies and the improvement of the workforce essential to these programs. To improve and expand the health care workforce, the Coalition has concentrated on increasing wages, health care benefits, training and monitoring. For at least the last five years we have focused on workforce issues our of concern that direct care workers the backbone of our system are ignored. Prior to that we worked to pass the Living Wage Legislation and support passage and implementation of the Nurse Assistant Personnel Regulations. These were finally published in 2019 after 10 years of negotiations and edits.

Covid-19 has only made the severe shortages of direct care workers worse. It is undermining the ability of providers to care for our growing population of seniors and people with disabilities. We are now at a crisis point. In some sectors, staff vacancy rates are already exceeding 18%. The shortage of staff, which has been exacerbated by COVID-19, is leaving your most vulnerable constituents without adequate care, adding additional pressures to families and to an already overburdened health care system. It has taken family members out of the DC workforce to provide care.

It appears now that passage of the living wage legislation was not the answer to recruitment and retention of direct care workers. A major factor of this crisis is the District's provider funding structure, which uses the DC Living Wage rate to fund the wages for direct care workers. Unlike the private sector, where wage rates can rise with the marketplace, wages for direct care workers are largely driven by Medicaid reimbursement rates because Medicaid is the largest payor for long-term care services and supports. When setting provider payment rates for long-term care services and supports, the Department of Health Care Finance (DHCF) calculates wages using the District's Living Wage. As of this January, the DC Living Wage has increased to $15.50/hour – only 30 cents an hour more than the DC Minimum Wage, and effective July, 2022, the Living Wage and minimum wage will once again be exactly the same at $16.10. This extraordinary reduction in the value of the Living Wage is graphically presented below.

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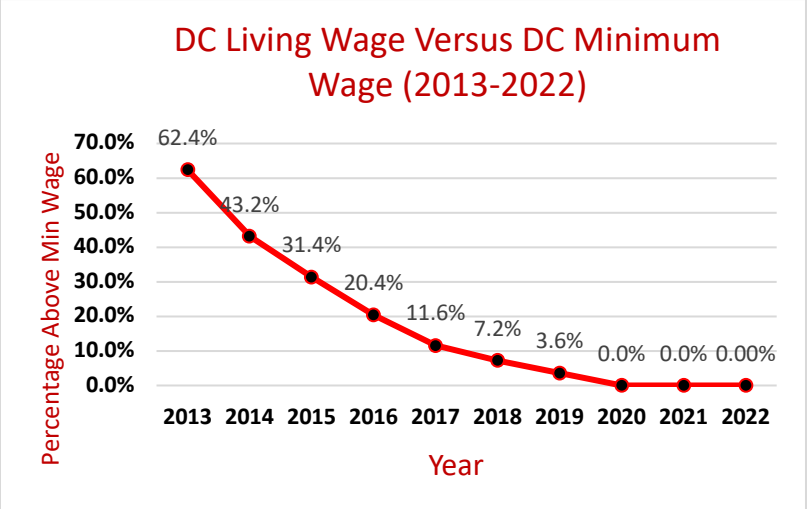

With wage rates at or close to the District's minimum wage, current workers are leaving their jobs for higher pay and less demanding work. For example, jobs for Community Health Workers (who do not need to take Board of Nursing approved training program or pass a certification exam) are being advertised for $26.12/hour. Bank teller positions are paying $21 an hour; Amazon warehouse workers start at $19 an hour, and dog walkers are being paid over $18/hour.

Current increase

Sadly, the other issue is that these jobs are not given the recognition in importance to the community as well as possible steps in further employment in the health care sector. Providers are unable to recruit millennials. Another major challenge faced by providers is retention. Direct Care staff are leaving their jobs because they can get higher wages (with less training and skill) in other service sectors. We must provide for progressive wage/salary increases for CNAs, HHAs and DSPs that advance their education and attain higher level certifications such as dementia care specialist and the Medication Aide Certification (MA-C), or we will continue to see high rates attrition. Progressive wage/salary increases are also keys to building career pathways that allow these workers to attain economic stability and upward mobility for themselves and their families.

Commendably, DHCF has recognized that its payment rates to providers for wages are no longer adequate or competitive and that they must be raised equitably across all providers. DHCF has listened to our concerns and has engaged in constructive dialogue on solutions. However, we are concerned that DHCF is not able to reach the wage funding rates necessary to meet this new, highly competitive market. The Mayor's proposed budget does not actually address the problem. We recognize that DHCF is proposing a rate study to establish "rate methodologies that will support Home Health Agencies to focus on improving beneficiary experience of care and appropriate services to obtain better outcomes for an individual". Implementation of the results will not take place until FY24.

The new reimbursement rate is described as follows: "reimbursement rate sufficient to support direct care service provider payment to direct care professions of a wage that, is equal to at least 11.7% of the District minimum wage or the District living wage, whichever is greater, by Fiscal year 2025". We do not understand the delay in implementing a reimbursement rate increase and we are concerned with what happened with legislation proposed more than three years ago under the Direct Support Professional Rate Payment Act which sought to raise the wage rates of direct support professionals to an average of 117.6 percent of the District's Living Wage. That legislation was never funded by the District, and now DC is even further behind on improving direct support/direct care wages and stemming the broadening exodus that the industry has experienced.

DHCF's current ARPA funding plan lists some 30 different projects. While many are intended to improve and strengthen access to home and community-based services, none will be successful if we are unable to address the current staffing crisis. In its ARPA Plan, DHCF has allocated approximately $30 million of its $88 million in ARPA funds to time-limited recruitment and retention "bonus" payments. The reality is that while they might be a short-term inducement until a long-term comprehensive plan is implemented in FY23, our collective experience over many years is that recruitment bonuses increase turnover and employer costs and do not lead to a stable workforce and that one-time retention bonuses, without adequate base pay and incremental pay increases, are insufficient to incentivize workers to remain on the job. In other words, spending $30 million on bonus payments will not have a positive impact on the workforce crisis and could even make it worse.

In the final analysis the following issues are either not addressed or present roadblocks in truly addressing the issue of low wages to a group of essential workers represented primarily by women, women of color and immigrants.

- The proposed provider reimbursement applies only to Home and Community Based Services participating in the District's Medicaid program not including assisted living or skilled nursing facilities.
- The Budget is not clear on how the APRA spending plan toward retention and recruitment will be used together to raise workers wages plus it would seem that the Public Health Emergency (PHE) adjusted rates are not taken into consideration in the planning of the rate increase.
- Planning to implement the wage increase over a three year period does not recognize the immediacy of the staffing crisis.
- Historically when the Living Wage Legislation was passed, it took several years before there was any enforcement mechanism. We remained concerned that this lack of enforcement continues to be a problem which will affect implementation of the wage increases.

Although we understand that many programs are needed to ensure adequate staffing of long-term care services and supports, our highest priority is increasing the minimum wage rate for direct care workers to $22/hour so the industry can compete with other employers.

Thank-you for the opportunity to testify. I am happy to answer questions

Testimony of Claudia Balog, Lead Researcher

1199SEIU United Healthcare Workers East

District of Columbia City Council Budget Hearing before the Committee on Health

Department of Healthcare Finance

March 28, 2022

Chairperson Gray and Members of the Council, thank you for the opportunity to testify at this Budget hearing regarding the Budget of the Department of Healthcare Finance. My name is Claudia Balog. I am the Lead Researcher with 1199SEIU, we represent thousands of healthcare workers in Hospitals, Clinics and Skilled Nursing Facilities in the District of Columbia. I'm here on behalf of all healthcare workers who are struggling to survive on poverty wages, while consumers who depend on them face the impact of severe staffing shortages. Our members could not attend this hearing today, the facilities they are working in are severely short-staffed, and I hope to provide a voice for their concerns.

The shortage of home health aides and CNAs in the District is not new. These jobs have always been characterized by high turnover. Our members include CNAs at Skilled Nursing Facilities who often moonlight as Home Health Aides, to make ends meet. We know that from the perspective of long-term care workers, their skills and experience allow them to jump from one setting to another. We know that they make the decision to work across multiple care settings because their wages are too low.

That is why we are disappointed in the failure of the Department of Healthcare Finance to address the issue of CNA wage rates in settings such Medicaid Provider Nursing Homes. Any plans to address the systemic staffing crisis that stakeholders are experiencing in healthcare must encompass low wages across the LTC spectrum.

As we have noted before, the funding that exists from American Rescue Plan, provides a unique opportunity to address these systemic workforce issues by jumpstarting a new wage floor. We are pleased to see that the Budget includes some wage increases for direct service workers who provide care in Medicaid Home and Community Based Service programs. Nevertheless, even when accounting for American Rescue Plan dollars to supplement the plans (and we remain uncertain of what this implementation will look like), $11.5 million will not go far enough to address the needs of District residents.

First, we would like to note that the Budget raises wages slowly over the next three years, which is not an adequate response to the immediacy of the crisis. Furthermore, the target wage rates of $18.93 in the "Mid-Level" wage tier for FY 2023, as illustrated by DHCF in their March 23 presentation[1] will not draw more workers into the healthcare pipeline. Setting the rates to 117.6% of the Living Wage by FY 2025 is simply not a Living Wage in the District of Columbia. According to a 2019 report of the National Low Income Housing Coalition, the District had the

[1] See MCAC Budget Presentation, FY 2023 Proposed Budget and Financial Plan, Department of Healthcare Finance, page 29.

"4th Highest Housing Wage" in the country.[2] The monthly affordable rent for the mean renter making $28.57/hour was $1486/month.[3] In fact, the fair market rent for a 2-bedroom apartment was $1665, which translated to a "housing wage" of $32.02/hour.[4] Because of the extraordinarily high costs of living here, we do not see it as helpful to compare the District's reimbursement for providers and wages for direct service workers with surrounding jurisdictions like Maryland. District residents simply cannot afford to do this work and live in the District.

We are also disappointed in the Budget legislation underpinning plans of DHCF to increase the living wage of direct service workers. There does not appear to be any enforcement mechanism to ensure that workers are paid the new wage. We agree with the Department of Healthcare Finance when it comes to the necessity of provider cost reports and industry accountability. We believe, however, that individual direct service workers are also owed a form of structural accountability when it comes to their paychecks.

The District should make a greater permanent investment in these jobs now, with funding that rises to the challenges we face. Estimates show the number of adults over 65 in the District will increase by nearly 25 percent within this decade.[5] Direct service workers also need additional training that includes dementia care and other high acuity skills, and that training and experience should be compensated. Our long-term members in skilled nursing facilities have experienced changes in their day-to-day work. They report caring for more residents on ventilators, or with traches, or who need wound care, or the services in memory units. The higher demands of their jobs should be reflected in their pay. We must build career ladders into the entry-level jobs of the long-term care workforce.

We would like to once again highlight states that are approaching their staffing crisis across long-term care settings. New Jersey just increased the Personal Care Assistant rate to $23/hour[6] and implemented a 10% Medicaid rate increase for nursing facilities and mandated that 60% of the money must be used towards increased CNA wages.[7]

Meanwhile, Michigan implemented a wage pass-through for workers including CNAs providing care in both long-term care facilities and in-home settings[8] and is looking to make the wage increase permanent.[9]

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[2] "Out of Reach" From the National Low Income Housing Coalition, 2019. See: https://reports.nlihc.org/sites/default/files/oor/OOR_2019.pdf

[3] Ibid, page 18.

[4] Ibid, page 52. This wage assumes a 40-hour workweek, and that no more than 30% of income is spent on housing.

[5] Source for demographic data: https://marylanddirectservicescollaborative.org/wp-content/uploads/2021/03/Collaborative-PHI-Landscape-Study-Final-Report.pdf

[6] Source: Office of the Governor | ICYMI: New Jersey to Invest $634M to Enhance Medicaid Services for Older Adults and Individuals with Disabilities (nj.gov)

[7] Source: NF SFY2021 Rate Increase FAQ.pdf (nj.gov)

[8] Source: Coronavirus - Long Term Care COVID-19 Plan (michigan.gov)

[9] Source: Governor_Whitmer_2021_State_of_the_State_Remarks_as_Prepared_for_Delivery_714535_7.pdf (michigan.gov)

And once again, I like to focus on Tennessee, because their work to improve home and community-based services illustrates the kind of multi-agency collaboration that we believe will be necessary to truly build a workforce to care for our residents. Tennessee will use their enhanced FMAP funding to invest nearly $140 million in wage increases. This is on top of dedicating $60 million to workforce development initiatives. Tennessee agency officials have also stated their commitment to finding ways to source these wage increases when the federal dollars run out in March 2024.[10]

Tennessee will use State Innovation Model grant funding. They plan to employ best practices in adult learning, combining online formats with work-based learning. Their State Agencies are coordinating with the Tennessee Board of Regents to award 18 hours of college credit and a post-secondary certificate for completion. Courses will be embedded within multiple degree paths and rolled out through Community Colleges and Technical schools.

Most importantly, the State Medicaid Agency is a key driver to underpin their workforce development plan. Under this plan, for each competency a worker achieves, they will receive a pay bump. The total incentive is as much as $6,000 a year for a Full-Time worker once certification is completed. Enhanced FMAP funds will be used to reimburse providers for these higher wages.

Finally, I want to remind this committee that this workforce crisis is an equity crisis. More than 87 percent of direct services workers in the region are people of color. Black or African-American women constitute most workers across all these care settings and many in this workforce are immigrants. Looking at direct service workers, nearly 1 in 5 in DC live in poverty and 63 percent rely on public assistance.[11] We simply do not see this budget as adequate to create a sustainable healthcare workforce for the District or to honor the skills or the physical and emotional toll that this work entails.

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[10] T Source: See PHI webinar: "How Should States Invest in the Direct Care Workforce," October 19, 2021. Webinar: How Should States Invest in the Direct Care Workforce? (10-19-21) - YouTube

[11]Source for demographic data: https://marylanddirectservicescollaborative.org/wp-content/uploads/2021/03/Collaborative-PHI-Landscape-Study-Final-Report.pdf

District of Columbia Behavioral Health Association
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Statement of the District of Columbia Behavioral Health Association
Department of Health Care Finance FY '23 Budget Oversight

To the District of Columbia Council Committee on Health
March 28, 2022

Chairman Gray and Members of the Council,

Thank you for the opportunity to testify today. My name is Mark LeVota. I am the Executive Director of the District of Columbia Behavioral Health Association and a Ward 2 homeowner. The District of Columbia Behavioral Health Association works to advance high-quality, whole-person care for all District residents with mental illness or substance use disorders, including the 35,000 District residents our 32 member organizations serve annually. The Department of Health Care Finance proposed FY '23 budget makes important progress to address District resident needs, and I encourage Councilmembers to identify additional funds to accelerate the progress funded in the Mayor's proposed budget.

As the Department of Health Care Finance takes additional responsibility for payment rates for DBH-certified provider organizations, the proposed budget addresses inflationary costs facing those providers for the first time in years. A temporary 20% rate increase is in effect for substance use disorder American Society of Addiction Medicine Level 1 and 2 providers that serve about 2,500 of DBH's 35,000 enrolled consumers, and this will expire with the end of the public health emergency. Otherwise, those rates and the provider rates for services to 32,500 other DBH enrolled consumers remain based on 2016 costs. The Department of Health Care Finance has requested a 1.8% inflationary cost adjustment from the Center for Medicaid Services for DBH-certified providers in FY '22 and plans an additional 1.6% increase in FY '23 to help offset future increases in inflation, cumulatively a 2.88% increase. This does not close the 16.1% gap from the fourth quarter of 2016 to the first quarter of 2023 shown in the Medicare Economic Index[1] data used by DHCF for rate-setting. The 1.8% and 1.6% increases fall 13.22% short of the rise in costs DBH-certified providers face. We encourage the Council to accelerate payment rate updates with funding to support greater inflationary cost offsets. If nothing else, the Council should provide sufficient funding for immediate implementation in FY '23 of adjusted rates from a cost study underway and anticipated changes to the benefit design for behavioral health rehabilitation services.

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[1] Centers for Medicare and Medicaid Services. Market Basket Data. Online. Available 3/21/2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

While the Council can take small comfort in DHCF starting to address years of poor rate-setting practices for DBH-certified providers, the Council can take much more comfort in seeing the DHCF FY '23 proposed budget resolve one of the most significant issues that both the public and the Council have sought to overcome for years in increasing alignment of DC Healthcare Alliance certification requirements with Medicaid eligibility standards. The elimination of the face-to-face interview requirement and extension of Alliance enrollment from six months to one year are two critical policy changes that the Council should celebrate. We join colleagues from the Coalition for Improving the Alliance in thanking the Mayor's team and DHCF for funding these changes in the Mayor's proposed budget and offering relevant enabling legislation in a Budget Support Act subtitle. We take great satisfaction encouraging the Council to adopt these proposed changes.

We again acknowledge other positive initiatives underway at DHCF that are strengthened and continued in the proposed FY '23 budget. We remain grateful for efforts underway to strengthen the District's digital health infrastructure and to offer provider organizations both technical assistance and direct financial support for adoption of enhanced health technologies, including new or upgraded electronic health records and deeper clinical integration with the District's Designated Health Information Exchange. We acknowledge other technical assistance also available to improve practice management and delivery of integrated care services.

Thank you again for the opportunity to testify today. I look forward to answering any questions that you might have.

Legal Aid Society
OF THE DISTRICT OF COLUMBIA
MAKING JUSTICE REAL

Testimony of Damon King
Director of Policy Advocacy
Legal Aid Society of the District of Columbia

Before the Committee on Health
Council of the District of Columbia

Budget Oversight Hearing Regarding the Department of Health Care Finance

March 28, 2022

The Legal Aid Society of the District of Columbia[1] submits the following testimony regarding the Mayor's proposed Fiscal Year 2023 budget for the Department of Health Care Finance (DHCF). Legal Aid thanks the Bowser Administration for using the FY23 Budget Support Act to propose ending the District of Columbia Health Care Alliance's six-month, in-person recertification requirement. If passed, this proposal would remove a longstanding barrier to healthcare for thousands of Washingtonians who are immigrants and represent a key step toward a more fair and equitable public health system in the District. It would also reduce administrative burdens for the Department of Human Services (DHS), hopefully to the benefit of all District residents who interact with DHS to secure safety net benefits. We urge the Council to approve the Mayor's proposed repeal of this policy when it approves the FY23 budget.

The Health Care Alliance's Onerous Recertification Requirements Have Created a Barrier to Immigrants' Healthcare Access for More Than a Decade

The District of Columbia Health Care Alliance (the Alliance) is a locally-funded healthcare program that provides health insurance coverage to low-income District residents who are not eligible for Medicaid. It is a crucial gap-filling source of health coverage for immigrants living in the District, offering the promise of continuous access to healthcare to thousands of residents whose immigration status leaves them vulnerable to economic marginalization and the numerous

[1] The Legal Aid Society of the District of Columbia was formed in 1932 to "provide legal aid and counsel to indigent persons in civil law matters and to encourage measures by which the law may better protect and serve their needs." Legal Aid is the oldest and largest general civil legal services program in the District of Columbia. Over the last 90 years, Legal Aid staff and volunteers have been making justice real – in individual and systemic ways – for tens of thousands of persons living in poverty in the District. The largest part of our work is comprised of individual representation in housing, domestic violence/family, public benefits, and consumer law. We also work on immigration law matters and help individuals with the collateral consequences of their involvement with the criminal justice system. From the experiences of our clients, we identify opportunities for court and law reform, public policy advocacy, and systemic litigation. More information about Legal Aid can be obtained from our website, www.LegalAidDC.org, and our blog, www.MakingJusticeReal.org.

health challenges that flow from that marginalization. The program is operated by DHCF, while DHS is responsible for administering its eligibility processes.

More than a decade ago, in October 2011, the District instituted a policy requiring Alliance participants to renew their coverage every six months and to complete an "in-person interview" as part of each recertification of their eligibility. This requirement was significantly more onerous than the recertification process for similarly situated low-income Washingtonians enrolled in Medicaid.[2]

The policy immediately prevented many eligible participants from being able to maintain their health coverage under the Alliance and resulted in needless terminations. As early as April 2012, Legal Aid testified before the Council's Committee on Health that we were seeing an increase in the number of Alliance participants seeking legal help because they attempted to recertify in-person but were unable to do so.[3] In the intervening years, Legal Aid has documented the extreme measures that Alliance participants have had to take in order to renew their coverage, including – in the pre-pandemic years – lining up outside of DHS service centers at 4 AM or earlier to attempt to complete the in-person interviews required to keep their coverage.[4] Enrollment and other data from those years have demonstrated that the Alliance participants Legal Aid has served are not outliers. As the DC Fiscal Policy Institute detailed in 2018, during the first year the six-month, in-person recertification requirement was implemented (FY12), Alliance enrollment plummeted by one-third, from roughly 24,000 participants to about 16,000.[5] Data on the monthly completion of recertifications showed that a substantial number of

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[2] Medicaid enrollees recertify once a year by mail and are not required to complete an in-person interview for recertification.

[3] Legal Aid Budget and Oversight Testimony Regarding the Department of Health Care Finance, April 19, 2012. Available at: http://www.legalaiddc.org/wp-content/uploads/2013/10/Apatterson4-19-12.pdf

[4] *See*, *e.g.*, Legal Aid Performance Oversight Testimony Regarding the Department of Human Services, January 29, 2020. Available at: https://www.legalaiddc.org/wp-content/uploads/2020/02/Legal-Aid-DHS-Oversight-Testimony-FY19-FY20YTD-Alliance-FINAL.pdf

Legal Aid Performance Oversight Testimony Regarding the Department of Health Care Finance, February 6, 2019. Available at: https://www.legalaiddc.org/wp-content/uploads/2019/02/Legal-Aid-FY18-19-DCHF-Oversight-Testimony-Health-Care-Alliance-FINAL.pdf

[5] Jodi Kwarciany, *What DC Can Do to Improve Access to Health Care for Thousands of Immigrant Residents*. DC Fiscal Policy Institute, April 26, 2018. Available at: https://www.dcfpi.org/all/what-dc-can-do-to-improve-access-to-health-care-for-thousands-of-immigrant-residents/

participants up for recertification each month failed to complete the recertification process on time.[6]

The COVID-19 pandemic brought temporary protection from this policy, as the Bowser Administration suspended recertification requirements for a number of safety net programs, including Alliance, with the Alliance's recertification suspension lasting from March 2020 to September 2021. Unfortunately, an attempt to restart recertifications in October 2021 resurrected many of the problems associated with the program's recertification requirements, and led to the termination – and fortunately, quick reinstatement by the Administration – of 6,100 participants in the Alliance and Immigrant Children's Program.[7]

Simply put, from the beginning, the decision to require Alliance participants to complete onerous requirements just to keep their healthcare has cost participants their health coverage and made the program less accessible and reliable than its participants deserve.

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[6] For example, over the first five months of FY20 (the last before the pandemic), between one-fifth (22%) and one-third (33%) of participants required to recertify in a given month did not complete the recertification process by their deadline or re-enroll in the program within 30 days after their deadline. DHCF FY20-FY21 Performance Oversight Responses, Q35. Available at: https://dccouncil.us/wp-content/uploads/2021/06/DHCF-FY20-Performance-Oversight-Responses_FINAL_Updated.pdf

Data from prior years paint an even grimmer picture. For example, from October 2017 through January 2019, between 44% and 66% of Alliance participants up for recertification each month did not complete the recertification process on time. DHCF FY18-FY19 Performance Oversight Responses, Q49. Available at: https://dccouncil.us/wp-content/uploads/2019/04/dhcf.pdf

And DHCF reported in 2016 that during calendar year 2015, between 56% and 71% of participants each month did not complete the recertification process. *See*, DHCF FY2017 Budget Presentation for MCAC, March 2016, at slide 33. Available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DHCF%20FY2017%20MCAC%20Budget%20Presentation%203-2016_1.pdf

[7] For a more detailed discussion of the events of fall, 2021, see Legal Aid's Performance Oversight Testimony Regarding the Department of Human Services. Legal Aid Performance Oversight Testimony Regarding the Department of Human Services, February 24, 2022. Available at: https://www.legalaiddc.org/wp-content/uploads/2022/02/Testimony-before-the-Committee-on-Human-Services-regarding-the-DHS-Damon-King.pdf

The Mayor's Budget Support Act Ends the Onerous Six-Month, In-Person Recertification Requirement and Creates a More Just and Equitable Policy

The FY23 Budget Support Act includes language that would permanently end the Alliance's six-month, in-person recertification requirement beginning in FY23.[8] If the Council approves this language and the accompanying funding to implement it, then, from October 1, 2022 onward, Alliance participants:

1. Would no longer be required to complete in-person interviews when applying for Alliance or recertifying their eligibility, and
2. Would only be required to recertify their eligibility once per year.

This policy change would bring the Alliance's recertification timeframes and policies into closer alignment with Medicaid.

Ending the six-month, in-person recertification requirement would have a number of benefits. First, and most importantly, the roughly 22,000 Alliance participants would face fewer barriers to staying covered.[9] Over the years, legal services attorneys and healthcare providers, as well as

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[8] Language passed in last year's FY22 Budget Support Act of 2021 stopped in-person interviews in FY22 but allowed them in FY23-FY25. It also required six-month recertifications before phasing them out after April 1, 2025. Fiscal Year 2022 Budget Support Act of 2021, Enrolled August 10, 2021, at 139. Available at: https://lims.dccouncil.us/downloads/LIMS/47312/Meeting3/Enrollment/B24-0285-Enrollment12.pdf

The FY23 Budget Support Act amends this FY22 BSA language. Specifically, it removes language allowing in-person interviews in FY23-FY25, as well as the delayed implementation of the annual recertification schedule. New language specifies that Alliance participants would be "required to recertify enrollment on an annual basis." The effect of the FY23 BSA language, if passed, would be to permanently end in-person interviews and shift to annual recertifications beginning in FY23. Fiscal Year 2023 Budget Support Act of 2022, Introduced March 16, 2022, at 36-37. Available at: https://lims.dccouncil.us/downloads/LIMS/49079/Introduction/B24-0714-Introduction.pdf

[9] For enrollment data, *see*, District of Columbia Department of Health Care Finance Monthly Enrollment Report – February 2022, Reflecting Period of January 2021-January 2022. Available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MCAC%20Enrollment%20Report%20-%20February%202022.pdf

Alliance participants themselves, have testified to the Council's Committee on Health and Committee on Human Services about the significant difficulty participants have had renewing their coverage. Ending the in-person interview requirement, as well as the requirement that participants renew coverage every six months, should substantially reduce these difficulties, allowing for greater access to and continuity of healthcare for Alliance participants.

Second, and more broadly, ending this requirement would reduce the administrative burden on DHS, allowing the agency to redirect resources to improving access to all other DHS benefits. By cutting the number of required Alliance recertifications per year in half, the BSA would significantly reduce the number of Alliance-related submissions that DHS would have to process each year. Removing the interview requirement would also help DHS. In the pre-pandemic years, the in-person interview requirement contributed significantly to the number of people lining up in front of ESA service centers in the morning, as Alliance participants had no choice but to "interview" with a District employee every six months to stay covered. While under the BSA's proposed changes, Alliance participants would still be permitted to recertify in person, the removal of the in-person requirement should mean that in the future, fewer people would be in the position of needing to go to DHS service centers as a matter of course. This should result in more capacity at the service centers, which should, in turn, benefit a broader population of District residents who need to contact DHS regarding District safety net programs administered by the Department.

Finally, the elimination of the six-month, in-person recertification requirement sends an important message to the District's immigrant communities. One of the more pernicious aspects of this requirement has been the District's choice to single out a program primarily serving low-income immigrants for requirements that *do not exist* in similar safety net programs serving mostly U.S. citizens. The fact that the District's Medicaid participants are not subjected to semi-annual recertifications or mandatory in-person interviews presents a sharp contrast to the treatment of Alliance participants over the last decade. At best, this policy has always reflected a deep insensitivity to the difficulties that immigrants face building lives for themselves and their families in the District, as well as the vital role that immigrant communities play in the District's day-to-day life and culture. At worst, it has reinforced the notion that those in positions of power in the District view members of immigrant communities (especially those with low incomes) with suspicion and simply do no prioritize their needs on the same level as non-immigrant Washingtonians. Addressing this unjust and unnecessary policy makes clear that, when it comes to accessing healthcare, immigrant Washingtonians should not be treated differently. This is a powerful message that we hope policymakers will keep in mind as they make future decisions impacting immigrants living in the District.

As the Medical Care Advisory Committee (MCAC) has highlighted, enrollment in both the Alliance and the Immigrant Children's Program (ICP) has increased since the early months of the pandemic. *See*, Slides January 19 DHCF MCAC Eligibility Enrollment Subcommittee, at slide 22. Available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCAC%20EE%20Subcommittee%20Meeting%20Presentation%20011922.pdf

Conclusion

Legal Aid is extremely pleased that the Mayor's proposed FY23 budget seeks to correct the longstanding injustice of the Health Care Alliance's six-month, in-person recertification requirement and we thank Mayor Bowser for taking this crucial step to improve healthcare access and equity. We urge the Council to approve this change. Legal Aid looks forward to continuing to work with the Administration and the Council to ensure that all District residents can access quality healthcare and other safety net support when they need it.

LA CLÍNICA DEL PUEBLO

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Testimony for the Committee on Health
Budget Oversight Hearing: Committee on Health

To: Chairman Vincent Gray, Committee members and Committee Staff
From: Selene Lara, Community Health Worker at La Clínica del Pueblo
Date: March 28th, 2022
Agency: Department of Health Care Finance (DHCF)

Good afternoon, Chairman Grey, members, and staff from the committee. My name is Selena Lara. I work as a Community Health Worker, and I am a member of the Patient Advisory Committee from La Clínica del Pueblo.

I am honored to work with the immigrant Latino community from the District of Columbia in the Health Promotion Program that works to prevent and treat chronic illnesses such as hypertension and diabetes. I have lived in DC for 10 years with my daughter, who is four years old, and with my husband, and I have been part of the DC Alliance Program for nine years.

Today, I would like to thank you, Charmain Gray for your support. Also, I would like to thank Councilmember Nadeau, Mayor Bowser, Wayne Turnage, and all other Councilmembers and people involve in the decision of including the repeal of the 6-month recertification requirement for the DC Alliance within her proposed 22-23 Budget Support Act to the City Council, as well as eliminating the need for an in-person requirement. This is an important step for immigrants like me and for all DC residents as it will be a key element to have continuous healthcare coverage.

The implications of not having to renew for me are important. First, I will not have to miss work and wait in long lines to be able to process the recertification. Second, I will not have to miss appointments so often due to inactive coverage. This has a great impact on my health since I have a condition called Mitral Valve Prolapse (MVP), which requires having regular examinations to monitor my heart condition. Third, I will be able to obtain medications with less interruptions in my treatment. Fourth, I will be able to renew the DC Alliance at the same time as a renew Medicaid for my daughter. Finally, I will be able to spend more time focusing on other priorities such as taking care of my daughter, spending time with my husband, working and finishing my business administration degree.

Eliminating all of these barriers to enrollment has enormous implications in the lives of many immigrants like me. Today, I kindly ask the DC Council to support this funding request from Mayor Bowser and keep protecting the DC Alliance program. This will be an important change so that we are able to make the most of the program benefits that are truly important for our well-being.

I appreciate the opportunity to testify before the Committee on Health.
Respectfully,
Selene Lara.

Testimony Submitted to the Committee on Health

By D.C. Long-Term Care Ombudsman For the District of Columbia

Budget Oversight Hearing for the D.C. Department of Health Care Finance

March 28, 2022

Good morning Chairman Gray and Members of the Committee on Health. My name is Mark Miller. I am the D.C. Long-Term Care Ombudsman with the Legal Counsel for the Elderly. Thank you for this opportunity to provide this testimony to you today on behalf of the approximately 9,000 District residents who receive long-term care services in nursing homes, assisted living residences, community residence facilities and in their homes through the Elderly and Persons with Physical Disabilities (EPD) Medicaid Waiver Program.

The Ombudsman Program is part of the Department of Aging & Community Living Service Network and is charged by federal and D.C. law with representing the interests of some of the District's most vulnerable citizens. The Ombudsman Program works to promote and ensure the highest quality of life and quality of care for these individuals.

The Ombudsman Program is Highly Effective. In 2021, our office handled 278 complaints, resolving 76% of those issues to the satisfaction of the care recipients or complainants. This resolution rate is well above the national average. Issues involved quality of life, quality of care and residents' rights. As a resource and advocate, the

Ombudsman Program works to educate and empower individuals. Informed consumers make more satisfying choices and can more effectively exercise their rights to quality care.

The District Ombudsman Program continues its work as one of only 13 programs in the country that also serve persons receiving long-term care services in the community, specifically EPD waiver beneficiaries. As you are aware, the EPD waiver program provides critical care and support to older adults and persons with disabilities that allow them to continue living independently in their own homes.

First, let me express my appreciation for the financial support which the Ombudsman Program receives from DHCF, which is made possible by an agreement with the Department of Aging & Community Living. This support is critical to our successful work resolving concerns on behalf of hundreds of EPD Waiver beneficiaries and nursing home residents. **Over 90% of persons receiving advocacy assistance in 2021 were Medicaid or dual eligible recipients.**

The DC Long Term Care Ombudsman Program supports the efforts of DHCF to provide District residents with a comprehensive package of benefits through the EPD Waiver, allowing many individuals to remain in their own homes and maintain vital connections with their families, neighbors and places of worship. This high level of commitment is exemplary by comparison to other states. However, we continue to receive numerous complaints that Home Health Agencies are not providing staffing to cover all assessed hours. One beneficiary, who was assessed for 18 hours of personal care aide (PCA) services, was not able to get an agency to provide these necessary

services for the more than four months. EPD Waiver beneficiaries have a nursing home level of care needs and must receive these services to remain safely in the community. DHCF has provided guidance on how PCA services can be obtained from more than one agency, however this option is not often exercised. We appreciate the ongoing assistance of DHCF staff to address these issues as they arise. However, the lack of staffing is a systemic problem across the long-term care services continuum, which must be addressed.

We support all necessary funding for the Department of Health Care Finance to continue EPD Waiver services at current levels. Adequate funding of Home and Community-Based Services (HCBS) is more critical now than ever before. Those funds support the providers and workforce that serve the people who rely on them to remain living safely in their homes and our community. Without these services, District residents will be unnecessarily forced into nursing homes and other congregate settings. For many that will mean having to leave the District, their families, friends and the city they love, because as we already know, there are an insufficient number of nursing home beds in the District.

For our Medicaid beneficiaries who are residing in nursing homes, we continue to advocate for an increase in the Personal Needs Allowance (PNA) from $70.00 to $100.00 with a COLA in order for it to keep pace with rising costs. It has been over 20 years since the PNA was last increased. Residents urgently request this increase so they can maintain a cell phone to keep up communication with family members and purchase needed clothing as well as regular haircuts and personal hygiene items. We continue to advocate on this important issue and have been in contact with DHCF. It is our

understanding that the PNA will be increased and a formal transmittal will be issued soon. However, we have not seen anything to date or heard how much the increase may be. We request that you ask DHCF about this issue at today's hearing.

Thank you for the opportunity to testify today on behalf of the Ombudsman Program. We commend you Chairman Gray, as an advocate and champion for District Medicaid beneficiaries. I welcome any questions you have regarding my testimony.

Submitted by Mark C. Miller
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Academy of Hope
Adult Public Charter School

Excellence in Adult Education Since 1985

DC Council Committee on Committee on Health
Department of Healthcare Finance (DHCF)
March 28, 2022

Mary Cabriele
Director of Workforce Services, Academy of Hope Adult PCS

Thank you, Councilmember Gray, for the opportunity to testify. My name is Mary Cabriele, and I am the Director of Workforce Services at Academy of Hope Adult Public Charter School (AoH).

For over 35 years, AoH has provided District adults education, high school credentialing through the GED/NEDP, workforce training, and supportive services.

As the pandemic continues, addressing the education and career development needs of District residents most impacted by COVID-19 remains more critical than ever. I'm here today to highlight how AoH is serving a critical role in ensuring a truly inclusive recovery and the ways next year's budget can bolster these efforts.

Moving District Residents Forward

Throughout the pandemic, our academic, healthcare and information technology programs—which are funded in part by a joint WIC/OSSE grant—continued to prepare learners for their high school credential and high-demand careers. Though lower than typical years, at the close of last school year in June, twenty eight (28) learners graduated with their high school credential by passing the GED or completing the NEDP program and 32 learners earned high level workforce certifications in Nursing Assistance, Phlebotomy and Microsoft Office. This school year we are currently at twelve graduates and projecting to end the school- year with twenty six graduates and 34 students receiving high level workforce certifications in CNA/Phlebotomy and Comptia A+.

Critical Action Needed Now

We were initially encouraged to see that Mayor Bowser allocated $11m to support Direct Support Professionals but were quickly disappointed when we saw that Certified Nursing Assistants were not included in that investment. District residents continue aging and the demand for services is growing. Today, the older adult population (age 60 and older) represents approximately 16.5% of the population; and the number of seniors is continuing to grow as the

baby boom population ages.[i] The DC Health Sector Partnership identified Certified Nursing Assistants and Home Health Aides as two of DC's five highest demand, highest growth entry level career health occupations and projects DC will need 13,000 workers among these five occupations within the next five years. Without sufficient numbers of high quality, direct care staff, DC cannot meet the current needs of residents and their families. Without action now, family caregivers, acute care hospitals, service providers and long-term care facilities will inevitably be overwhelmed.

Academy of Hope has been working to create access and opportunities for DC residents to help the city meet this critical need through our highly sought after CNA program. Over the last 2.5 years we have developed a robust Certified Nursing Assistant training program with employer partners, expanded our Healthcare pathway training to our W8 site to add 12 seats for DC Residents this school year (limitations due to covid). Our interest applications for the CNA program alone to date this school year is at 165 and growing.

This past school year, one hundred percent (100%) of learners who completed our nursing assistant program became Certified Nursing Assistants (CNA) (the highest success rate in DC) (CNA). 90% of our CNA learners reported obtaining employment and 47% were placed in CNA roles. Those in CNA positions are making an avg salary of $16.40 and the remaining moved into Non CNA roles, making $19+/per hour. While we continue to see waitlists, we suspect that we could begin to see a decline in interest due to the low wages learners make once certified as Nursing Assistants.

We are growing very concerned about the long-term sustainability of the CNA pathway as a solution to meet the growing needs of the District's vulnerable, older and disabled residents. The work requires significant training, passing an exam, continuing education and oversight by regulators. Yet, CNA's are paid less than other allied health workers and non-health sector workers who need less training and have less responsibility.[1]

Community Health Worker	$26.12/hour
Bank Teller	$21.00 per hour
Amazon warehouse workers	$19.00 per hour
Dog walker	$18.24 per hour

CNAs are also paid far less than other allied health workers including Pharmacy Technicians ($19.08/hour), Medical Assistants ($19.83/hour), Phlebotomists ($20.02/hour), and Community Health Workers ($26.12/hour). If we are truly expecting CNA's to help the District's healthcare worker shortage, we have to ensure that they are paid a real living wage.

Academy of Hope is in support of the Massachusetts Institute of Technology (MIT) and Bureau of Labor Statistics (BLS) recommendation that a real Living Wage for DC in 2022 should be $22 an hour.[2] We are asking that Council consider including Certified Nursing Assistants in the

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[1]See Table A, Comparison of XXXXX

[2]According to MIT, the Living Wage for Washington DC in 2020-2021 is $20.12. MIT Living Wage Calculator for the District of Columbia 2020-2021, https://livingwage.mit.edu/states/11. According to the Bureau of Labor Statistics, the CPI-U increased 5.8 percent over the 12 month period ending in November 2021. Thus, adjusted for inflation, the Living Wage for DC should be $21.89 as of November 2021. We have rounded up to get to $22/hour. See https://www.bls.gov/regions/mid-atlantic/news-release/consumerpriceindex_washingtondc.htm.

$11 million allocation to increase provider wages over a three year period. Please also consider increasing provider rates to ensure a payment of a real living wage to direct care workers of $22 an hour.

The adult education and workforce providers have done our part in providing exceptional healthcare career training options to DC Residents. We really need the Council's support in bridging this gap in our system to ensure that CNA's across the District are paid real living wages to help stabilize the sector before it is too late.

Looking Ahead

Academy of Hope is ready to be a critical partner in training DC residents. Our education and workforce programs meet adult learners where they are and move them efficiently toward achieving a high school credential, improved skills, and in-demand occupational certifications that lead to employment. We look forward to assisting more DC residents and partnering with the Council and the Department of Healthcare Finance to best serve DC residents in the critical months and years ahead.

Thank you, and I am happy to answer any questions.

COUNCIL OF THE DISTRICT OF COLUMBIA
Committee on Health
Vincent C. Gray, Chair

FY 2023 Budget Hearing
Department of Healthcare Finance (DHCF)

March 28, 2022

Testimony of Veronica Sharpe
President
District of Columbia Health Care Association

My name is Veronica Sharpe. I am the President of the District of Columbia Health Care Association (DCHCA), representing all the licensed nursing facilities and assisted living communities in the District. Thank you, Chairman Gray, and members of the Council for allowing me to testify and for granting me the ability to testify out of order today.

On behalf of the DCHCA facility members and the over three thousand District residents who rely on them for essential care and services, I must say that we are disappointed in the DHCF budget.

DC's Medicaid program is eligible for $88 million in Federal American Rescue Plan Act (ARPA) funds that must be spent by 2024. These funds can be used one time to draw down an additional $61.6 million in Federal funds for a total of $149.6 million.

Long term care providers across all provider types are facing an unprecedented workforce crisis. Nursing homes and residential care facilities employed lost over 234,000 employees during the pandemic and in some facilities in DC the employee loss is in the high teens.

Before the supply of PPE was available and before there was a vaccine, the intimate work of a CNA put them and their families at risk. It is still a difficult job

even with the protections. The workers that perform these jobs for the vulnerable in our population deserve and should be paid a true minimum wage of $22.00/hour. Surely the work they perform is as important as being a bank teller or an Amazon driver. I understand that the ARPA dollars are a one-time funding opportunity and there is hesitancy to use them for permanent increases. The District has been a leader in providing access to healthcare for all of it's citizens. I urge the District to be a leader in preserving that access to healthcare for seniors and the disabled by supporting the workforce that cares for them. Limited workforce decreases access.

The other problem that DCHCA members have with the use of the ARPA funding is that besides not using it to support the direct care workforce in a meaningful way, the District spending plan creates an unlevel playing field for nursing home and assisted living providers. The plan will subsidize an increase for home health and EPD waiver providers' direct service employees with an hourly increase of 117.6% over the living wage or minimum wage whichever is higher, and not a true living wage in DC. Nursing home and assisted living CNA's are not included in the funding, despite the similarities in training which means our employees who enjoy working in senior care can just switch provider type and be paid more. Attached to my testimony are several examples of how states have included nursing homes and assisted living in their spending plans. I understand that the ARPA funding was meant to strengthen home and community-based services but to put it bluntly most of the residents in our District facilities do not have a home to return to and the community where they reside IS THEIR HOME.

In 2021 DHCF completed the scheduled re-basing of rates for nursing home providers. The process was efficient and transparent. Melisa Byrd, Angelique Martin, Andrea Clark, and their team are always extremely professional and DCHCA members have the greatest respect for them and Deputy Mayor Turnage.

In our rebased rates, the department gave some consideration to the increased costs for staffing and supplies but with today's inflation it is doubtful that they will be sufficient for the next four years. The 20% and 15% add-ons for nursing home and assisted living providers have been critical in keeping providers able to continue their quality care throughout the pandemic but before they are rolled back DHCF should evaluate current costs and make corrections if necessary. Included in that evaluation must be the ability for providers to pay their CNA's a true living wage of $22.00 per hour and to be able to establish career ladders for CNA's that take advanced training including becoming a certified medication aide.

The long-term care industry is in a staffing crisis and the resolve to remedy the situation must start now. We ask the Committee to repurpose funds toward that goal.

Thank you and I'm happy to answer any questions.

Veronica Sharpe

From: Jalene Carpenter via American Health Care Association <Mail@ConnectedCommunity.org>
Sent: Friday, March 25, 2022 11:07 AM
To: Veronica Sharpe
Subject: RE: State Executives : ARPA Funds

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State Executives

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Re: ARPA Funds

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Mar 25, 2022 11:07 AM
Jalene Carpenter

Here is the current ARPA proposal, we are in the middle of session so it isn't finalized.

Assisted Living $5.4 million ($400/per licensed bed) for recruitment and retention or cost for covid supplies / equipment.

Nursing Homes $47.5 million, spread over 3 years. Premium pay for any direct care staff, specifically designated for recruitment and retention.

Thanks

Jalene Carpenter
President & CEO
Nebraska Health Care Association
Lincoln NE
JaleneC@nehca.org

Veronica Sharpe

From: Kevin Warren <kwarren@txhca.org>
Sent: Thursday, March 24, 2022 3:21 PM
To: Veronica Sharpe
Subject: ARPA Funds Request

Hey there Veronica,

I believe we'd sent that information to AHCA back a couple of months ago, so you may check w/ Mike Cheek to make sure you capture responses from everyone.

As for us:

$200M is for providing critical staffing needs resulting from frontline health care workers affected by COVID-19, including recruitment and retention bonuses for staff.

Assisted Living facilities are part of a $178M funding allocation for the same needs however, they included home health agencies, and facilities that serve persons with intellectual or developmental disabilities in an intermediate care facility for individuals with intellectual disabilities or related conditions (ICF/IID)

We also still have the CARES funds of $19.63 per Medicaid day that's in effect as long as the PHE in in effect. That began in April 2020.

Hope this helps.

Regards,

Kevin

Kevin Warren
President/CEO
Texas Health Care Association
(512) 458-1257
www.txhca.org

Veronica Sharpe

From: Jesse Samples via American Health Care Association <Mail@ConnectedCommunity.org>
Sent: Friday, March 25, 2022 12:57 PM
To: Veronica Sharpe
Subject: RE: State Executives : ARPA Funds

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State Executives

Post New Message to this Community

Re: ARPA Funds

Reply to Group | Reply privately to Sender

Mar 25, 2022 12:57 PM
Jesse Samples

Veronica,
Here is a breakdown of ARPA funding so far in TN.

$50M for salary and wage assistance for LTC facilities. $34 Million for NHs and $16M for AL
$25M for capital investment grants for facility upgrades and infection control for NHs
$25M for practice transformation grants for technology, delivery models and improving access for NHs/ALs

Salary assistance checks should be going out within the next couple of weeks. Specific details on the rest have yet to be determined. They were just awarded yesterday.

Best,
Jesse

Jesse W. Samples, Executive Director
Tennessee Health Care Association / Tennessee Center for Assisted Living
5120 Virginia Way, Suite A21, Brentwood, TN 37027
615-834-6520 Office; 615-346-7120 Direct

Veronica Sharpe

From: Tara Gregorio via American Health Care Association <Mail@ConnectedCommunity.org>
Sent: Thursday, March 24, 2022 3:06 PM
To: Veronica Sharpe
Subject: RE: State Executives : ARPA Funds

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State Executives

Post New Message to this Community

Re: ARPA Funds

Reply to Group | Reply privately to Sender

Mar 24, 2022 3:06 PM
Tara Gregorio

Below are the ARPA investments that have been made in Massachusetts thus far:

1) $25 Million Nursing Facility Retention and Recruitment Initiatives – Directs EOHHS in consultation with Massachusetts Senior Care Association to provide $25 million for initiatives to address nursing facility workforce shortages and assist with workforce retention and recruitment efforts.

2) $25 Million Nursing Facility Capital Improvements Program – Directs EOHHS in consultation with Massachusetts Senior Care Association to develop and administer a zero-interest or forgivable loan program of no less than $25 million to improve, modernize and update facilities. The program would support the establishment of specialized care units and innovative projects; help offset the cost of capital improvements including air filtration upgrades and infrastructure replacements; alternative energy conversation projects; and elevator renovations to comply with new government requirements.

3) $500 Million COVID-19 Essential Employee Premium Pay Program – Nursing facility staff will qualify for a bonus payment under the COVID-19 Essential Employee Premium Pay Program, which will provide a total of $500

million for an essential workers' premium pay program for low-income workers with household income below 300% of the federal poverty level. The direct financial support would total between $500 and $2,000 per eligible worker.

4) $500 Million Unemployment Insurance Fund - $500 million in statewide funding is allocated to subsidize the state's Unemployment Trust Fund and cushion the impact of future unemployment insurance increases on employers including nursing facilities.

5) Workforce Development Grants - $107 million in workforce development grants for a variety of health care providers, including nursing facilities.

6) Chronic Homelessness Supportive Housing - $150 million for the production of permanent supportive housing for individuals, including those classified as chronically homeless. **Funds may be expended for the acquisition of temporary housing for designated populations including the conversion of nursing facilities into permanent and affordable supportive housing**.

7) Health Policy Commission (HPC) study on the state of the health care workforce in the Commonwealth which includes an assessment identifying chronic and acute workforce shortages affecting various sectors including, skilled nursing facilities. The HPC is required to file the report with the legislature no later than May 1, 2022.

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Original Message:
Sent: 3/24/2022 2:44:00 PM
From: Veronica Sharpe
Subject: ARPA Funds

Can you please share with me if your State is allocating ARPA funds to be used in nursing homes and for what purpose? Thanks
Veronica

Sent from Mail for Windows

You are subscribed to "State Executives" as vdamesyn@dchca.org. To change your subscriptions, go to My Subscriptions. To unsubscribe from this community discussion, go to Unsubscribe.

Veronica Sharpe

Subject: FW: ARPA Funds

From: Mike Cheek <mcheek@ahca.org>
Sent: Thursday, March 24, 2022 4:20 PM
To: Veronica Sharpe <vdamesyn@dchca.org>
Subject: RE: ARPA Funds

Hey Veronica,

NCSL has a great APRA Grant Fund database located at: https://www.ncsl.org/research/fiscal-policy/arpa-state-fiscal-recovery-fund-allocations.aspx

Click on State Allocations. This will take you to a searchable map – you can review what the states has used the APRA funds to accomplish. I checked MD, DE, and VA for you. And found the following health care related items:

- MD: $26 million for a temporary nursing home rate increase
- DE: $25 million to the Delaware Healthcare Facilities Fund
- VA:
    - $528,300 to the Department for Aging and Rehabilitative Services to fund HVAC/air quality systems and physical plant improvements in assisted living facilities that serve a disproportionate share of auxiliary grant residents.
    - $1.2 million budgeted for the 2022-2024 biennium to the Department of Behavioral Health and Developmental Services for the purchase of personal protective equipment at state facilities.
    - $1.65 million budgeted for the 2022-2024 biennium to the Department of Behavioral Health and Developmental Services to continue an expanded pilot program in FY 2023 to serve approximately 60 additional individuals with a primary diagnosis of dementia who are ready for discharge from state geriatric behavioral health hospitals to the community and who are in need of nursing facility level care. Funding for the pilot program shall be dependent upon an agreement between the department and the Community Services Board in the jurisdiction the pilot program is located.
    - $10 million to the Department of Health for the procurement and deployment of an electronic health records system.
    - $10 million to the Department of Medical Assistance Services to address operational backlogs by hiring contractors to assist with eligibility re-evaluations and member appeals. Funding also will be used to perform COVID-19 related outreach and engagement activities.

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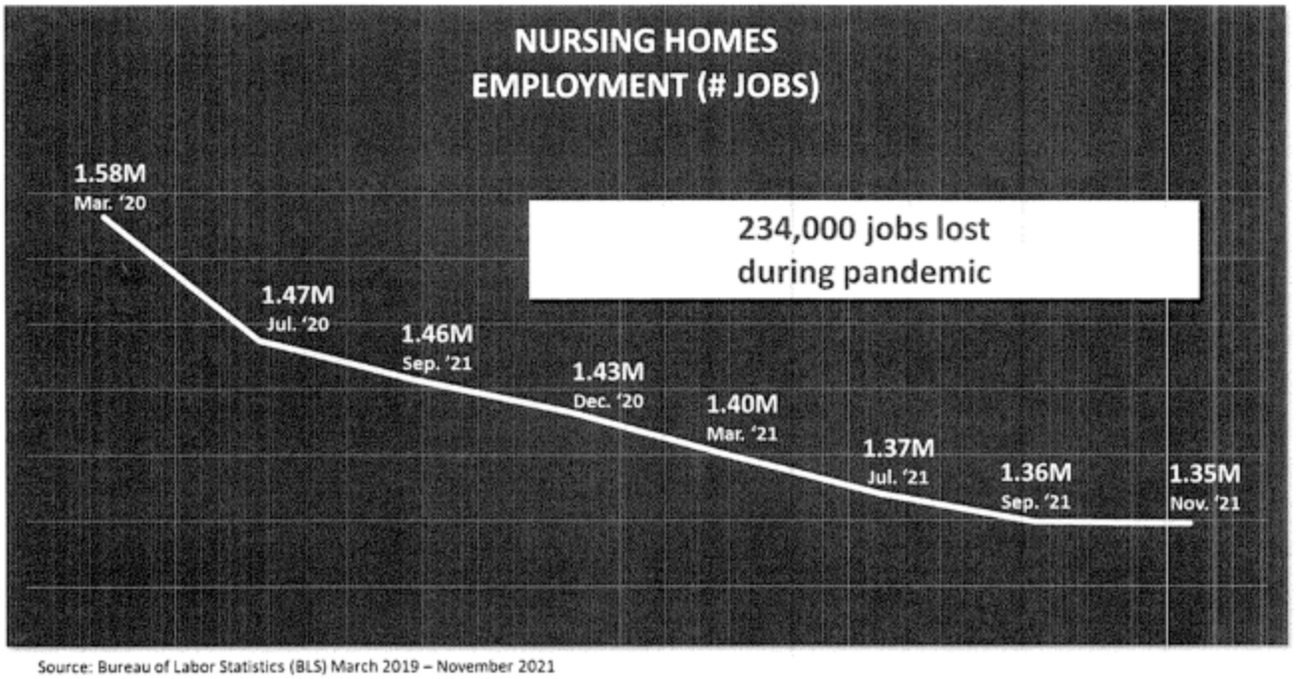
BLS NOVEMBER JOBS REPORT: NURSING HOMES

Nursing Homes have lost 234,000 employees since start of pandemic

According to the latest Bureau of Labor Statistics report, the nursing home industry has lost 234,000 employees since the start of pandemic and another 8,000 employees in the last month.



Source: Bureau of Labor Statistics (BLS) March 2019 – November 2021

NURSING HOMES WORST IMPACTED INDUSTRY OF HEALTH CARE SECTOR

While hospitals, physicians' offices, outpatient care centers and other health care facilities have reached or surpassed pre-pandemic staffing levels, nursing homes are still experiencing substantial job losses according to the latest November employment data from the Bureau of Labor Statistics (BLS).

BLS Employment Data by Healthcare Sector (Mar. 2020 vs. Nov. 2021)

	Physicians' Offices	Outpatient Care	Home Health	Hospitals	Nursing Homes	Assisted Living*
Mar. 2020	2,699,000	998,000	1,543,000	5,236,000	1,582,000	465,000
Nov. 2021	2,731,000	1,015,300	1,525,700	5,145,900	1,348,100	426,100
Difference #	**32K jobs gain**	**17K jobs gain**	**17K jobs lost**	**90K jobs lost**	**234K jobs lost**	**39K jobs lost**
Difference %	1.2%	1.7%	-1.1%	-1.7%	-14.8%	-8.4%

Source: Bureau of Labor Statistics (BLS) March 2019 – November 2021
**Assisted Living BLS data through October 2020*

Good afternoon, Chairman Gray and members of the Committee on Health.

My name is Susan Hargreaves. I am the Administrator of the Lisner Louise Dickson Hurt Home, a five-star public charity, where I have had the honor and privilege of sharing in providing care to underserved elders of the District for 32 of the Home's 82 total years of continuous service. As you may know, the Lisner Home recently received a DC Department of Housing and Community Development award to construct the first affordable senior housing project in Ward 3. This will allow us to continue expanding our services to those we serve in a long-term continuum of care.

Additionally, I have served on the Board of DCHCA in numerous roles over the past 15 plus years. Therefore, I speak not only from an independent providers perspective, but as a member of the Association representing both skilled and Assisted Living facilities serving 3000 of the most vulnerable elders of our community. I want to start by thanking the Mayor and the Council for the 20% increase during the PHE and for the care and support we received during this extraordinarily difficult time in history.
What is most startling and disconcerting to me is the fact that the proposed budget fails to adequately recognize the needs of the District's senior population. Their needs will only become more compelling as this age group continues to increase in size. This will, in turn, place a tremendous burden on facilities such as the Lisner Home to recruit and retain highly skilled direct care workers…workers who are already subject to stringent regulatory oversight and who earn lower salaries. This includes our Certified Nursing Assistants, who perform some of the most intimate tasks in caring for our residents and who remain at the lower end of the income spectrum. Add to this the proposal that only HCBS workers get a raise of 117% over the living wage and we have exacerbated the problem significantly. It would likely drive numbers of these trained, talented employees to leave their jobs at local nursing homes to take these higher paying positions.

Candidly, I was shocked that our great city, which champions the underserved, would consider not giving this well-deserved increase across the board!
Please keep the playing field equal and extend the increase to all LTC workers who are hard to find, hard to keep, and woefully underpaid for the work that they do. I urge this committee to address this issue thoughtfully and with generous intent.

Testimony of a coalition of Affordable Assisted Living Communities
before the Committee on Health
Regarding the FY 23 Proposed Budget of the
Department of Health Care Finance
March 28, 2022

Chairman Grey and Committee Members,

Thank you for the opportunity to appear before the Committee on March 28, 2022, to discuss budgetary concerns related to the Department of Healthcare Finance's 2023 Budget, and for reviewing this written testimony and follow-up.

Livingston Place at Southern Avenue is an Assisted Living Residence (ALR), where 100% of our residents are low-income seniors who need assisted living services. The overwhelming majority of our residents are Medicaid recipients. The community is financed with low-income housing tax credits. For residents who qualify, services are reimbursed through the Medicaid Home and Community Based Settings (HCBS) Elderly and Disabled Persons (EPD) Waiver program; residents are responsible for paying their rent and many qualify for the Districts Optional State Supplement Program (OSSP).

With the impending end of the public health emergency (PHE) and the end of enhanced PHE rates for HCBS services, we present testimony relating to what a feasible EPD ALR reimbursement rate would be going forward. We will present data that makes two points:

1. **Return to "Normal" –** Reasonable escalation assumptions for the EPD Assisted Living reimbursement rate suggest a FY2023 daily rate in excess of **$180 per day**. This is not an "ask," it is intended to put the post-PHE rate setting into a relevant context;
2. **The "Rate Cliff" –** The 15% reduction in service revenue represented by the end of the temporary PHE enhanced EPD Assisted Living reimbursement rates ignores **the permanent increase to the cost structure** for long term care providers resulting from the PHE. This will have dramatically negative impacts on providers' financial feasibility.

Return to "Normal"

Among the HCBS assisted living waivers around the nation, The District of Columbia's is notable as the only one with a built-in annual escalator for its reimbursement rate. This is an innovative and beneficial feature that we greatly appreciate.

There is no question that the enhance PHE reimbursement rate will and must end. The end of enhanced rates and a return to "normal" or base rates should account for not only the permanent changes to the LTC cost structure precipitated by the pandemic, but also reflect both the historic and recent annual escalations in other indices.

Figure 1 demonstrates that the escalation in EPD ALR reimbursement rates, while appreciated, lags behind other related and relevant indices. The current rate setting methodology is in fact a function of the CMS Market Basket and DC Living Wage. Combined with the recent dramatic increases in US inflation and Supplemental Security Income (SSI), we believe the pace of increase on the ALR rate should be accelerated.

EPD Asisted Living Reimbursement Rates % Change In Comparative Indices					
Year	**EPD AL Rates Incraease**	**US Inflation**	**CMS Market Basket**	**DC Living Wage**	**SSI Increases**
Average	**2.26%**	**3.36%**	**2.63%**	**5.79%**	**2.32%**
2022	1.97%	7.87%	2.70%	5.92%	5.90%
2021	1.33%	4.70%	2.20%	1.33%	1.30%
2020	3.45%	1.23%	2.80%	7.14%	1.60%
2019	2.52%	1.81%	2.80%	5.66%	2.80%
2018	2.01%	2.44%	2.60%	6.00%	2.00%
2017		2.13%	2.70%	8.70%	0.30%

Figure 1

We stress that neither this testimony nor our position in general is a call for any type of fixed annual escalation factor for EPD ALR reimbursement rate. We feel that the rate setting methodology can be improved, and are working with DHCF to that end. Our point here is that EPD ALR reimbursement has not kept up with cost increases in the broader economy, historically and as a result of the pandemic.

If we look at annual escalations of the EPD Assisted Living waiver reimbursement rate (figure 2), prior to the pandemic (2018-2020) the average annual increase was 2.66%. Increases during the pandemic have been below that level. If that 2.66% annual increase were applied to the pre-PHE rate of $167.70, the rate in 2023 would be over $181 per day; if escalated at national inflation levels since 2020, the 2023 rate would be almost $196 per day.

Again, we are not advocating for a specific reimbursement rate or escalation percentage. Our hope is that the post pandemic rate will adequately address broader economic realities providers face.

The "Rate Cliff"

The enhanced rate was desperately needed and put in place to account for costs associated with the pandemic. Today there is no indication as to when or if those costs will go away. And, of course, there is no chance those costs will simply disappear when the enhanced rate ends in September or December this year.

Livingston Place has been open for less than a year and is just over 50% occupied today. So we have no actual full year/full occupancy cost data, and it is difficult to project annual costs based on just a few months of operations at less than half occupancy. However, using our full year budget for 2022 and 2023 (prepared in October, 2021), a 15% reduction in the enhanced PHE assisted living rate of $199.28/day would result in a $1,270,000 reduction in service revenue for the 152 units at Livingston Place in 2023, with increasing revenue losses going forward if trends are unchanged.

Since the start of the pandemic, Livingston Place is experiencing 10%, 15% and more increases in the salaries demanded by management level staff and the hourly rates needed to attract Direct Support Personnel ("DSP"). At the same time, the supply of healthcare workers has dramatically diminished. Both the increased salaries for, and diminished supply of, healthcare workers are well documented at a national level. Any dramatic change to reimbursement rates should take into account the current state of the healthcare labor market.

We are aware of and support the testimony of other HCBS providers relating to hourly wages for DSPs. This testimony relates only to the EPD assisted living reimbursement rate.

In light of widely acknowledged new inflationary pressures, the consistent lagging of EPD ALR reimbursement rate increases behind increases in other indices, and the likely persistence of current pandemic related costs beyond the end of the declared public health emergency and extended enhanced PHE rate period, we urge the Council to direct DHCF to consider current actual costs when setting post-PHE EPD ALR reimbursement rate.

EPD Asisted Living Reimbursement Rates				
Base & Enhanced PHE				
Year	**Anticipated post-PHE Base Rate**	**AL EPD Base Rates**	**% Increase**	**PHE Enhanced Rates**
	pre-PHE	*Average increase 2018 - 2020: 2.66%*		
	Including PHE	*Average increase 2018 - 2022: 2.26%*		
2023	???			
2022*		$173.29	1.97%	$199.28
2021*		$169.94	1.33%	$195.43
2020		$167.70	3.45%	$192.86
2019		$162.11	2.52%	
2018		$158.12	2.01%	
2017		$155.00		
* Enhanced PHE Rate is		15%	of Base Rate	
* 2022 PHE Rate set in January 2022				

Figure 2

In closing, Livingstone Place staff and owners appreciate the tremendous effort DHCF staff have made in assisting us in approving EPD and SSI applications for prospective residents during our lease-up phase. It has been an unanticipatedly difficult effort in getting so many frail low-income seniors into new housing with assisted living services, all at the same time. I can tell you that the nearly 70 residents living there now, and their families, are thrilled with the new homes, and we look forward to quickly doing the same for another 82 residents and their families.

We are committed to continue our collaborative work with DHCF on improving the financial model and delivery of EPD Assisted Living, and providing any information or data that will help in that effort.

Submitted on behalf of:

Livingston Place at Southern Avenue
Marigold at 11th Street
Residence at Kenilworth Park
Hillcrest Affordable Assisted Living
Residence at Benning Road

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Testimony of Kate Coventry, Senior Policy Analyst
Performance Oversight Hearing on the DC Department of Health Care Finance
DC Council Committee on Health
February 28, 2022

Chairman and members of the Committee, thank you for the opportunity to testify today. My name is Kate Coventry, and I am a senior policy analyst at the DC Fiscal Policy Institute (DCFPI). DCFPI is a nonprofit organization that promotes budget choices to address DC's economic and racial inequities and to build widespread prosperity in the District of Columbia, through independent research and policy recommendations.

I would like to focus my testimony on the need for services for residents with low incomes who have traumatic brain injuries (TBIs), also known as acquired brain injuries (ABIs), and the need to simplify the DC Healthcare Alliance recertification process.

The fiscal year (FY) 2021 budget included $698,000 to allow some behavioral health outpatient providers to offer enhanced services for TBIs as well as autism spectrum disorders. This is a great new public investment, but the DC Department of Health Care Finance (DHCF) needs to create a path forward for Department of Behavioral Health (DBH) certified-provider organizations to be among those allowed to offer these services. We also encourage DHCF to consult with stakeholders about proposed rules and move forward expeditiously with issuing formal rules to allow these services to become available.

The Council should also add additional funding to allow Alliance recipients to renew online annually, just like Medicaid recipients do to make the process more equitable and better ensure stable coverage.

TBIs Have Significant Negative Effects

TBIs are injuries resulting from a blow or jolt to the head, or a penetrating injury to the head, that disrupts the function of the brain.[1] TBI in adults is associated with an increased risk for substance misuse, major depression, anxiety, and unemployment.[2]

TBIs can negatively affect self-regulation and executive functioning. Self-regulation refers to a person's ability to manage behavior associated with stress and anxiety. For a person with TBI, this might entail difficulty waiting or taking turns; difficulty calming down; or feeling overwhelmed in new places. Executive functioning refers to higher-order brain functions associated with setting goals, organizing, remembering, following directions, and focusing attention. People with TBIs can become easily confused or forgetful; have difficulty learning new information; filling out forms; and using public transportation. Some have difficulty problem-solving, and others have problems with judgment and decision-making. After experiencing a TBI, people may have trouble keeping track of time, making plans, making sure to complete

[1] "Traumatic Brain Injury & Concussion," Center for Disease Control and Prevention.
[2] Suzanne Polinder, Juanita A. Haagsma, David van Klaveren, Ewout W. Steyerberg, and Ed F van Beeck, "Health-Related Quality of Life after TBI: A Systematic Review of Study Design, Instruments, Measurement Properties, and Outcome," *Population Health Metrics,* February 17, 2015.

plans or assignments, applying previously learned information to solve problems, analyzing ideas, and looking for help or more information when needed.

Vulnerable Populations Are Particularly at Risk

People who are homeless are at high risk of acquiring a TBI: 50 to 80 percent of them have sustained at least one brain injury prior to homelessness, national statistics show.[3] The DC rate is elevated as well. In 2010, 199 DC homeless individuals were surveyed and nearly two-thirds had a TBI.[4] TBI may be a risk factor for becoming homeless, research shows.[5] Homeless individuals are also at a higher risk of acquiring a TBI because they are more likely to be victimized by assault, experience trauma, and have substance use disorders that can cause falls.[6]

A 2016 survey of 159 adult DC behavioral health clients found that approximately 50 percent had a history of TBI.[7] Additionally, active-duty military personnel are at very high risk. Domestic violence survivors are also at high risk because "the head and face are among the most common targets of intimate assaults."[8] And finally, TBI is a common co-occurring disorder among people who are diagnosed with a major mental illness and who have a history of substance misuse and criminal justice involvement.

DC Residents with TBIs Are Not Getting the Services They Need, with Devastating Implications

Right now, DC behavioral health providers generally do not screen, identify, or treat the symptoms of TBI because TBI is not an official billable diagnosis in DC's behavioral health system, and there is no system to train mental health providers. Community-based providers cannot receive payment for services provided to treat TBI, whether it is a standalone diagnosis or co-occurring disorder. This results in DC residents with TBIs not getting the care that they need. The new investment of $698,000 to allow some outpatient providers to offer enhanced services for both TBIs as well as autism spectrum disorders is a great first step, but more funding is needed to reach all residents in need.

The lack of services has terrible implications for individuals with TBI. Research has found that people with cognitive impairments like TBI may be falsely considered non-compliant and then get expelled from programs because these impairments prevent them from fully participating in the services. Or, sometimes they are banned from sites because of "disruptive behavior or failure to comply with prescribed treatments."[8] To the untrained eye, problems with executive functioning can look like lack of motivation, laziness, disregard for others, and a reluctance to engage in social activities. Given that a 2010 survey of 12 DC homeless service providers found that only one provider had received any training on TBIs, it is likely that many homeless individuals with TBI are being excluded from mainstream homeless services.[9]

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[3] Jennifer L. Highley and Brenda J. Proffit, "Traumatic Brain Injury Among Homeless Persons: Etiology, prevalence, and severity, Health Care for the Homeless Clinicians' Network," revised June 2008

[4] "Findings from the District of Columbia Traumatic Brain Injury Needs and Resources Assessment of Homeless Adult Individuals, Homeless Shelter Providers, TBI Survivors and Family Focus Group, TBI Service Agency/Organizations," DC Department of Health, revised August 2010.

[5] Jane Topolovec-Vranic, Naomi Ennis, Angela Colantonio, Michael D. Cusimano, Stephen W. Hwang, Pia Kontos, Donna Oucherlony, and Vicky Stergiopoulos, "Traumatic brain injury among people who are homeless: a systematic review," *BMC Public Health,* 2012.

[6] "Findings from the District of Columbia Traumatic Brain Injury Needs and Resources Assessment"

[7] Amy Burkowski, David Freeman, Faiza Majeed, Jennifer "Niki" Novak, Paul Rubenstein, and Celeste Valente, "Traumatic Brain Injury in the District: The Ignored Injury: A Paper Examining the Prevalence of TBI in the District and the Need for Services," revised July 2018.

[8] "Findings from the District of Columbia Traumatic Brain Injury Needs and Resources Assessmen.t"

[9] Ibid.

DHCF needs to create a path forward for DBH certified provider organizations to be among the providers allowed to offer these services. We also encourage DHCF to consult with stakeholders about proposed rules and move forward expeditiously with issuing formal rules to allow these services to become available.

Ensuring DC Alliance Recertification Is as Easy as Possible Is a Matter of Racial Equity

The DC Healthcare Alliance program provides critical health care coverage to residents with low incomes who do not qualify for Medicaid, most of whom are immigrants. Given their shared purpose, the DC Healthcare Alliance and Medicaid program should have identical, low-barrier application and recertification requirements. But the DC Healthcare Alliance requires participants to recertify every six months and normally does not allow participants to do this online, while Medicaid only requires annual recertification and allows participants to do so online. The District should be doing all it can to ensure that as many residents as possible have access to insurance and that access is as easy as possible. It is a matter of public health and racial equity.

This policy primarily hurts DC's Black and brown residents. In FY 2020, 50 percent of Alliance recipients were Hispanic and 20 percent were Black.[10]

DC's current policy is part of a long, racist history of restrictions on immigrant access to public benefits. Prior to 1965, immigrants to the United States primarily came from Northern and European countries and federal law did not exclude immigrants from public benefit programs.[11] In 1965, the immigration system changed, leading to greater numbers of immigrants coming from Asia and Latin America.[12] Starting in the early 1970s, Congress and some states began restricting immigrants from public benefit programs. Political leaders and the press promoted stereotypes, including that Mexican women immigrated unlawfully to the United States to give children citizenship and public benefits, that Latinx immigrants were lazy and committing fraud when they accessed the benefits for which they were eligible.[13] A 1990 survey of white people found that 46 percent thought Hispanics "generally preferred to live off welfare rather than be self-sufficient."[14] As a result of these racist stereotypes and a desire to cut spending on programs that benefited people who with low incomes, federal lawmakers excluded many legal immigrants and all undocumented immigrants from Medicaid. Because of this exclusion, DC immigrants have to rely on the Alliance but have stricter recertification requirements then other DC residents who receive Medicaid.

DHS should work with the DHCF to allow Alliance recipients to renew online annually, just like Medicaid recipients do. We should not erect higher barriers just because a resident is an immigrant or has a very low income—DC is a welcoming city, and our policies should reflect that value. The District waived the in-person interview requirement for the Alliance during the public health emergency. DC needs to make this improvement permanent and move to annual, virtual recertification to reflect our DC values.

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[10] DC Department of Health Care Finance. "FY 20-21 Oversight Questions Attachments." Accessed on February 2, 2022.
[11] Elissa Minoff, Isabella Camacho-Craft, Valery Martinez, and Indivar Dutta-Gupta. "The Lasting Legacy of Exclusion: How the Law that Brought Us Temporary Assistance for Needy Families Excluded Immigrant Families & Institutionalized Racism in Our Social Support System." Center for the Study of Social Policy and the Georgetown Center on Poverty and Inequality. August 2021.
[12] Ibid.
[13] Ibid
[14] Cybelle Fox 'The Changing Color of Welfare? How Whites' Attitudes toward Latinos Influence Support for Welfare." American Journal of Sociology, 110(3): 580–625, 2004.

Shortened Eligibility Period Has Led to Turnover, Poorer Health, and Higher Costs

In 2011, DC implemented restrictive procedures to maintain Alliance eligibility that immediately led to a sharp drop in participation. Thousands of residents who should have health insurance do not have it, and the uninsured rate is much higher among Latinx DC residents than others.[15]

The restrictive rules also contribute to a high rate of turnover in the Alliance, as residents join the program but then drop off due to the time-intensive requirements. Prior to the pandemic, only 55 percent of Alliance participants renewed their eligibility when it comes up, data from the District's DHCF show.[16] Given that many Alliance members are working at jobs without paid leave and that visiting a DHS center can take an entire day or longer, it is not surprising that many are not able to renew their benefits.

We ask that the Department work with DHCF to simplify recertification requirements so that residents can retain their benefits.

Thank you for the opportunity to testify, and I'm happy to answer any questions.

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[15] Jodi Kwarciany, "DC Has Disparities in Health Coverage Despite Its Low Uninsured Rate," DC Fiscal Policy Institute, revised September 25, 2017.

[16] Ed Lazere, "No Way to Run a Healthcare Program: DC's Access Barriers for Immigrants Contribute to Poor Outcomes and Higher Costs," DC Fiscal Policy Institute, revised March 17, 2019.

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Testimony Before the District of Columbia Council
Committee on Health
Submitted April 8, 2022

Public Hearing:
Budget Oversight Hearing
Department of Health Care Finance

Sharra E. Greer
Policy Director
Children's Law Center

Introduction

Chairman Gray and members of the Committee, my name is Sharra E. Greer and I am the Policy Director of Children's Law Center[1] and a resident of the District. I am submitting this testimony on behalf of Children's Law Center, which fights so every DC child can grow up with a stable family, good health, and a quality education. With nearly 100 staff and hundreds of pro bono lawyers, Children's Law Center reaches 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year. I also serve as a member of the DC Medical Care Advisory Committee, a forum for key participants and stakeholders in DC's Medicaid program to review the program's operations and provide feedback to the Department of Health Care Finance (DHCF).[2]

Thank you for this opportunity to provide testimony regarding the proposed FY2023 budget for DHCF. At Children's Law Center, nearly all of our clients are Medicaid beneficiaries. We know the importance of having a public health system that can meet the health needs of District children and families. From pregnancy, onward, families need strong investments in their physical and mental health. A strong beginning can have long-term, positive effect on the parent and child relationship, including building key resiliency factors early on in a child's life that can improve physical and mental health in the future.[3] To help create strong beginnings, we must ensure that families can access critical health benefits with ease and maintain their

benefits. There also must be adequate and appropriate providers available in the District to meet the health needs of children and families. With this in mind, my testimony today focuses on four critical areas of the Mayor's proposed FY2023 budget.

First, we applaud the Mayor's investments in maternal health, but ask the Council to seek clarity to ensure funding to all maternal health programs including the addition of doula services to Medicaid. Second, we thank the Mayor for the elimination of burdensome enrollment and recertification requirements for the Alliance Healthcare Program, and for the appropriate funding to stand-up the new recertification criteria. Finally, we encourage the Council to take steps towards properly funding behavioral health professionals and services in the District through Medicaid. Specifically, this includes the Council ensuring local Medicaid financing adequately compensates the HealthySteps model for both the clinical and non-clinical services and care coordination. Additionally, we ask that the Council bring behavioral health provider rates to 2022 costs and accelerate payment rate updates with funding to support greater inflationary cost offsets.

The investments in maternal health proposed in this budget are significant. However, to the extent the Council identifies other areas of investment to strengthen maternal health and behavioral health care in the District, we ask that they do so. We are fortunate in that the District's financial recovery from the pandemic is looking much better than expected. According to the latest projections from the Office of the Chief

Financial Officer (OCFO), the District will take in approximately $506 million more in revenue for FY2022 than was anticipated when the Council approved the FY2022 budget in August 2021.[4] This is in addition to the over $570 million excess surplus from FY2021.[5] Projected revenues for each year of the upcoming financial plan are also higher than previously anticipated.[6] OFCO estimates that FY2023 revenues will be 3.9 percent more than FY2022 revenues – an increase of nearly $360 million dollars.[7] Given this unanticipated additional revenue and the projected financial strength of the city, the Council is well-positioned to ensure areas in maternal health receive the needed financial support to provide resources and services to all District families and children. Further, the city has the resources to invest in both behavioral health professionals and services including to provide the necessary rate increases to behavioral health providers to ensure we can recruit and retain people in this high demand area.

The District has made Significant Investments in Maternal Health, We Must Ensure Those Investments are Preserved in the FY2023 Budget

The District faces some of the worst maternal health outcomes in the United States, including a distressingly high maternal mortality rate – particularly for Black pregnant and postpartum persons.[8] In a study of maternal mortality rates across the United States between 2007 and 2015, DC fared the worst by having the highest average maternal mortality rate at 33.3 per 100,000 live births.[9] Almost four years later, the maternal mortality rate in DC has not improved but in fact has worsen. According to data from the United Health Foundation, as of 2019, the maternal mortality rate in the

District was 35.6 per 100,000 live births.[10] Moreover, Black pregnant and postpartum people of all ages are three times more likely to die from pregnancy-related complications than their White peers.[11] In the District, Black pregnant and postpartum people made up 95 percent of pregnancy-related deaths in DC between 2013 and 2017.[12]

Significant investments are needed to address disparities in maternal health and outcomes in the District. Councilmember Henderson's Maternal Health Resources and Access Act of 2021 sought to address poor maternal health outcomes in the District.[13] We applaud this Committee and the Council for incorporating several elements of this bill into the FY2022 budget.[14] Under the FY2022 Budget Support Act and the American Rescue Plan Act of 2021 (ARPA), Section 9812, DHCF is authorizing three categories of new coverage or benefits related to maternal health in FY2022:

1. DHCF will submit a State Plan Amendment (SPA) for Medicaid coverage of doula services;[15]

2. DHCF will submit a SPA to extend postpartum coverage from 60 to 365 days postpartum;[16] and

3. Non-Emergency Medical Transportation (NEMT) for Alliance beneficiaries.[17]

This is a tremendous step forward to improve maternal health in the District. We are glad the Mayor is building on the momentum of the FY2022 approved budget, and we would like to thank the Mayor for the investments to maternal health in the FY2023 proposed budget.[18] This includes $480,000 in ARPA funds to support the NEMT transportation services.[19] Providing transportation is an important step to helping

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2023

Budget Oversight Hearing

Testimony of
Wayne Turnage
Deputy Mayor for Health and Human Services
and
Director, Department of Health Care Finance

Before the
Committee on Health
Council of the District of Columbia
The Honorable Vincent C. Gray, Chairperson

March 28, 2022
10:00 A.M.
Virtual Meeting Platform
The John A. Wilson Building
1350 Pennsylvania Avenue NW
Washington, DC 20004

Good morning, Chairman Gray, and members of the Committee on Health. I am Wayne Turnage, Deputy Mayor for Health and Human Services (DMHHS) and Director of the Department of Health Care Finance (DHCF). It is my pleasure today to report on Mayor Muriel Bowser's Fiscal Year 2023 (FY2023) Fair Shot Budget and Financial Plan for DHCF. I am joined by DHCF staff who were key in developing the agency's budget proposal for the Mayor's consideration.

As I often note, DHCF has one of the more complex budgets in the District and the team involved in crafting proposals is without peer in terms of their excellence and commitment to what we do. Much of the work in formulating a proposal for the Mayor's consideration was conducted by members of my Executive Management Team, which includes both my Deputy Director for Medicaid, Melisa Byrd, and our Deputy Director of Finance, Angelique Martin. The comprehensive data analytical work was spearheaded by senior staff member and Director of Data Analytics, April Grady. The work of April and her exceptional team of analysts was complimented by Darrin Shaffer, our Agency Fiscal Officer, along with members of his talented staff. Their collective efforts have been instrumental in producing this budget.

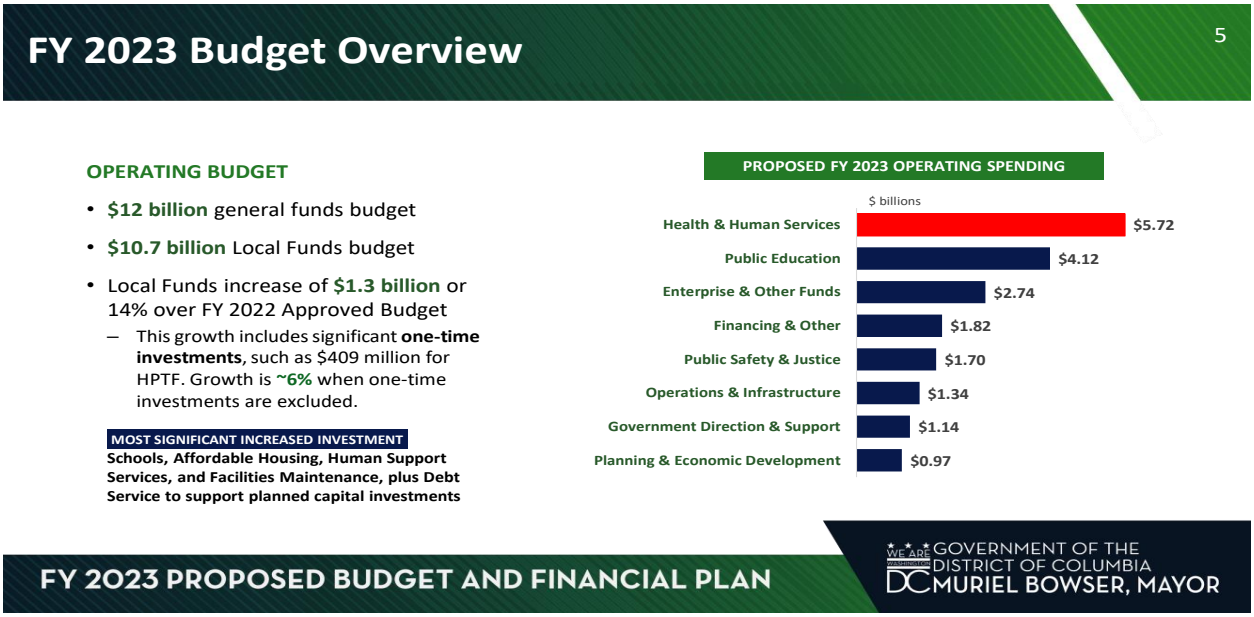
Introduction

As Mayor Muriel Bowser noted in her March 16, 2022, presentation to the Council, her FY2023 budget proposal is a "recovery budget"—one that offers a sweeping plan to fund initiatives that will allow the District to recover from a two-year pandemic that drained jurisdictions around the country of the resources necessary for sustained growth and prosperity. Now, the city is clearly perched on the precipice of a strong recovery. To wit, unemployment has declined to 5.8%, consumer spending is up by 7.3%, and the restaurant industry—always a leading indicator of the District's economic fortunes—has seen its revenue losses slow from -49% in the early days

of the pandemic to -20% today. While the industry still has room to grow, these metrics are moving in a favorable direction.

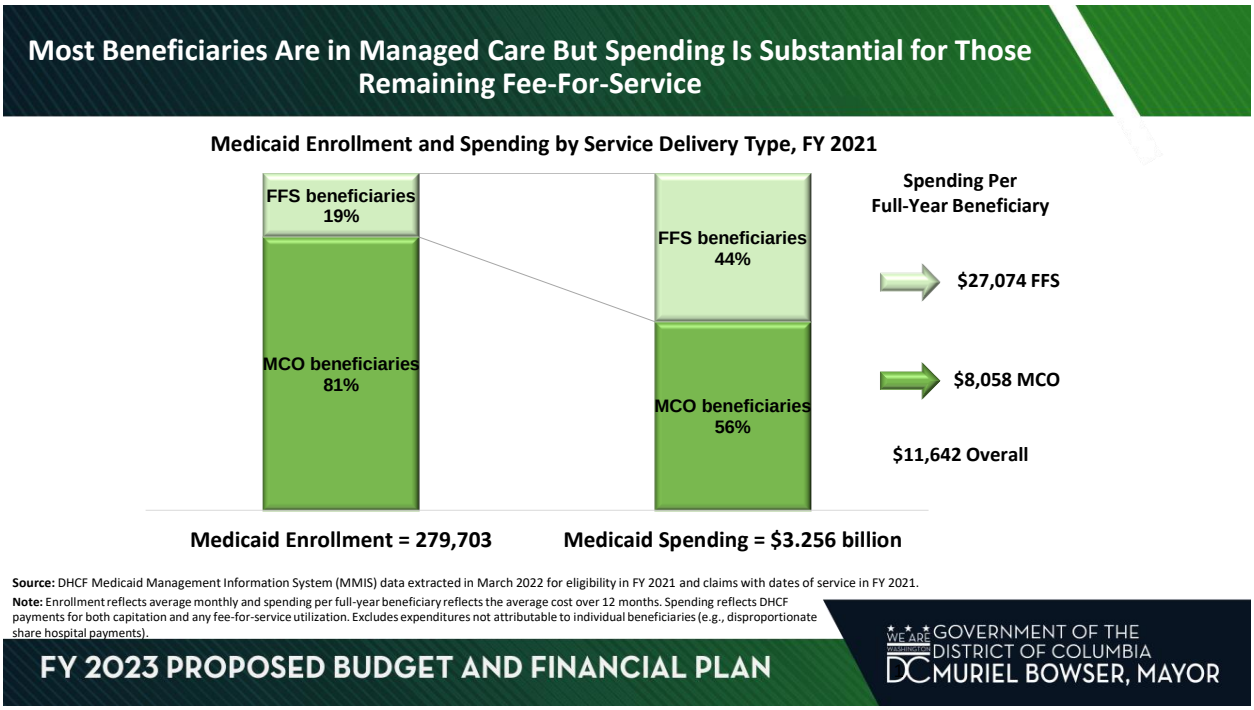
So, with significant federal support and a surging DC economy, the Mayor has proposed a FY2023 budget that is built on a record $19.55 billion in total operating dollars. As was the case in 2021, rather than have the normal budget town halls across multiple wards, the Mayor led a virtual process where Deputy Mayors outlined their cluster agencies' mission and goals, and then community members provided input through online voting. This process afforded communities across the city a window into the formulation process and the opportunity to voice their beliefs of how money should be allocated in the budget.

The Mayor's commitment to funding the health and human services agencies at levels necessary to ensure that all District residents have a "fair shot," is unchanged from previous years. Comprising nearly 30 percent of the proposed operating budget, the Mayor has allocated $5.72 billion for FY2023 to a range of health and human services programs, the majority of which will fund health insurance coverage for more than 45 percent of District residents (see graphic below).



The Challenge In Building DHCF's FY2023 Budget

DHCF's FY2023 budget supports access to care through health insurance coverage for more than 45 percent of District residents—the highest enrollment in the agency's history. Recall that the agency is in year three of a five-year Medicaid Reform plan aimed at improving health outcomes so that District residents can live their best lives. The challenges of reform are complicated by DHCF's program structure. As shown below, DHCF has a bifurcated program of managed care and fee-for-service (FFS) beneficiaries. Of the nearly 280,000 Medicaid beneficiaries, 81% are fully enrolled in managed care, accounting for 56% of Medicaid spending—this amounts to $8,058 per member. By comparison, the remaining 19% of FFS members, though smaller in number, disproportionately represent 44% of our total Medicaid spending, and on a per-member basis, are more than three times as expensive to insure. These differences must be accounted for as we pursue our Medicaid reform work.



As we have discussed previously, our Medicaid reform efforts are guided by four strategic priorities:

1. Building a health system that provides whole person care;
2. Ensuring value and accountability;
3. Strengthening internal operational infrastructure; and
4. Public health emergency response, monitoring and closure.

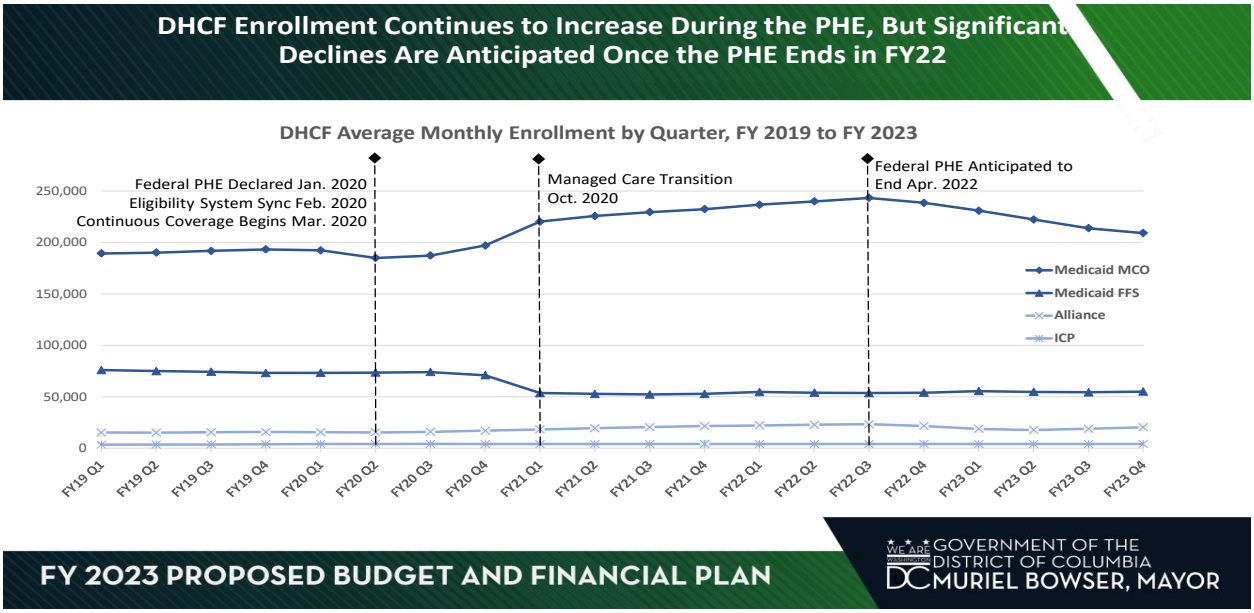
In addition to supporting ongoing reform efforts, the FY2023 budget must also address significant challenges facing the agency as we prepare to unwind from the federal public health emergency (PHE) and ensure continued access to services. Through the PHE, we must maintain continuous coverage in exchange for enhanced federal support. The enhanced federal support ends on the last day of the quarter in which the PHE terminates. Currently, the PHE is scheduled to end on April 14, 2022, and the enhanced federal funding will end at the end of that quarter on June 30, 2022. Renewals will start as early as July. This means we will carry higher enrollment levels for a number of months, largely without the benefit of the enhanced federal financial support.

So DHCF faces two challenges. First, we inherit the monumental task of returning to normal operations once the PHE concludes. Second, the health care system is struggling with unprecedented healthcare workforce shortages. Our goal, realized through this budget, is to ensure that District residents who are eligible for coverage, maintain enrollment while stabilizing the Medicaid provider network to ensure continued access to healthcare services. You will see that our proposed budget combines immediate and long-term financial investments to ensure stability in FY2023 and years to come.

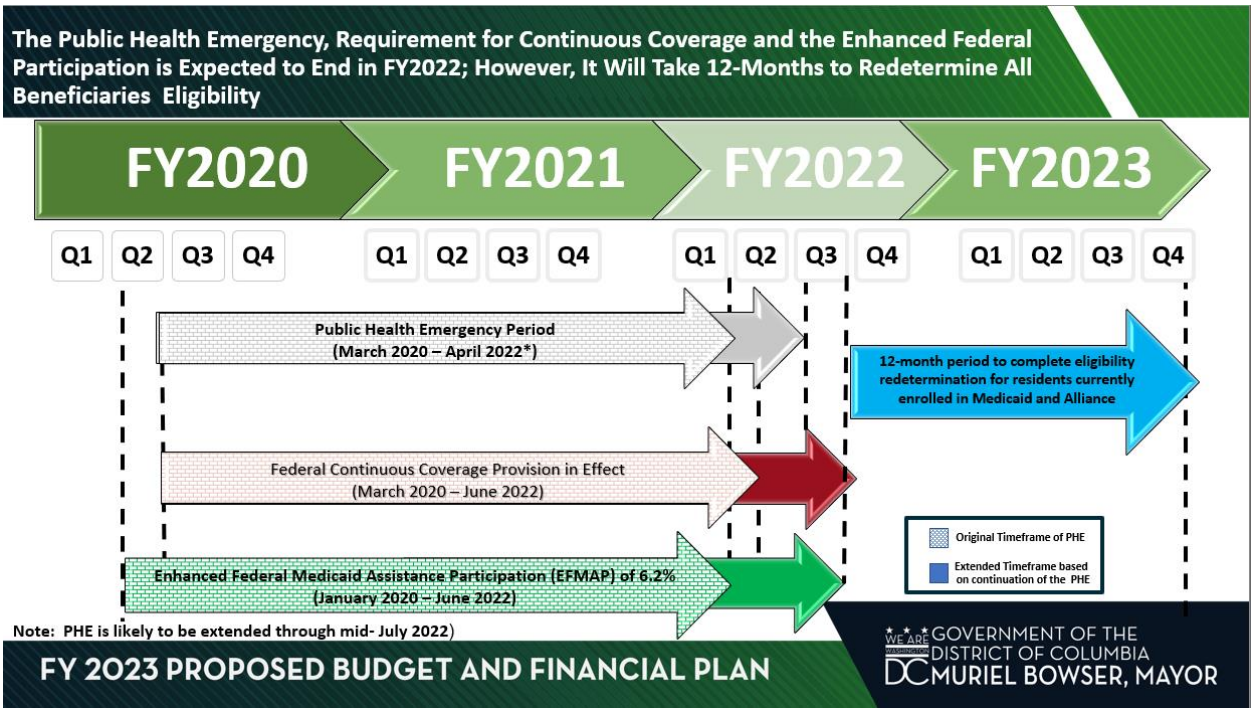
Capturing Enrollment Dynamics. When submitting DHCF's FY2022 budget a year ago, we predicted that after the federal PHE ends, a steep decline in the largest program within Medicaid

—managed care—would occur. We also expected that this decline would be accompanied by limited to no growth in the other programs. Accordingly, we anticipated an overall decline in expected enrollment, as the net effect of these adjustments. In the District, we have aligned Medicaid and Alliance on the same renewal schedule, therefore, we expect that following July of this year, the decline in enrollments for these two programs will begin.

The chart below illustrates the forecasted enrollment changes for each of our insurance programs—Medicaid managed care, Medicaid fee-for-service (FFS), Alliance, and the Immigrant Children's Program (ICP). The most perceptible decline in monthly enrollments is anticipated for Medicaid managed care beginning in the 3rd Quarter of FY2022. There is virtually no predicted change in enrollment for Medicaid FFS. With respect to Alliance, we expect a slight decline in that program when renewal certifications resume, but virtually no change in ICP enrollment levels. Given that total Medicaid spending is a function of enrollment levels, beneficiary utilization, and provider payments, the dynamics created by the renewal process must be calibrated into the agency's planned spending.



As shown by the graphic below, DHCF's budget proposal assumes the first renewals will be implemented at the end of June and then enrollment declines follow. Of course, if this end date is pushed out further, we will maintain the higher enrollment for a longer period, but this will create an upward pressure on the program's monthly cost that is not presently contemplated.



Chairman, for the remainder of my testimony today, I will focus on the agency's budget structure and the year over year changes in the key components that shape the agency's spending plan. In addition, I will report on the budget development process with special attention to how DHCF's proposed $3.7 billion spending plan was constructed, including investments made by the Mayor in support of health care delivery in Ward 8.

DHCF's Budget Structure

DHCF has a complex budget structure which is supported by six funding types. The two funding types which pay for our largest expenditures are the federal Medicaid Entitlement Grant

and the agency's local fund source. Dedicated taxes, federal grants, intra-district funds, and special revenue funds complete the funding types.

The chart below shows each funding source, the proposed FY2023 budget amount and the year over year comparison from FY2022 to FY2023. Overall, the FY2023 budget increases by 1.4%, or $52.1 million over the FY2022 approved budget. It is important to highlight the near 10% increase in local funds. This larger than usual increase was necessary to account for the end of the enhanced federal matching assistance percentage (FMAP) that was available in FY2022. Specifically, during the PHE, the District's FMAP increased from 70% to 76.2%, meaning the federal government paid 6.2% more towards the cost of the Medicaid program. The FY2023 budget assumes the District's standard FMAP of 70%.

DHCF's FY2023 Year Over Year Budget Increased By Only 1.4 Percent, But Local Dollars Had To Be Increased By 10% To Account For End Of Federal Enhanced Payments

Appropriated Fund		FY 2022 Approved Budget	FY 2023 Proposed Budget	YoY Budget Change	% Change
0100	Local	847,228,958	927,658,867	80,429,909	9.5%
0110	Dedicated Taxes	103,219,385	105,105,077	1,885,692	1.8%
0150	Federal Payments	2,000,000	2,000,000	-	0.0%
0200	Federal Grants	3,206,819	5,174,115	1,967,296	61.3%
0250	Federal Medicaid Payments	2,553,572,305	2,663,283,088	109,710,783	4.3%
0400	Private Grants	-	365,701	365,701	100.0%
0600	SPR Revenue (Type)	6,434,236	5,643,542	(790,694)	-12.3%
0700	Intra Districts	141,368,841	-	(141,368,841)	-100.0%
Grand Total		**3,657,030,545**	**3,709,230,390**	**52,199,846**	**1.4%**

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

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DC MURIEL BOWSER, MAYOR

DHCF's proposed budget also reflects significant year over year increases in federal and private grants. First, DHCF was awarded a $5 million federal Money Follows the Person (MFP) Capacity Building grant. The grant extends through FY2025 and will support existing efforts to

maintain and expand home and community-based long-term services, with an emphasis on person-centered service planning and delivery. This includes workforce development for home health providers, gap funding for environmental accessibility adaptations and assistive technology maintenance and repairs, funding for EPD (Elderly and Persons with Physical Disabilities) waiver case management system improvements, and outreach on HCBS (home and community-based services). Second, DHCF applied for a private grant to support outreach to District residents eligible for both the Medicaid and Medicare programs and their options for integrated care programs like Dual Choice and PACE.

DHCF's Budget Development Process

Mr. Chairman, at this point, I would like to discuss the budget development process for DHCF and illustrate the actions taken to shape our proposed FY2023 budget (see table below). DHCF began the process with a FY2022 recurring operating local fund budget of $814.6 million. The amount was increased by $37.7 million as a restoration adjustment to the agency's budget

How DHCF's Local Funds Budget Reached More Than $927 Million

In millions

FY22 Recurring Budget	**814,646,705**
Adjustments Made During MARC Formulation	52,826,742
2% Reduction	(16,480,565)
FY2023 Revised Baseline	**850,992,882**
Budget Adjustments:	
Restoration of Agency Budget Reductions to Meet MARC	37,773,425
Additional Vacancy Savings	(930,581)
Total Restored of Proposed Budget Savings Initiatives	**36,842,844**
Mayor's Enhancements:	39,343,141
Final FY2023 Local DHCF Budget	**927,178,867**

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

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DC MURIEL BOWSER, MAYOR

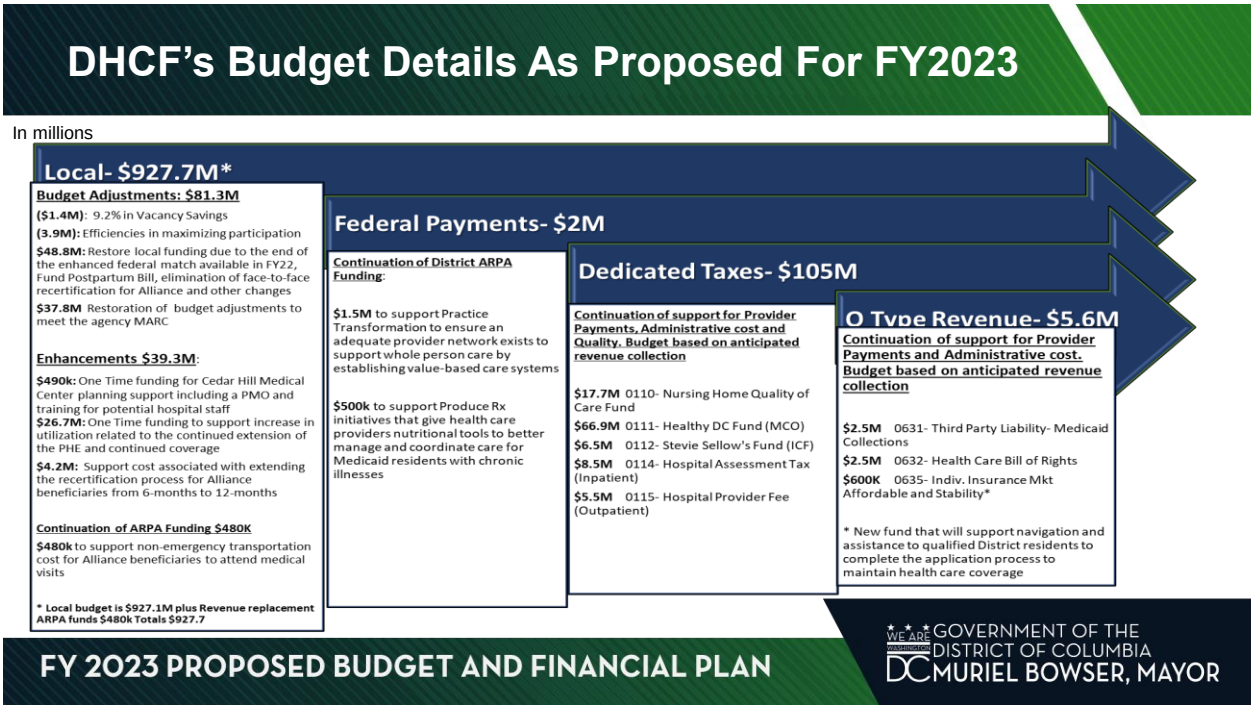
target. Added to this amount was more than $39 million in program enhancements that were included by the Mayor. The agency was also able to produce a 9.2% vacancy savings (or $1.4 million) which is 3% higher than in FY2022. Finally, DHCF's FY2023 budget includes a new O Type fund of $600,000 to support assisting residents with completing applications for insurance on the individual marketplace to maintain health care coverage.

Program Enhancements. As noted, the Mayor funded program enhancements totaling $39.3 million. Most of these funds support the associated costs with the continuance of the federal PHE through mid-April. As I discussed earlier in my testimony, the District must keep beneficiaries enrolled in the Medicaid program through the duration of the federal PHE—otherwise we forgo the enhanced federal support. Our program enrollment projections predict a decline once the PHE ends— but with the January extension of the PHE to April, the current higher enrollment will continue further into the year. Declines in enrollment are thus pushed further into the future, requiring additional funding to support care for District residents.

Chairman Gray, I know the personal importance to you of the Mayor's funding to allow Alliance beneficiaries to renew coverage only once a year. This is a welcomed end to a much-debated issue. When coupled with the elimination of the mandatory face-to-face requirement, the renewal process for Alliance beneficiaries will closely align with Medicaid.

The remaining two program enhancements support District hospitals that serve a high proportion of Medicaid beneficiaries. As with last year, included in DHCF's budget is $8 million in grant funding for Howard University Hospital to cover the loss of Disproportionate Share Hospital (DSH) funding for the hospital—a problem that was created by a federal change to DSH law that produced the unintended consequence of a $21 million loss in funds for the hospital. This grant ends in FY2023. The second enhancement is $490,000 for planning support for the Cedar

Hill Medical Center project. The details of DHCF's FY2023 budget are shown below with the additions and subtractions ultimately resulting in a proposed budget of more than $927 million in local funding.



Ensuring Access to Coverage and Services

Especially important in the FY2023 budget is the overall maintenance of the Medicaid and Alliance programs. Mayor Bowser's proposal ensures that the District remains a national leader in providing coverage to residents, as we strengthen our already comprehensive benefit package and access to services. I am pleased to share that Mayor Bowser's proposed budget for DHCF sustains our programs' foundational components—eligibility, benefits, and provider rates—at levels comparable to, or greater than, those observed in FY2022. This is crucial in ensuring stability across the Medicaid and Alliance programs as we continue to emerge from the pandemic. Building on this foundation, the budget also incorporates elements to strengthen the Medicaid and

Alliance programs over time to guarantee a more resilient public health care delivery system and a stronger, healthier, and more equitable DC.

Coverage. The District leads state Medicaid programs across the nation with some of the most generous eligibility levels. The extension of postpartum coverage from 60 days to one year will allow women who otherwise may lose coverage after 60 days to remain covered for an entire year. This coverage expansion will be effective April 1, 2022, and is supported through the FY2023 budget. For the Alliance program, the FY2023 budget maintains the removal of the face-to-face requirement for eligibility recertification. Combined with the new annual renewal requirement, we are removing barriers to continuous coverage for all District residents. Finally, the budget provides the funds needed to return to normal operations at a reasonable pace, maintaining the historical cadence for renewals and decreasing the likelihood that District residents will experience a lapse in coverage.

Health Care Services. The array of benefits available through the Medicaid program consist of both federally mandated and optional services. In the District, we cover nearly all optional services in addition to mandated services such as inpatient hospital care, physician services, federally qualified health clinic (FQHC) services, and transportation to medical appointments (see list of services on page 13). In FY2023, DHCF will implement doula services as a new optional benefit for beneficiaries in both the fee for service (FFS) and managed care programs. Recognizing the important role of pharmacists as a trusted and accessible health care provider, DHCF will expand allowable services by pharmacists to include tele-pharmacy, point of care testing for certain viruses, and medication management services. This service enhancement may also dampen beneficiaries' unnecessary use of emergency rooms for non-emergency services, which might also generate cost savings to the Medicaid and Alliance programs.

The Mandatory And Optional Benefits Funded in The Mayor's FY2023 Budget Are Comprehensive And Extensive

Mandatory Service Benefits

- Inpatient hospital services
- Outpatient hospital svcs. (incl. Emergency Room)
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Service Benefits

- Prescription Drugs
- Clinic services
- Physical therapy and Occupational therapy
- Speech, hearing and language disorder services
- Other diagnostic, screening, preventive and rehab. svcs
- Podiatry svcs, Optometry svcs & Other practitioner svcs
- Dental Services and Dentures
- Prosthetics, Eyeglasses
- Private duty nursing services
- Personal Care
- Hospice
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Intermediate care facility for Individuals with IDD
- Adult Day Health Program
- Inpatient psychiatric services for individuals under age 21
- Health Homes Programs

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

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Ensuring access to services is achieved not only through the array of covered benefits but also through the payment of adequate and equitable provider rates. Provider payments comprise 93% of the agency's budget and reflect the maintenance of provider rates in the FY2023 budget. You may see fluctuations in year over year changes, but the proposed budget reflects the projected service costs. These fluctuations are mostly attributable to three factors:

1. The end of enhanced rates made available under the federal PHE – meaning spending by provider type may appear lower because the budget assumes a return to the normal, pre-pandemic rate structure.

2. The full reflection of the transition of 17,000 beneficiaries from the FFS program to the managed care program. As the managed care program expanded in October 2020, costs shifted from fee for service Medicaid to managed care.

3. Policy changes that are not realized but were previously incorporated into our budget. For example, we planned for personal care aide (PCA) services to no longer be available under the State Plan Medicaid for EPD waiver beneficiaries, effective 2020. This shifted PCA spending from State Plan/FFS Medicaid into the EPD waiver and increased the EPD waiver

budget. However, this policy change will not be implemented, and projected spending will shift from EPD waiver to State Plan PCA.

The chart below shows the year over year changes for major provider types. The highest projected costs cover services provided by managed care, DD (developmental disability) waiver providers, skilled nursing facilities, and hospital provider types. Deserving special note is the increase to direct service professionals. The proposed budget targets a rate increase for those working in home and community-based settings for behavioral health, home health agencies, and IDD (intellectual and developmental disability) waiver providers. Their wages will be set to an average of 117.6% of the District's Living Wage or Minimum Wage (whichever is higher) beginning in FY2023, fully realizing the increase by FY2025.

For Several Reasons, Proposed FY2023 Provider Payments Vary Significantly From Those Approved In The FY2022 Budget

Provider Payment Category	FY2021 Expenditures	FY2022 Approved Budget	FY2023 Proposed Budget*	YoY Variance		Variance Explanation
Hospital	253,726,006	191,495,044	220,699,190	29,204,146	15%	Alignment with anticipated utilization post pandemic in Inpatient and a decrease in DSH as a result of the cahnges in DSH requirements
Hospital Support Funding	9,900,000	8,000,000	8,000,000	-	0%	
ICF/IID	98,625,562	109,758,823	92,556,719	(17,202,104)	-16%	Based on anticipated enrollment (XXX), FY23 includes funding to pay increased DSP wages for FY21 and FY23 does not include enhanced rate but assumes rebasing
Skilled Nursing Facility	303,898,273	280,101,143	286,081,727	5,980,584	2%	
Primary Care (Physicians, Clinics and FQHC)	96,373,867	99,627,598	69,156,102	(30,471,496)	-31%	Assumes end of enhanced rates and "normal" utilization for FFS population post transition
Other (Medicare Part A, B, etc)	123,232,012	136,125,533	154,916,714	18,791,182	14%	
DME	15,289,893	18,155,075	24,990,621	6,835,546	38%	Includes assumptions in utilization and updates in Fee Schedule adjustments
Behavioral Health (Inc. BH Waiver)	152,854,816	165,838,412	158,235,140	(7,603,273)	-5%	
Skilled Care	25,941,841	20,449,326	29,432,902	8,983,576	44%	Alignment of Nursing Rates including inflation
LTCS (incl PCA and PACE)	181,910,430	166,808,814	87,793,560	(79,015,254)	-47%	Assumes end of enhanced rates for PCA and ADHP, and a full year of PACE
DSNP	-	-	123,215,268	123,215,268		
EPD Waiver	170,957,106	203,578,632	210,349,699	6,771,068	3%	
DD Waiver	308,558,556	294,924,043	313,866,978	18,942,935	6%	
IFS Waiver	1,548	4,114,601	5,975,703	1,861,102	45%	Assumes increase in enrollment in the waiver
Emergency Medicaid	30,027,240	34,995,382	31,855,709	(3,139,673)	-9%	
MCO	1,598,723,474	1,475,732,863	1,516,854,052	41,121,188	3%	
Permanent Supportive Housing	-	10,667,822	70,575,546	59,907,724	562%	FY23 assumes a full year of implementation and increased enrollment
Total	**3,370,020,624**	**3,220,373,110**	**3,404,555,630**	**184,182,519**		
Note: FY23 Budget includes funds interagency funding that supports the provider payment category						

FY2021
- Full Year of PHE
- Enhanced Provider Rates
- First Year of FFS Transition

FY2022
- 1 Qtr. of PHE Enhanced Provider Rates

FY2023
- Post Enhanced Rates
- Return to Regular Provider Rates
- New Utilization Trends
- Adjusted Enrollment

* Transition Population represents the FFS Populations that shifted to MCO in FY24 (including SSI adults and Beneficiaries eligible for MCO but opted out)

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

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DC MURIEL BOWSER, MAYOR

The phased approach is purposeful and balances providing immediate financial support to providers while revising the rate methodologies for federal approval. This is important as changes to the rate methodologies are necessary to allow for the proper oversight to ensure providers are complying with the wage requirement. Initially, the increased funding will be provided in FY2023 and FY2024 to providers through lump sum allotments which DHCF will make at the beginning of FY2023. By FY2025, the increased rate will be incorporated directly into the provider's rate.

Other states are choosing to use American Rescue Plan Act (ARPA) Section 9817 Home and Community Based Services (HCBS) funding for DSP wage increases. As our proposal illustrates, the Mayor is raising the wage that direct service workers receive—directly increasing the take home pay for the health care professional by significant amounts (see table below page).

DHCF Will Utilize HCBS ARPA Funds To Support Providers In Paying Direct Support Professionals An Average of 117.6% of Living Wage/Minimum Wage By FY2025

In response to the recent workforce shortage in Direct Support Professional (DSP) Workforce, DHCF will use HCBS ARPA funding in FY2023 and March 2024 and the District will support with local funds for fiscal years forward.

Mayor's Proposal

- Support HCBS providers, through the Medicaid rate; the ability to pay DSP's a wage above the living and minimum wages (whichever is greater). The current proposal aligns the concept of the original Bill (B23-214) to pay DSP's an average of 117.6% of LW or MW but expands it to cover the following DSP's: PCA's, Participant Direct Care Workers (PDW's in Services My Way an EPD Waiver service), DD DSP's, Certified Addiction Counselors (in MHRS- Mental Health Rehab Services and ASARS- Adult Substance Abuse Residential Services) that provide services to Medicaid participants in home and community-based settings. Providers will determine the rates they pay their DSP workers; however, they are required to pay an average of 117.6% of the LW/MW.
- This concept establishes a career ladder and promotes longevity by offering a range of pay from living wage (entry level) to $4 more for a tenured DSP

How Will Funds Be Allocated?

- DHCF will allot funds in FY2023 and FY2024 in a lump sum allotment to each Provider based on DSP data provide- due October 1st including Schedule of DSP's, salaries, date of hire and vacancy rate
- The allotment will be issued in December and the requirement for Providers to pay qualifying DSP's new rate will be aligned with regular living wage adjustments on January 1st
- DHCF will complete a reconciliation at the end of the period to determine the increase in DSP wages over the year and the impact it had on the vacancy rate
- In FY2025, DHCF will amend the State Plan and Waivers to increase the rate methodology for the respective provider to support the impact of achieving the average of 117.6% for the DSP workforce

What Will the Allotment Cover?

- The increase will cover the cost of paying an average of 117.6% of living/minimum wage (whichever is greater)
- Fringe
- Administrative rate

Example: The example assumes that living wage continues to increase annually

	Living Wage	Mid Level	Higher Level
FY2023	$16.10	$18.93	$22.37
FY2024	$16.45	$19.35	$23.20
FY2025	$16.82	$19.78	$24.05

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

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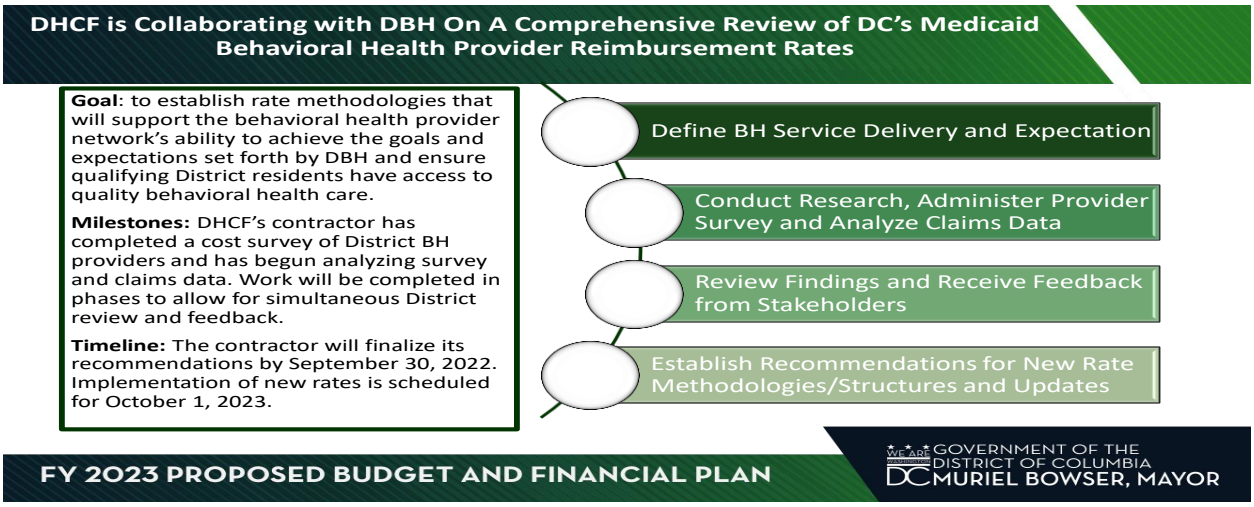
For example, the current DC Medicaid rate for home health agencies—through which many direct care workers are employed—is $22.56. However, this rate is inclusive of the living/minimum wage for the direct care worker plus the administrative costs borne by the HHA.

Some advocates and state proposals represent the overall rate to the agency as the wage level, though only a portion will go the direct care work. It is important to recognize these differences as 100 percent the rates funded by the Mayor and reported on page 16 are allocated to the worker.

There are other ways—in addition to rate increases—where we can support providers and the overall delivery system. It is through this lens that we are leveraging new federal opportunities. For example, we are targeting ARPA HCBS initiatives to support providers in recruiting and retaining direct care workers. This is in addition to the rate increase initiative described above. These bonus payments will alleviate the pressure on providers to utilize revenues reserved to cover the cost of providing services.

The FY2023 budget also provides inflationary increases for Mental Health Rehabilitation Services and Adult Substance Abuse Rehabilitation Services—the first in years. We have acknowledged that behavioral health providers require a complete rate adjustment to reflect year over year rising costs to meet service expectations. Therefore, we are engaged with the provider community and the Department of Behavioral Health in a comprehensive rate study of behavioral health services. The rate study is underway, and the results will inform the agency's FY2024 budget proposal. The schedule for this effort is shown below.



Strengthening the System. The federal American Rescue Plan Act (ARPA) provides states with a temporary 10 percentage point increase to the federal medical assistance program (FMAP) for Medicaid HCBS. States must use funds equivalent to the amount of federal funds attributable to the increased FMAP to implement activities that enhance, expand, or strengthen Medicaid HCBS. Unlike other enhanced FMAPs where the additional federal funds decrease the amount of local funds necessary to fund services, the District must maintain its full local commitment to HCBS. Further, any initiative must be sustainable beyond the duration of the enhanced funding.

ARPA gives states the authority to fund initiatives that are traditionally unallowable through the Medicaid program. It also broadens the definition of HCBS to be inclusive of behavioral health services and providers. Hence, the typical constraints we are challenged with in the Medicaid program are absent, hence creating a singular opportunity to transform the HCBS delivery system and support equity for individuals primarily served through the Medicaid program.

As we heard at our oversight hearing in February, many providers and stakeholders expressed their desire for the District to use the ARPA HCBS funding to increase rates. However, we have existing mechanisms to adjust rates as needed – they are the routine and normal operations of a Medicaid program. As shown, the FY2023 budget reflects the commitment to increase wages for direct service professionals to 117.6% of Living Wage or Minimum Wage over the next three years without using a significant portion of ARPA HCBS funding.

It is for that reason that we are utilizing the ARPA HCBS funding for initiatives that are not traditionally allowed through the Medicaid program so that we can further enhance the home and community-based system. Through the ARPA HCBS funding, we will support HCBS providers in both the short- and long-term. This includes funding to facilitate the recruitment and retention of direct service professionals, vaccine incentives for HCBS providers, incentive

payments and technical assistance to support provider adoption and use of digital tools, and other training and professional development programs. This influx of funding into the HCBS system will provide a new layer of support for providers above and beyond the traditional mechanism of payment rates.

Reforming Medicaid. The District's Medicaid program is transitioning to a fully managed care program. Today, over 81% of beneficiaries receive care through a managed care plan in the Healthy Families program, CASSIP, or the newly expanded District Dual Choice program. In FY2023, we will expand the array of options for better integrated care for Medicaid beneficiaries participating through the PACE program and through the implementation of new managed care contracts.

As I detailed in my oversight testimony a month ago, we are in the middle of the managed care program solicitation. The District is still currently on schedule to meet the estimated award date of June 30, 2022. When awarded, the contracts will be for a five-year base period with one five-year option period. We are hopeful that extending the base period of the contract will bring stability to the managed care program after multiple protracted procurements.

One of our four strategic priorities mentioned earlier—to ensure value and accountability—means that we will make substantial efforts to move partly away from traditional volume-based health care payments to payments based on value that support positive member health outcomes and cost savings. The transition to these new reimbursement methodologies will allow the introduction of provider flexibilities to innovate and deliver more equitable and integrated care, including creating new care models and teams that the current methodologies do not support.

Beginning October 2022 and continuing through 2027, the DHCF's value-based payment (VBP) policies require increased use of payment methodologies that emphasize quality rather than

quantity of services provided through the MCOs (managed care organizations). To provide the vision for, and parameters of, the VBP expectations, DHCF will being developing a VBP Roadmap and drawing on lesson learned from other states like Oregon, California, and New York which have a rich history in health care transformation. VBP allows providers' control to be more accountable to the care they provide and allows them to enhance staff salaries if they can control costs without lowering the quality of care. The FY2023 budget continues the District's commitment to assist providers so they can be successful in the transition to VBP through various technical assistance opportunities, including Integrated Care DC, RevUp DC, and the business transformation grant.

Capital Funds For Cedar Hill Regional Hospital – GW Health

Mr. Chairman, I conclude my testimony by drawing your attention to the Mayor's FY2023 proposed capital budget, which includes an additional $15 million to construct the new hospital—this is a 4% increase in the overall project cost. The increase is due to three factors:

1. The hospital was designed and budgeted for in 2019, prior to the emergence of COVID-19. The partners incorporated lessons learned during COVID into the design – for example the use of 100% outdoor air HVAC systems.

2. Inflation, global and national supply chain shortages, and market conditions have increased the cost of non-residential construction and new health construction by 12% from October 2020 to 2021—with uncertainty about future trends.

3. The hospital partners made a strategic decision to build a larger diagnostic and treatment area to accommodate future growth and potential health emergencies.

It is important to note that Universal Health Services will contribute $5.5 million to assist with the additional costs associated with the larger diagnostic and treatment center.

Workforce Training and Project Management. In addition to this proposed capital outlay, the budget includes $250,000 in operating funds for the District to establish voluntary training

courses for any United Medical Center staff interested in working at the new hospital, who might also need to upskill or reskill to meet the new hospital's hiring requirements. This reflects prior legislation and associated agreements. The funds will be used for a 3rd party construction project manager to be overseen by DHCF.

Conclusion

Mr. Chairman this concludes my testimony on DHCF's proposed budget for FY2023. As has been demonstrated, the Mayor continues to fund health care through the Medicaid and Alliance programs at levels that support expansive coverage to promote critical access, as well as comprehensive services to ensure the enrollees receive the full range of preventive, diagnostic, emergency, specialty care and acute services. My team and I are happy to address any questions from you and others on the health committee. Thank you for this opportunity to testify.

Deputy Mayor for Health and Human Services (DMHHS) and Department of Health Care Finance (DHCF) Fiscal Year 2023 Budget Presentation

Presentation Before the
Committee on Health
Council of the District of Columbia
The Honorable Vincent Gray, Chairperson

March 28, 2022
Washington, DC

WE ARE WASHINGTON GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

Presentation Outline

- ☑ **Rebounding Economy and General Budget Overview**
- ☐ Funding and Functions of Office of Deputy Mayor for Health and Human Services
- ☐ DHCF and Important Medicaid and Alliance Program Trends
- ☐ Key Budget Proposals For DHCF
- ☐ Status of New Hospital

The District's Economy Is Rebounding

	Pre-COVID	Early COVID	Mid-COVID	Today
DISTRICT REVENUES	$8.7B	$7.9B	$8.5B	$9.4B
UNEMPLOYMENT RATE	5.0%	11.1%	7.2%	5.8%
RESIDENTIAL VACANCY (Multi-Family)	7.7%	11.4%	12.7%	9.0%
COMMERCIAL VACANCY	11.1%	11.9%	12.5%	14.3%
DC RESIDENTS VACCINATED	-	0%	49%	72%
CONSUMER SPENDING	-	-41%	-17%	+7.3%
RESTAURANT SPENDING	-	-49%	-26%	-20%
PUBLIC HEALTH RESTRICTIONS	NONE	MANY	SOME	FEW

This budget will give District residents a “Fair Shot” by ……

investing $19.5 billion in helping us emerge from the pandemic stronger and more ready to thrive than ever

The Operating Budget is Funded With More Than $12 Billion

OPERATING BUDGET

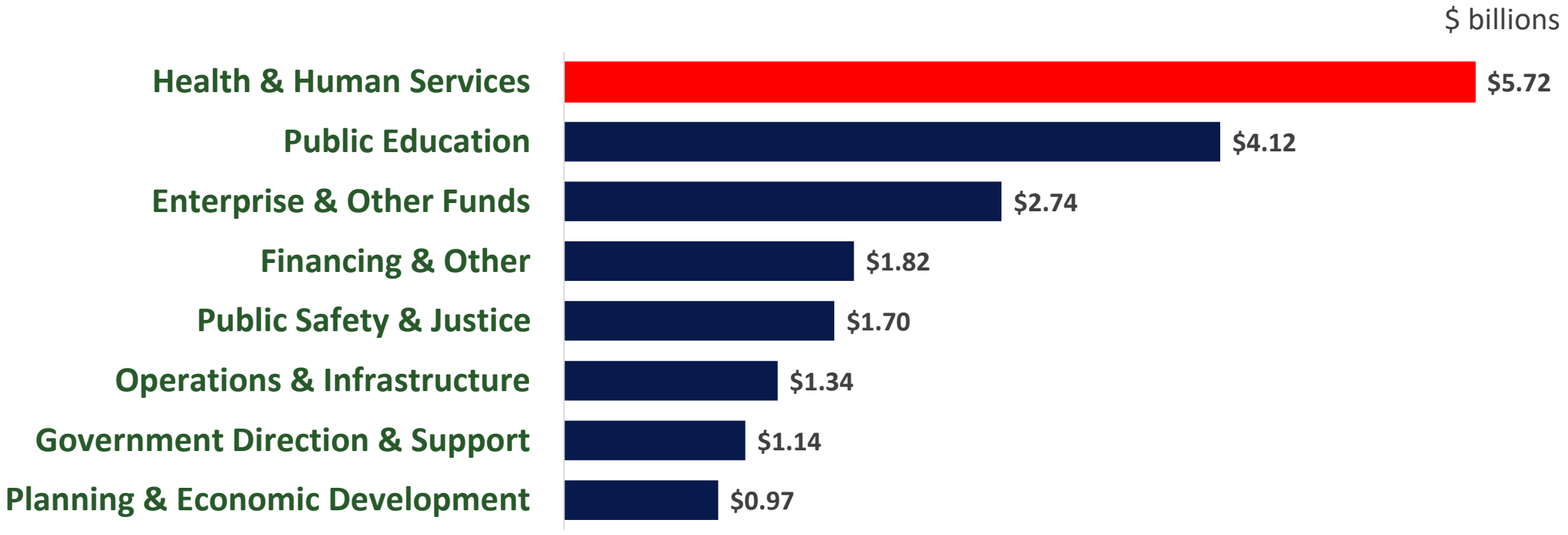
- **$12 billion** general funds budget
- **$10.7 billion** Local Funds budget
- Local Funds increase of **$1.3 billion** or 14% over FY 2022 Approved Budget
  - ❖ This growth includes significant **one-time investments**, such as $409 million for HPTF
  - ❖ Growth is **~6%** when one-time investments are excluded

Key Investments

- ➢ Schools
- ➢ Affordable Housing
- ➢ Health and Human Support Services, and
- ➢ Facilities Maintenance, plus Debt Service to support planned capital investments

Health And Human Services Account For Largest Portion Of Mayor Bowser's FY 2023 Budget

Proposed FY2023 Operating Budget



Total $19.55 Billion

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DMHHS Office Has $2.86 Million Budget To Support 15 Staff Who Perform A Range Of Key Oversight And Programmatic Activities

Key functions of the office:

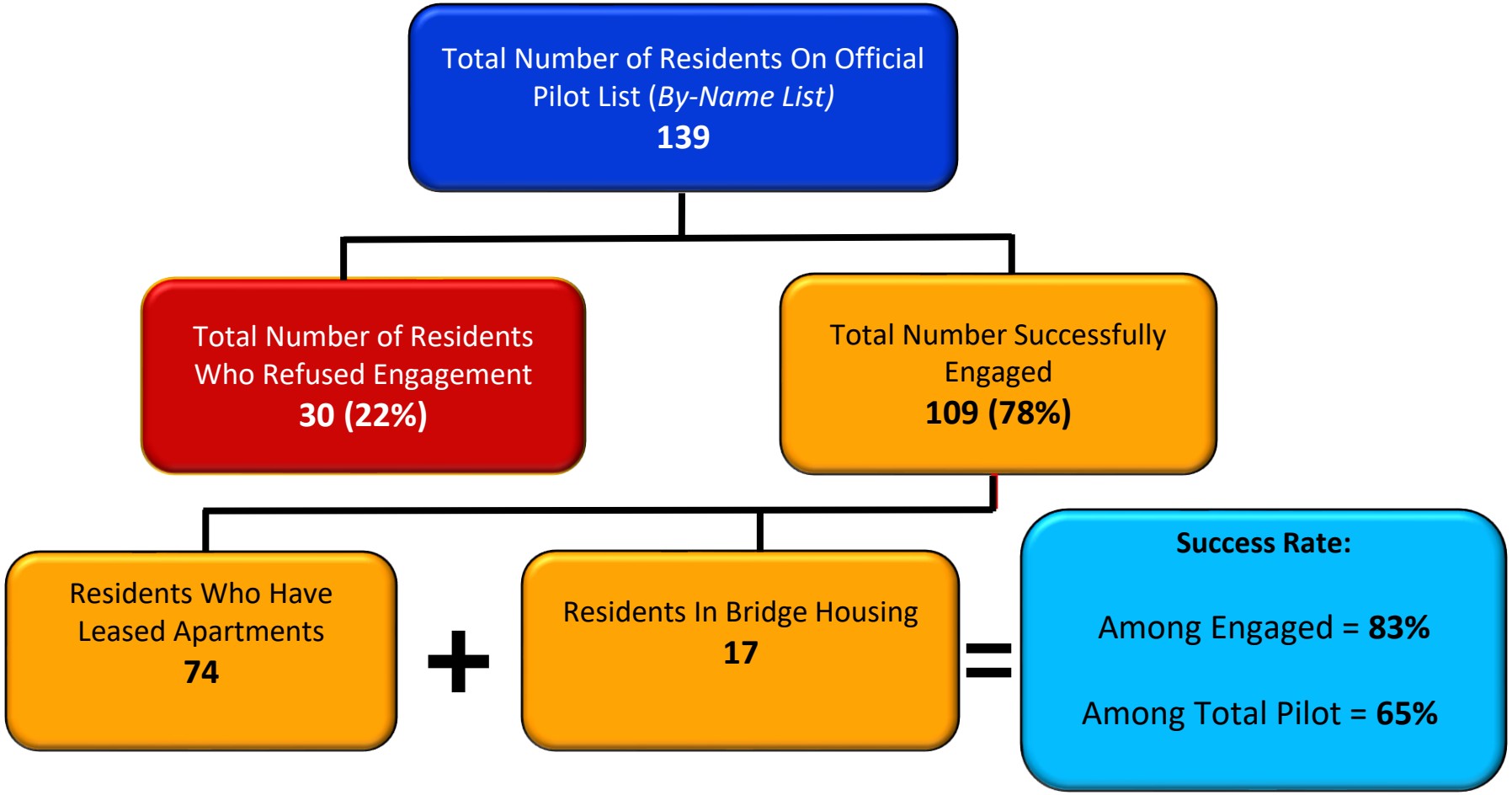
- Coordinate the work of interagency teams including Short-term Family Housing programs, Opioid Crisis, Commission on Health Care Systems Transformation, and the Coordinating Council on School Behavioral Health
- **Lead coordination of Encampment Response and Implement CARE Pilot**
- Provide oversight of interagency crisis response, including the COVID-19 response and recovery along with pressing issue of elevated opioid overdoses across the city
- **Facilitate our internally-directed programs – The Interagency Council on Homelessness, Encampment Protocol Engagements, and Age-Friendly DC**
- Partner with agencies to promote policy, legislative, and budget changes

Executing A Response To Encampments Is A Major Aspect Of Our Work

DMHHS leads Encampment Response and Engagement and Implements CARE Pilot.

- The Encampment Team conducts welfare checks and provides services to over 280 encampment sites in the District
- Mayor Bowser's CARE Pilot Program is a "Housing First" model for persons living in encampments. The goal is to establish permanent housing as the platform from which all other needs of those experiencing homelessness can be addressed.
  - Cross agency coordination with DBH, DPW, DHS, and the federal government through NPS along with CBOs (Pathways to Housing and Miriam's Kitchen).
  - **FY22 Budget of $3.9M**
  - **$4.2M** for **DHS** for expanded outreach, housing subsidies, staffing costs, and client costs which will assist in continuing services provided through the CARE pilot'
  - Coordinate with National Park Service which is planning to close several encampment sites
  - Report to Mayor this Spring with recommendations for next steps

Outcomes To Date Support Plans For Citywide Program



Key Investments Designed To Make DC an Easier Place to Grow Older

The Mayor's FY23 budget continues to invest in the District's older adults. It includes:

- **$500K** for free dental services
- **$2.6M** towards greater community connection and wellness through technology by distributing personal tablets
  - Approximately **1000** wireless enabled iPads in FY23. **500** distributed in FY21
- **$1M** to continue expanding city-wide mobility via the ***Connector Card Program***
- **$750K** towards a new ***grocery gift card*** pilot program

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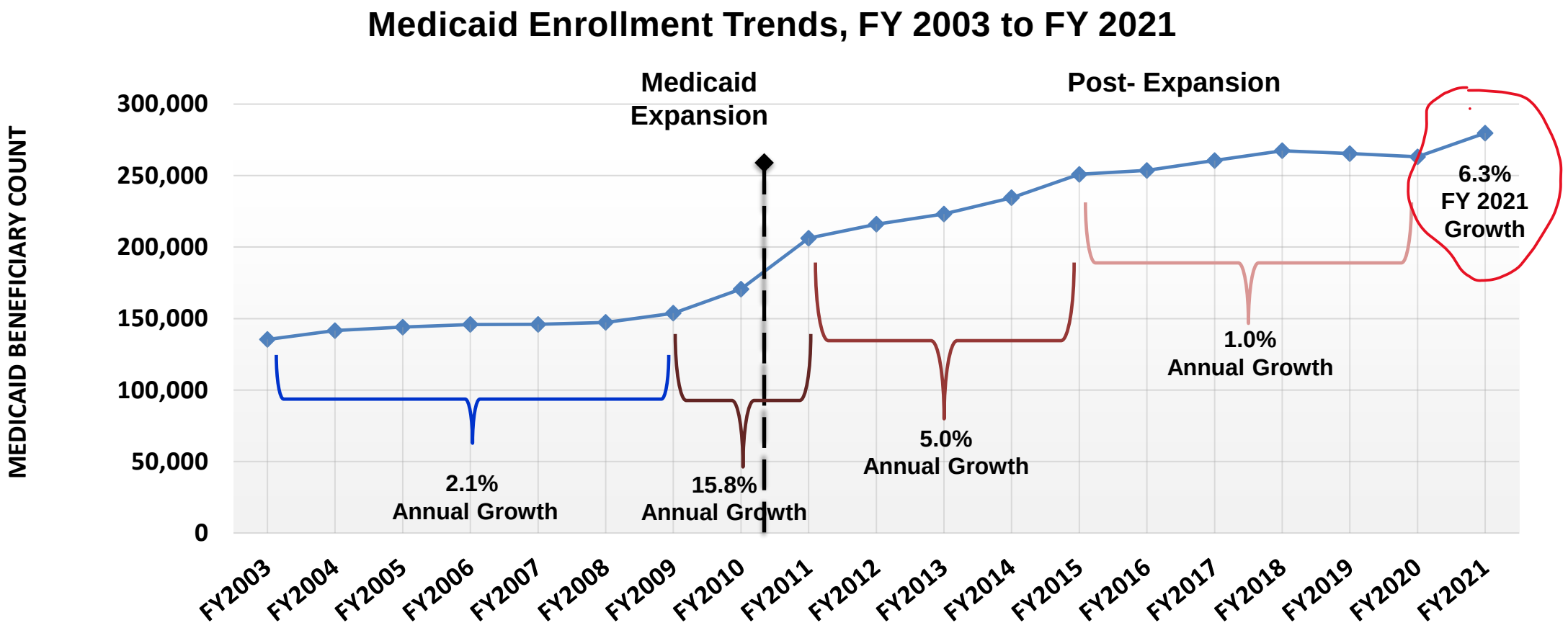
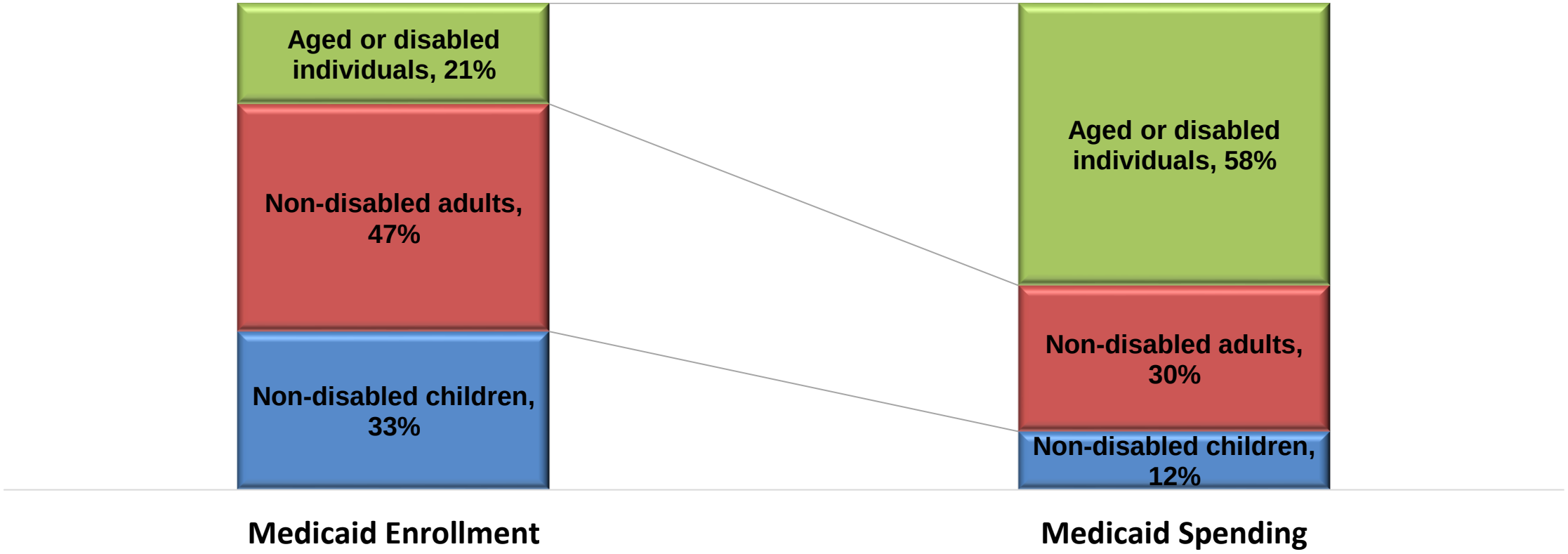
Medicaid Enrollment Spiked During The Pandemic



Source: Data for FYs 2000-2009 extracted by Xerox from tape back-ups in January 2010. Data for FYs 2010-2020 from DHCF's Medicaid Management Information System as of March 2022. Figures are average monthly.

Aged and Disabled Beneficiaries Account for About 20 Percent of Enrollment, But Nearly 60 Percent of Spending

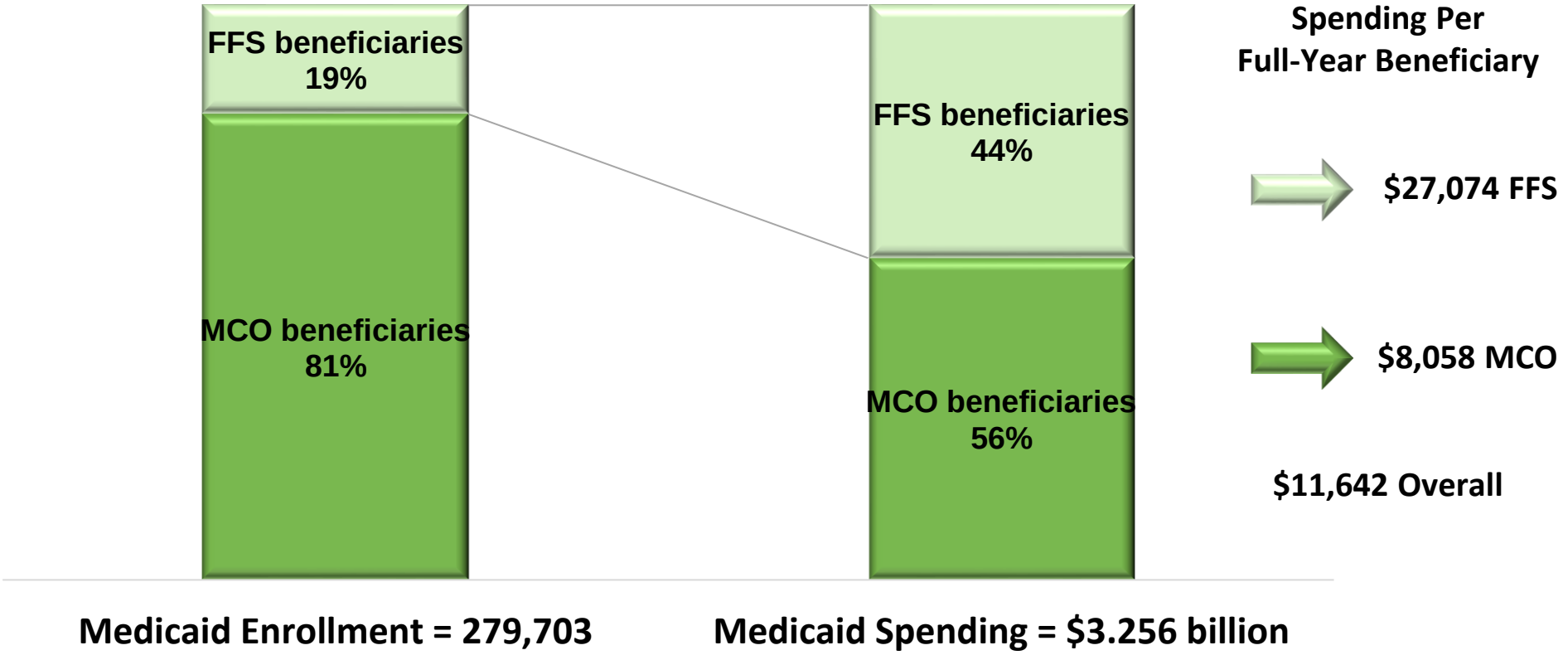
Medicaid Enrollment and Spending by Eligibility Group, FY 2021



Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for eligibility in FY 2021 and claims with dates of service in FY 2021.
Note: Reflects eligibility group at the time of payment. Disabled includes individuals eligible for long-term services and supports an institutional level of care. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

Most Beneficiaries Are In Managed Care But Spending Is Disproportionately Greater For Those Remaining In Fee-For-Service

Medicaid Enrollment and Spending by Service Delivery Type, FY 2021



Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for eligibility in FY 2021 and claims with dates of service in FY 2021.

Note: Enrollment reflects average monthly and spending per full-year beneficiary reflects the average cost over 12 months. Spending reflects DHCF payments for both capitation and any fee-for-service utilization. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

The Reason – A Lower Incidence of Chronic Disease in Managed Care Compared to FFS

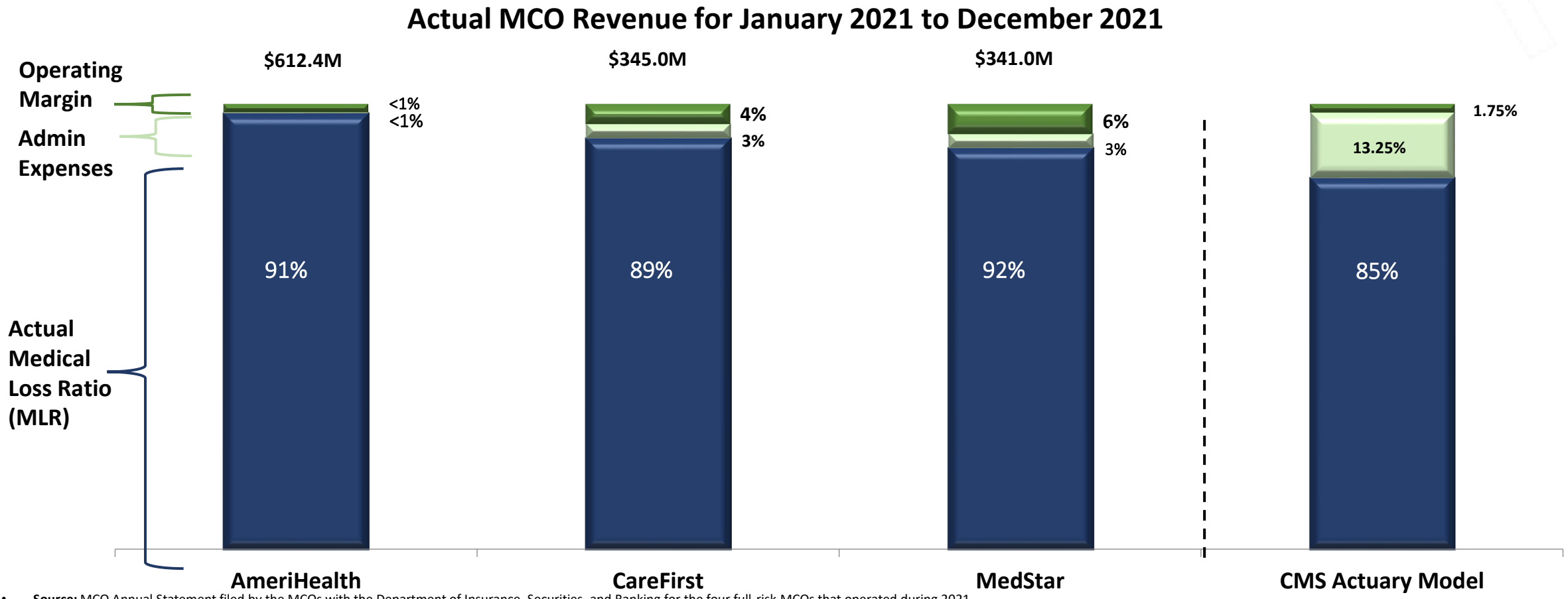
Medicaid FFS Population

- **FFS Medicaid-enrolled adults were most likely to have the following chronic conditions**:
  - Hypertension (48%)
  - Diabetes (27%)
  - Hyperlipidemia (27%)
  - Rheumatoid Arthritis/Osteoarthritis (19%)
  - Chronic Kidney Disease (18%)
- **FFS Medicaid-enrolled children were less likely than adults to have a chronic condition and were more likely to have different conditions affecting them:**
  - Asthma (8%)
  - Depression (3%)
  - Anemia (2%)

Medicaid Managed Care Population

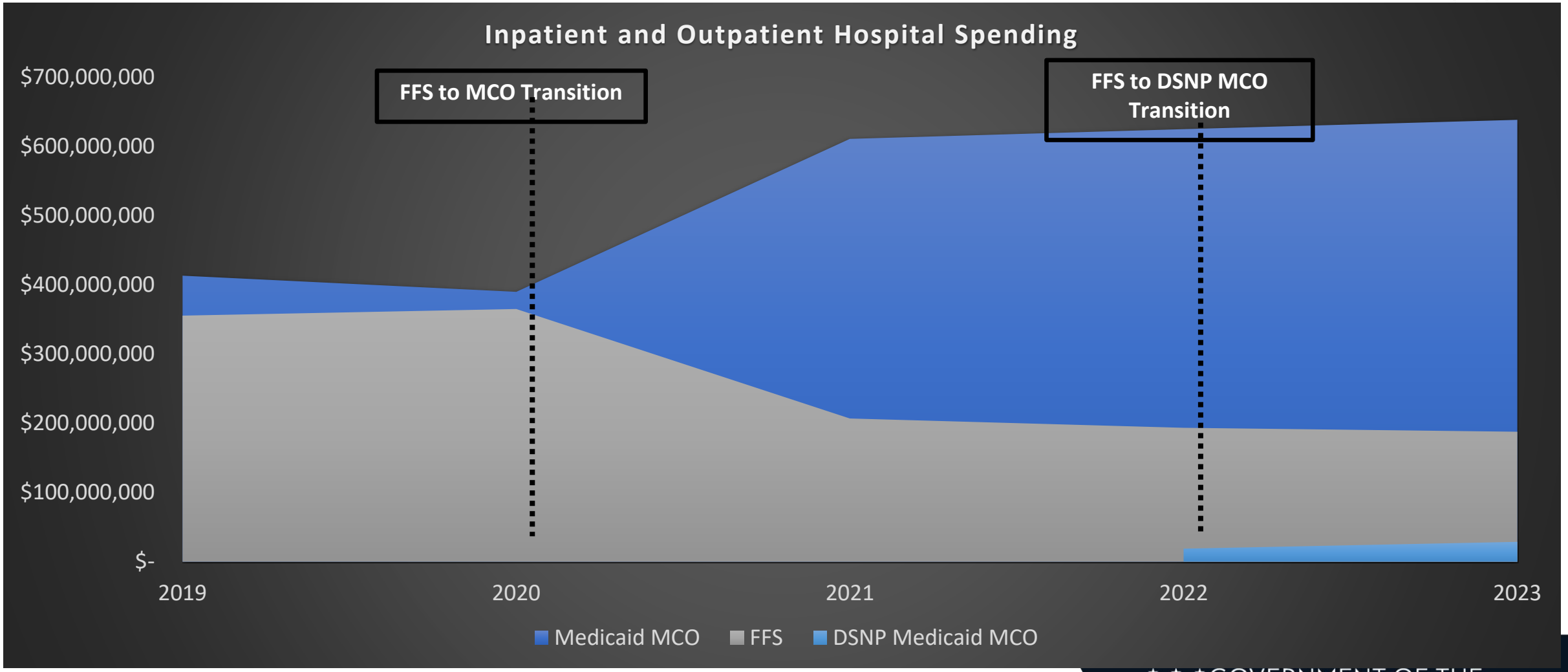
- **MCO Medicaid-enrolled adults were most likely to have the following chronic conditions:**
  - Hypertension (19%)
  - Hyperlipidemia (11%)
  - Depression (9%)
  - Diabetes (9%)
  - Asthma (9%)
- **MCO Medicaid-enrolled children were less likely than adults to have a chronic condition and were more likely to have different conditions affecting them:**
  - Asthma (10%)
  - Depression (3%)
  - Anemia (2%)

The Unquestioned Value Of Universal Contracting In The Managed Care Program



- **Source:** MCO Annual Statement filed by the MCOs with the Department of Insurance, Securities, and Banking for the four full-risk MCOs that operated during 2021
- **Note:** MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings and self reported quarterly filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes as reported in MLR report/calculation provided by the MCOs. MLR numerator is medical expenses – i.e., total annual incurred claims (including incurred but not reported (IBNR)) and cost containment expenses as of December 31, 2021, net of reinsurance recoveries. DHCF requires through its managed care contracts that all full-risk MCOs maintain a minimum MLR of 85%. *MCO reported reserve estimates included in DISB filings impact reported medical expenses and MLR amounts, and actual claims expense may differ from estimated reserves.

As the District Moves Toward More Coordinated Care For Medicaid And Alliance Beneficiaries, More Hospital Costs are Captured Under Managed Care



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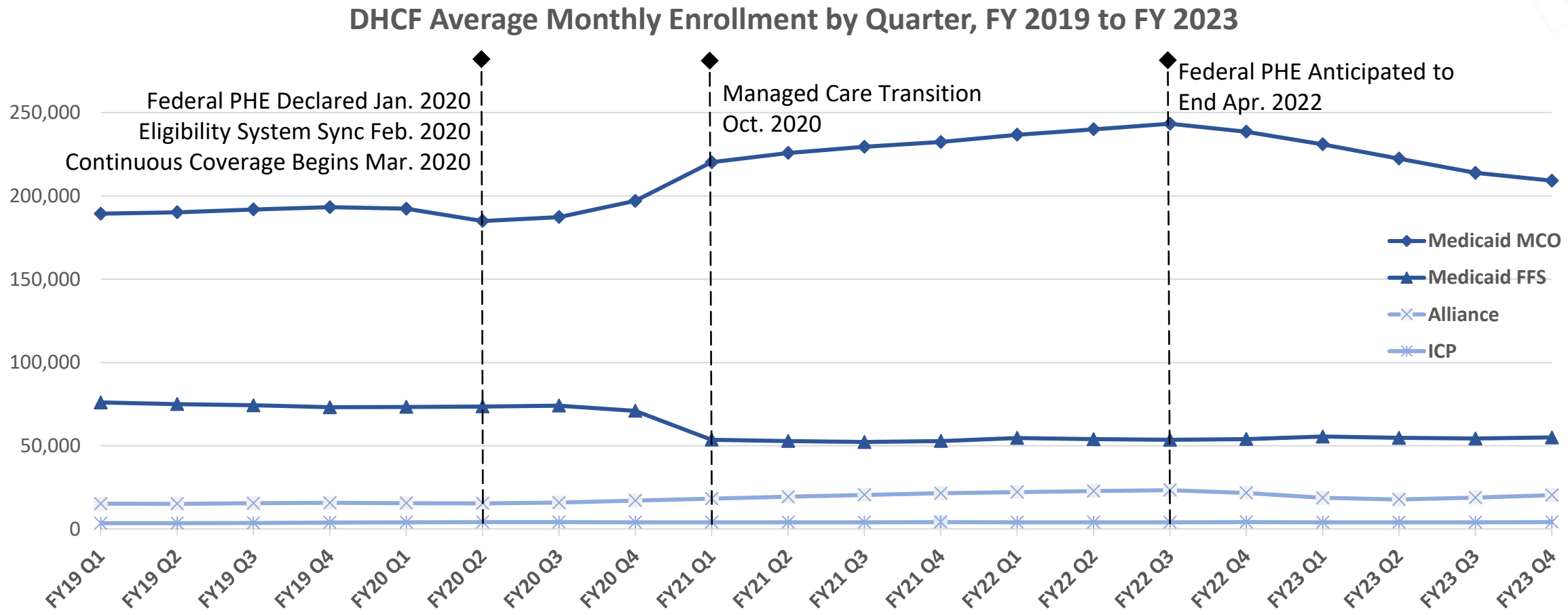
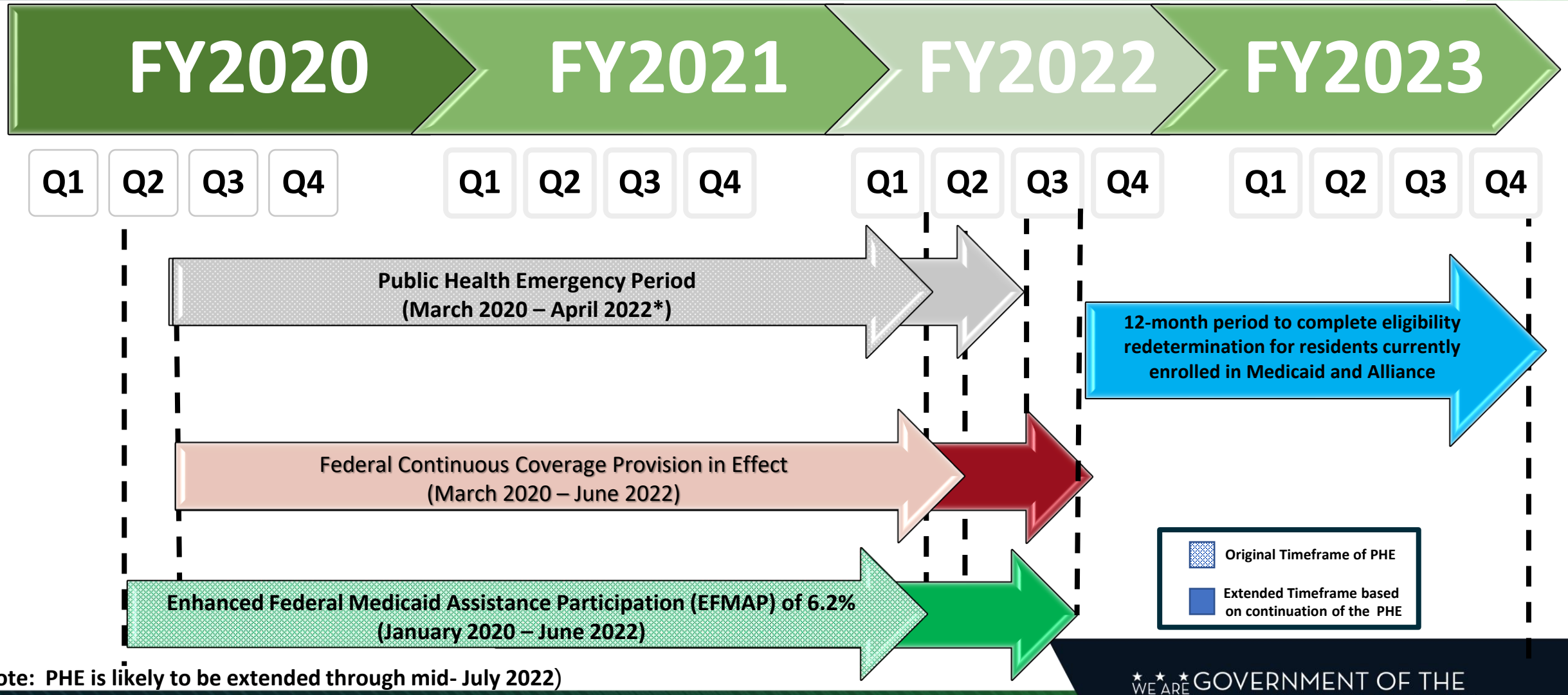
Enrollment Projections – The Foundation For DHCF's FY2023 Budget Proposal – Are Especially Challenging During the Public Health Emergency



The Full Resumption Of Medicaid and Alliance Eligibility Will Not Be Complete Until 12 Months Following The End Of The Public Health Emergency



Note: PHE is likely to be extended through mid- July 2022)

How DHCF's Local Funds Budget Reached More Than $927 Million

In millions

FY22 Recurring Budget	**814,646,705**
Adjustments Made During MARC Formulation	52,826,742
2% Reduction	(16,480,565)
FY2023 Revised Baseline	**850,992,882**
Budget Adjustments:	
Restoration of Agency Budget Reductions to Meet MARC	37,773,425
Additional Vacancy Savings	(930,581)
Total Restored of Proposed Budget Savings Initiatives	**36,842,844**
Mayor's Enhancements:	39,343,141
Final FY2023 Local DHCF Budget	**927,178,867**

DHCF's Budget Details As Proposed For FY2023

In millions

Local- $927.7M*

Budget Adjustments: $81.3M

($1.4M): 9.2% in Vacancy Savings

(3.9M): Efficiencies in maximizing participation

$48.8M: Restore local funding due to the end of the enhanced federal match available in FY22, Fund Postpartum Bill, elimination of face-to-face recertification for Alliance and other changes

$37.8M Restoration of budget adjustments to meet the agency MARC

Enhancements $39.3M:

$490k: One Time funding for Cedar Hill Medical Center planning support including a PMO and training for potential hospital staff

$26.7M: One Time funding to support increase in utilization related to the continued extension of the PHE and continued coverage

$4.2M: Support cost associated with extending the recertification process for Alliance beneficiaries from 6-months to 12-months

Continuation of ARPA Funding $480K

$480k to support non-emergency transportation cost for Alliance beneficiaries to attend medical visits

*** Local budget is $927.1M plus Revenue replacement ARPA funds $480k Totals $927.7**

Federal Payments- $2M

Continuation of District ARPA Funding:

$1.5M to support Practice Transformation to ensure an adequate provider network exists to support whole person care by establishing value-based care systems

$500k to support Produce Rx initiatives that give health care providers nutritional tools to better manage and coordinate care for Medicaid residents with chronic illnesses

Dedicated Taxes- $105M

Continuation of support for Provider Payments, Administrative cost and Quality. Budget based on anticipated revenue collection

$17.7M 0110- Nursing Home Quality of Care Fund

$66.9M 0111- Healthy DC Fund (MCO)

$6.5M 0112- Stevie Sellow's Fund (ICF)

$8.5M 0114- Hospital Assessment Tax (Inpatient)

$5.5M 0115- Hospital Provider Fee (Outpatient)

O Type Revenue- $5.6M

Continuation of support for Provider Payments and Administrative cost. Budget based on anticipated revenue collection

$2.5M 0631- Third Party Liability- Medicaid Collections

$2.5M 0632- Health Care Bill of Rights

$600K 0635- Indiv. Insurance Mkt Affordable and Stability*

* New fund that will support navigation and assistance to qualified District residents to complete the application process to maintain health care coverage

DHCF Will Utilize HCBS ARPA Funds To Support Providers In Paying Direct Support Professionals An Average of 117.6% of Living Wage/Minimum Wage By FY2025

In response to the recent workforce shortage in Direct Support Professional (DSP) Workforce, DHCF will use HCBS ARPA funding in FY2023 and March 2024 and the District will support with local funds for fiscal years forward.

Mayor's Proposal

- Support HCBS providers, through the Medicaid rate; the ability to pay DSP's a wage above the living and minimum wages (whichever is greater). The current proposal aligns the concept of the original Bill (B23-214) to pay DSP's an average of 117.6% of LW or MW but expands it to cover the following DSP's: PCA's, Participant Direct Care Workers (PDW's in Services My Way an EPD Waiver service), DD DSP's, Certified Addiction Counselors (in MHRS- Mental Health Rehab Services and ASARS- Adult Substance Abuse Residential Services) that provide services to Medicaid participants in home and community-based settings. Providers will determine the rates they pay their DSP workers; however, they are required to pay an average of 117.6% of the LW/MW.
- This concept establishes a career ladder and promotes longevity by offering a range of pay from living wage (entry level) to $4 more for a tenured DSP

How Will Funds Be Allocated?

- DHCF will allot funds in FY2023 and FY2024 in a lump sum allotment to each Provider based on DSP data provide- due October 1st including Schedule of DSP's, salaries, date of hire and vacancy rate
- The allotment will be issued in December and the requirement for Providers to pay qualifying DSP's new rate will be aligned with regular living wage adjustments on January 1st
- DHCF will complete a reconciliation at the end of the period to determine the increase in DSP wages over the year and the impact it had on the vacancy rate
- In FY2025, DHCF will amend the State Plan and Waivers to increase the rate methodology for the respective provider to support the impact of achieving the average of 117.6% for the DSP workforce

What Will the Allotment Cover?

- The increase will cover the cost of paying an average of 117.6% of living/minimum wage (whichever is greater)
- Fringe
- Administrative rate

Example: The example assumes that living wage continues to increase annually

	Living Wage	Mid Level	Higher Level
FY2023	$16.10	$18.93	$22.37
FY2024	$16.45	$19.35	$23.20
FY2025	$16.82	$19.78	$24.05

The Mandatory And Optional Benefits Funded in The Mayor's FY2023 Budget Are Comprehensive And Extensive

Mandatory Service Benefits

- Inpatient hospital services
- Outpatient hospital svcs. (incl. Emergency Room)
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Service Benefits

- Prescription Drugs
- Clinic services
- Physical therapy and Occupational therapy
- Speech, hearing and language disorder services
- Other diagnostic, screening, preventive and rehab. svcs
- Podiatry svcs, Optometry svcs & Other practitioner svcs
- Dental Services and Dentures
- Prosthetics, Eyeglasses
- Private duty nursing services
- Personal Care
- Hospice
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Intermediate care facility for Individuals with IDD
- Adult Day Health Program
- Inpatient psychiatric services for individuals under age 21
- Health Homes Programs

For Several Reasons, Proposed FY2023 Provider Payments Vary Significantly From Those Approved In The FY2022 Budget

Provider Payment Category	FY2021 Expenditures	FY2022 Approved Budget	FY2023 Proposed Budget*	YoY Variance		Variance Explanation
Hospital	253,726,006	191,495,044	220,699,190	29,204,146	15%	Alignment with anticipated utilization post pandemic in Inpatient and a decrease in DSH as a result of the cahnges in DSH requirements
Hospital Support Funding	9,900,000	8,000,000	8,000,000	-	0%	
ICF/IID	98,625,562	109,758,823	92,556,719	(17,202,104)	-16%	Based on anticipated enrollment (XXX), FY23 includes funding to pay increased DSP wages for FY21 and FY23 does not include enhanced rate but assumes rebasing
Skilled Nursing Facility	303,898,273	280,101,143	286,081,727	5,980,584	2%	
Primary Care (Physicians, Clinics and FQHC)	96,373,867	99,627,598	69,156,102	(30,471,496)	-31%	Assumes end of enhanced rates and "normal" utilization for FFS population post transition
Other (Medicare Part A, B, etc)	123,232,012	136,125,533	154,916,714	18,791,182	14%	
DME	15,289,893	18,155,075	24,990,621	6,835,546	38%	Includes assumptions in utilization and updates in Fee Schedule adjustments
Behavioral Health (Inc. BH Waiver)	152,854,816	165,838,412	158,235,140	(7,603,273)	-5%	
Skilled Care	25,941,841	20,449,326	29,432,902	8,983,576	44%	Alignment of Nursing Rates including inflation
LTCS (incl PCA and PACE)	181,910,430	166,808,814	87,793,560	(79,015,254)	-47%	Assumes end of enhanced rates for PCA and ADHP, and a full year of PACE
DSNP	-	-	123,215,268	123,215,268		
EPD Waiver	170,957,106	203,578,632	210,349,699	6,771,068	3%	
DD Waiver	308,558,556	294,924,043	313,866,978	18,942,935	6%	
IFS Waiver	1,548	4,114,601	5,975,703	1,861,102	45%	Assumes increase in enrollment in the waiver
Emergency Medicaid	30,027,240	34,995,382	31,855,709	(3,139,673)	-9%	
MCO	1,598,723,474	1,475,732,863	1,516,854,052	41,121,188	3%	
Permanent Supportive Housing	-	10,667,822	70,575,546	59,907,724	562%	FY23 assumes a full year of implementation and increased enrollment
Total	**3,370,020,624**	**3,220,373,110**	**3,404,555,630**	**184,182,519**		
Note: FY23 Budget includes funds interagency funding that supports the provider payment category						

FY2021
- Full Year of PHE
- Enhanced Provider Rates
- First Year of FFS Transition

FY2022
- 1 Qtr. of PHE Enhanced Provider Rates

FY2023
- Post Enhanced Rates
- Return to Regular Provider Rates
- New Utilization Trends
- Adjusted Enrollment

* Transition Population represents the FFS Populations that shifted to MCO in FY21 (including SSI adults and Beneficiaries eligible for MCO but opted out).

DHCF is Collaborating with DBH On A Comprehensive Review of DC's Medicaid Behavioral Health Provider Reimbursement Rates

Goal: to establish rate methodologies that will support the behavioral health provider network's ability to achieve the goals and expectations set forth by DBH and ensure qualifying District residents have access to quality behavioral health care.

Milestones: DHCF's contractor has completed a cost survey of District BH providers and has begun analyzing survey and claims data. Work will be completed in phases to allow for simultaneous District review and feedback.

Timeline: The contractor will finalize its recommendations by September 30, 2022. Implementation of new rates is scheduled for October 1, 2023.

- Define BH Service Delivery and Expectation
- Conduct Research, Administer Provider Survey and Analyze Claims Data
- Review Findings and Receive Feedback from Stakeholders
- Establish Recommendations for New Rate Methodologies/Structures and Updates

Presentation Outline

- ☐ Rebounding Economy and General Budget Overview
- ☐ Funding and Functions of Office of Deputy Mayor for Health and Human Services
- ☐ DHCF and Important Medicaid and Alliance Program Trends
- ☐ Key Budget Proposals For DHCF
- ☑ **Status of New Hospital**

Cedar Hill Regional Medical Center GW Health

Committee on Health – FY23 Budget Update, March 28, 2022

Status Update March 2022

https://newhospitals.dc.gov/

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REGIONAL MEDICAL CENTER

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DC MURIEL BOWSER, MAYOR

GW Medical Faculty Associates

Children's National

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

WE ARE WASHINGTON GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

Mayor's Budget Includes $15 Million Allocation For Increased Cost For The New Hospital in Ward 8

- Hospital construction cost have increased due to three factors –

  1. The hospital was designed and budgeted for before COVID-19, in late 2019. The partners incorporated lessons learned during COVID into the design – for example the use of 100% outdoor air HVAC systems.
  2. Inflation, global and national supply chain shortages, and market conditions have increased the cost of non-residential construction and new health construction by 12% from October 2020 to 2021 – with no expected end in sight.
  3. The hospital partners made a strategic decision to build a larger diagnostic and treatment area to accommodate future growth and potential health emergencies.

- Universal Health Services will contribute $5.5 million to assist with the additional costs associated with the larger diagnostic and treatment center, part of their $75M investment in agreement with the District.

- Workforce training and project management funds are also included in the budget.

  - $250,000 for the District to establish voluntary training courses for any United Medical Center staff who are interested in working at the new hospital and need to upskill or reskill to meet the new hospital's hiring requirements. This is a requirement of the Council passed legislation and associated agreements.
  - $240,000 to support the project's overall implementation, specifically these funds would be used for a 3rd party construction project manager to be overseen by DHCF.

Work on the new hospital has begun…

- Removal of former 801 East Men's Shelter
- Removal of former steam tunnels

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FY 2023 PROPOSED B

Cedar Hill Memorial Health Center Will Be A Full-Service Community Hospital with Verified Trauma Center

- 136 inpatient beds (can expand to 196 in the future)
- Verified Trauma Center
- ICU, Surgery and Operating Rooms
- Newborn Delivery and Women's Services w/ Level II Neonatal Intensive Care Unit
- Behavioral Health
- Adult and Children's Emergency Department
- The solar panels on the garage will provide energy assistance to over 200 households in the adjacent community.
- The hospital must comply with the District's CBE, First Source and Project Labor Agreement Requirements.
- Staffed by the George Washington Medical Faculty Associates, George Washington School of Medicine and Health Sciences and by Children's National
- Helipad if FAA Approves

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DISTRICT OF COLUMBIA

MURIEL BOWSER, MAYOR

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

A Fair Shot

pregnant and post-partum people in the District access proper maternity care and decrease their risk of maternal mortality.[20]

However, the FY2023 proposed budget does not make clear the full picture of maternal health investments for the upcoming fiscal year. DHCF is diligently working on preparing a State Plan Amendment (SPA) for Medicaid to cover doula services in the District.[21] Doulas have been found to help address inequities in maternal health.[22] Despite clear benefits, doula services are currently inaccessible to many low-income District residents who rely on Medicaid for their health coverage, which does not cover costs associated with doula care. Medicaid coverage of doula services will drastically increase access by eliminating out-of-pocket cost barriers to patients.[23]

DHCF plans to have the doula Medicaid benefit effective by October 1, 2022.[24] Because the benefit will be effective at the start of FY2023, we ask this Committee and the Council to ensure proper investment in this benefit. According to the Fiscal Impact Statement submitted with the Budget Support Act, Alliance Doula Coverage and Medicaid Doula Coverage, Local Share, in FY2023 should be funded at $320,000 and $396,000 respectively.[25] We want to ensure the doula Medicaid benefit is funded in the FY2023 budget so the benefit, pending approval by the Center for Medicare and Medicaid Services (CMS), can begin on October 1, 2022.[26] While DHCF has reported that there will be funding for the Doula Service Implement in the FY2023 proposed budget, the Agency has not indicated the specific level of funding the implementation of this

service will receive.[27] We ask this Committee to seek clarity to ensure the correct amounts based on the Fiscal Impact Statement for doula services are included in DHCF's FY2023 budget to continue the great work that began in FY2022 to improve maternal health outcomes in the District.

Changes in the Alliance Enrollment and Recertification Process will Make it Easier for District Residents to Have Access to Health Insurance

The Healthcare Alliance program provides health care coverage to residents with low incomes who do not qualify for Medicaid, most of whom are immigrants.[28] Starting in 2011, residents looking to enroll in the Alliance program were required to have a face-to-face interview with an official from the Department of Human Services (DHS), followed by a recertification interview every six months.[29] If an enrollee missed their interview, they lost their insurance until they could re-apply six months later. This caused many District residents enrolled in the Alliance to lose their insurance because of the time intensive requirements to recertify.[30]

During the COVID-19 public health emergency, however, the District has suspended many of the barriers that prevented Alliance beneficiaries from recertifying including, getting rid of the in-person interview requirement, allowing enrollment online and over-the-phone, and scaling back recertification to only once per year. The public health emergency is extended through April 16, 2022, but once the emergency ends so will these changes.[31] Therefore, we applaud the Mayor's proposed Alliance Enrollment Amendment Act of 2022, Subtitle C of the FY2023 Budget Support Act.[32]

This Act permanently removes the requirement that Alliance beneficiaries must complete in-person certification interviews.[33] Additionally, it extends the length between recertification from six months to one year.[34] The FY2023 proposed budget includes a recurring enhancement of $4,175,720 to extend the Alliance enrollment to 12 months and end the 6 month in-person re-certification.[35] The Mayor has not only eliminated restrictive barriers in Alliance but has also provided the money to make sure this law is fully and meaningfully implemented. This is a critical step forward to ensure that all District residents have access to health insurance, which is especially important given the health inequities made even greater by the pandemic.[36]

The District Must Invest in Behavioral Health Services and Professionals to Successfully Recover from the COVID-19 Pandemic

HealthySteps

National research has revealed significant negative behavioral health effects in children and families since the start of the pandemic.[37] One national survey found that 14 percent of parents reported that their children's behavioral health had worsened during the pandemic.[38] Additionally, parents have reported the toll the pandemic has taken on their own behavioral health citing increased depression, anxiety, and substance use.[39] The worsening behavioral health of children and families, however, can be mitigated by integrated care programs like HealthySteps that help families access appropriate and timely behavioral health services.[40]

HealthySteps is an evidence-based national program model that provides infants and toddlers with social-emotional and development support by integrating child behavioral health professionals into primary care.[41] Here in the District, HealthySteps is currently being implemented at six sites, three of which are funded using local dollars through DC Health and three which have other sources of funding.[42] DC Health has plans to open up an additional two HealthySteps sites in FY2022, bringing the total number of HealthySteps sites in the District to eight.[43]

One of the core components of the HealthySteps in the District is the care coordination and system navigation provided by the Family Services Coordinators (FSCs). FSCs are trained DC residents who provide dedicated case management and care coordination for families by drawing on their own lived experiences navigating systems.[44] FSCs build ongoing relationships with families and connect them to community resources.

Under the current financing structure, however, this type of care coordination is not eligible for Medicaid reimbursement meaning the soon to be eight HealthySteps in the District must rely on local or philanthropic funds to continue operations. These funding streams are often time-limited or not sufficient to cover the true cost of services rendered. It is important that care coordination be made consistently available in the pediatric primary care setting because care coordination can help to establish trusting

relationships between the patient, the patient's family, and their provider, which allows for better health outcomes for both child and their caregivers.[45]

Therefore, we ask this Council to ensure that any local Medicaid financing of the HealthySteps model adequately compensates for the clinical and nonclinical services and the care coordination components delivered in the pediatric primary care centers. Options include incorporating HealthySteps into the Medicaid rate study, which was recommended by the Behavioral Health Integration Stakeholder Advisory Committee,[46] and/or advancing HealthySteps through other coverage options, such as the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit.[47]

Behavioral Health Care Provider Rates

There is a nationwide shortage of behavioral health clinicians and mental health professionals – the same is true here in DC. The public's overall demand for mental health treatment has increased exponentially during the pandemic.[48] Further, the demand for mental health professionals in the District has increased tremendously as more and more programs and sectors across the city are looking to mental health professionals and behavioral health supports to address social problems such as community violence.[49] In order to attract and retain providers the District needs to adjust rates.

Currently, our provider rates are based on 2016 costs. We are shifting to have DHCF take additional responsibility for payment rates for DBH certified provider

organizations. We are happy to see the proposed budget addresses inflationary costs facing those providers for the first time in years. The proposed budget reflects a 1.8% inflationary cost adjustment from the Center for Medicare and Medicaid Services (CMS) for DBH-certified providers in FY2022 and plans an additional 1.6% increase in FY2023 to help offset future increases in inflation, cumulatively a 2.88% increase.[50]

Unfortunately, this increase falls short of the need. The Medicare Economic Index data used by DHCF for rate-setting shows a 16.1% gap from the fourth quarter of 2016 to the first quarter of 2023.[51] The 2.88% increases fall 13.22% short of the rise in costs for DBH-certified providers. We encourage the Council to accelerate payment rate updates with funding to support greater inflationary cost offsets. At a minimum, the Council should provide sufficient funding for immediate implementation in FY2023 of adjusted rates from a cost study underway and anticipated changes to the benefit design for behavioral health services.

Conclusion

Thank you for the opportunity to submit testimony today.

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[1] Children's Law Center fights so every child in DC can grow up with a stable family, good health, and a quality education. Judges, pediatricians, and families turn to us to advocate for children who are abused or neglected, who aren't learning in school, or who have health problems that can't be solved by medicine alone. With nearly 100 staff and hundreds of pro bono lawyers, we reach 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year. And we multiply this impact by advocating for city-wide solutions that benefit all children.

[2] DHCF, DC Medical Care Advisory Committee, *available at*: https://dhcf.dc.gov/page/dc-medical-care-advisory-committee.

[3] *See generally*, Amal Hussain Farahat, et al., *Effect of Implementing a Birth Plan on Womens' Childbirth Experiences and Maternal & Neonatal Outcomes*, Journal of Education and Practice, (2015) *available at:*

https://files.eric.ed.gov/fulltext/EJ1083654.pdf#:~:text=positive%20childbirth%20experience%20include%20self-esteem%2C%20efficient,and%20enhanced%20maternal%20attachment%20and%20compliance%2C.

[4] On September 30, 2021, the Office of the Chief Financial Office (OCFO) released the September 2021 Revenue Estimates Letter, which reported that for the May 2021 Revenue Estimate used for the FY2022 Budget was adjusted to $8,580.1 Billion. On February 28, 2022, the OCFO reported the February 2022 revenue estimate for FY2022 was reported as $9,086.7 Billion. Therefore, the revenue used to set the FY2022 budget as compared to the current revenue estimate is a difference of $506.6 Million ($9,086.7-$8,580.1 = $506.6). *See* Government of the District of Columbia, Office of the Chief Financial Officer, *Re: September 2021 Revenue Estimates,* September 30, 2021, *available at*: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/Sept_2021%20Revenue%20Estimate%20Letter.pdf. Government of the District of Columbia, Office of the Chief Financial Officer, *Re: February 2022 Revenue Estimates,* February 28, 2022, *available at*: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/February%202022%20Revised%20Revenue%20Estimates%20for%20FY%202022%20-%202026.pdf.

[5]Government of the District of Columbia, Office of the Chief Financial Officer, *Re: February 2022 Revenue Estimates,* February 28, 2022, *available at*: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/February%202022%20Revised%20Revenue%20Estimates%20for%20FY%202022%20-%202026.pdf.

[6] *Id.*

[7] *Id.*

[8] Marcella Robertson, *DC councilmember's f*ight to r*educe maternal mortality is personal*, WUSA9, (April 16, 2021), *available at*: https://www.wusa9.com/article/news/health/black-maternal-health-week-councilmembers-fight-to-reduce-maternal-mortality-is-deeply-personal/65-4cb90fe5-25d7-472c-b4c1-1254ec45384d; Press Release, *Councilmember Henderson introduces first bill to increase access to maternal health resources,* The DC Line, (January 15, 2021), *available at*: https://thedcline.org/2021/01/15/press-release-councilmember-henderson-introduces-first-bill-to-increase-access-to-maternal-health-resources/.

[9] Ebonie Meigbow, Dawn Godbolt, Alise Powell,and Joia Crear-Perry, *Evidence-Informed and Community Based Recommendations for Improving Black Maternal Health,* Urban Institute, April 201, p. 2, *available at*: https://www.urban.org/sites/default/files/publication/104088/evidence-informed-and-community-based-recommendations-for-improving-black-maternal-health_1.pdf.

[10] Marcella Robertson, *DC councilmember's f*ight to r*educe maternal mortality is personal*, WUSA9, (April 16, 2021), *available at*: https://www.wusa9.com/article/news/health/black-maternal-health-week-councilmembers-fight-to-reduce-maternal-mortality-is-deeply-personal/65-4cb90fe5-25d7-472c-b4c1-1254ec45384d; Press Release, *Councilmember Henderson introduces first bill to increase access to maternal health resources,* The DC Line, (January 15, 2021), *available at*: https://thedcline.org/2021/01/15/press-release-councilmember-henderson-introduces-first-bill-to-increase-access-to-maternal-health-resources/.

[11] Stacey D. Stewart, *Birthing While Black: Examining America's Black Maternal Health Crisis*, March of Dimes, (May 6, 2021), available at: https://www.marchofdimes.org/news/birthing-while-black-examining-americas-black-maternal-health-crisis.aspx.

[12] Jocelyn Johnston, et. al, *Maternal Health Outcomes in DC: Why are Black Women Dying from Pregnancy – Related Complications in Ward 7 & 8?*, American University, (April 26, 2020), *available at:* https://www.american.edu/spa/metro-policy/upload/maternal-mortality-in-dc-poster-spr-2020.pdf.

[13] B24-0026, *Maternal Health Resources and Access Act of 2021, available at:* https://lims.dccouncil.us/downloads/LIMS/46331/Introduction/B24-0026-Introduction.pdf.

[14] B24-0285, *Fiscal Year 2022 Budget Support Act of 2021,* p. 133, *available at:* https://lims.dccouncil.us/downloads/LIMS/47312/Signed_Act/B24-0285-Signed_Act.pdf.

[15] Department of Health Care Finance, Maternal Health Projects, *available at:* https://dhcf.dc.gov/publication/maternal-health-projects.

[16] Authorized by the American Rescue Plan Act. Department of Health Care Finance, Maternal Health Projects, *available at:* https://dhcf.dc.gov/publication/maternal-health-projects.
[17] Department of Health Care Finance, Maternal Health Projects, *available at:* https://dhcf.dc.gov/publication/maternal-health-projects.
[18] Mayor's Proposed FY 2023 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Health Care Finance [HT0], p. E-61, E-62.
[19] Mayor's Proposed FY 2023 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Health Care Finance [HT0], p. E-62.
[20] Lack of transportation options (including poor public transportation systems) means that pregnant and postpartum persons in DC can spend hours traveling to and from medical appointments. *See* TransitCenter Equity Dashboard, *The Washington D.C. Story*, *available at:* https://dashboard.transitcenter.org/story/dc. Given the demands of work, childcare, and school, excessively long travel times can be a significant barrier to people attending necessary medical appointments. Maureen I. Heaman, et al., *Barriers and facilitators related to use of prenatal care by inner-city women: perceptions of health care providers,* BMC Pregnancy and Childbirth, (2015), *available at* https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0431-5; Samina T. Syed, et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access,* Journal of Community Health, (October 2013), *available at:* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/; Annie Wood, *5 Barriers Pregnant Women in Poverty Face in Getting the Care They Need,* Mid-Iowa Health Foundation, (July 1, 2020), *available at:* https://www.midiowahealth.org/blog/5-barriers-pregnant-women-in-poverty-face-in-getting-the-care-they-need.
[21] Department of Health Care Finance, Maternal Health Projects, *available at:* https://dhcf.dc.gov/publication/maternal-health-projects.
[22] Doulas help pregnant people advocate for their personal care preferences, as well as combat interpersonal and institutional bias that occurs frequently in the maternal health care context. Cara B. Safon et al., *Doula Care Saves Lives, Improves Equity, and Empowers Mothers. State Medicaid Programs Should Pay for it,* Health Affairs, (May 26, 2021), *available at:* https://www.healthaffairs.org/do/10.1377/forefront.20210525.295915/full/. Doula support during birth has been shown to lead to fewer c-sections, less need for emergency interventions, and increased breastfeeding rates, all of which correlate to many positive health outcomes for the parent and baby. Sharon Muza, *The Doula Difference: Lowering Cesarean Rates,* DONA International, (March 28, 2017), available at: https://www.dona.org/cesarean-rates/#:~:text=Depending%20on%20the%20study%20or,)%20for%20full%2Dterm%20births; Gruber, Kenneth et al., *Impact of Doulas on Healthy Birth Outcomes,* The Journal of Perinatal Education, (Winter 2013), *available at:* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/. *See also* National Health Law Program, *How Can Doulas Help Address Racial Disparities in Care?*, *available at:* https://healthlaw.org/wp-content/uploads/2020/04/DoulasRacialDisparity_4.16.2020.pdf; Taylor, Jamila et al., *Eliminating Racial Disparities in Maternal and Infant Mortality*, Center for American Progress, (May 2, 2019), *available at:* https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infant-mortality/; Cara B. Safon et al., *Doula Care Saves Lives, Improves Equity, and Empowers Mothers. State Medicaid Programs Should Pay for it,* Health Affairs, (May 26, 2021), *available at:* https://www.healthaffairs.org/do/10.1377/forefront.20210525.295915/full/.
[23] Doula fees can range from $600 to $2,000 per appointment, a cost that is prohibitive for most Medicaid beneficiaries. Karen S. Greiner, et al., *The Cost-Effectiveness of Professional Doula Care for a Woman's First Two Births: A Decision Analysis Model,* J. Midwifery Women's Health, 2019, *available at:* https://pretermbirthca.ucsf.edu/sites/g/files/tkssra2851/f/wysiwyg/Greiner%20-%202019%20-%20The%20Cost-Effectiveness%20of%20Professional%20Doula%20Care%20for%20a%20Woman%E2%80%99s%20First%20

Two%20Births-%20A%20Decision%20Analysis%20Model.pdf. Last year, DHCF covered 4,034, or 45 percent, of overall DC births. Dr. Pamela Riley, *Maternal Health Projects Kickoff Meeting*, Department of Health Care Finance, (December 14, 2021), *available at:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Slides%20Maternal%20Health%20Kickoff%20121421.pdf.

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[29] Sec. 5022. Section 7b of the Health Care Privatization Amendment Act of 2001, effective December 13, 2017 (D.C. Law 22-35; D.C. Official Code § 7-1407).

[30] DC Fiscal Policy Institute, Kate Coventry, Testimony at the Oversight Hearing on "The Public Health Element of the District's COVID-19 Response," About Health Care Access, November 4, 2021, *available at*: https://www.dcfpi.org/all/testimony-of-kate-coventry-at-the-oversight-hearing-on-the-public-health-element-of-the-districts-covid-19-response/#_edn4.

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[32] Fiscal Year 2023 Proposed Budget Support Act of 2022.

[33] *Id.*

[34] *Id.*

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mental health. American Academy of Pediatrics, *available at:* https://publications.aap.org/aapnews/news/17718/AAP-AACAP-CHA-declare-national-emergency-in.

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[48] KKF, *Mental Health in the District of Columbia*, December 13, 2021, *available* at: https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/; American Psychological Association, *Demand for mental health treatment continues to increase, says psychologists,* October 19, 2021, *available at*: https://www.apa.org/news/press/releases/2021/10/mental-health-treatment-demand; District of Columbia Department of Health, *COVID-19 Pandemic Health and Healthcare Recovery Report,* May 2021, *available at*: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Pandemic-Recovery-Report_May-2021.pdf.

[49] Elliot C. Williams, *D.C. extends program to dispatch more 911 mental health calls to social workers,* NPR WAMU 88.5, November 15, 2021, *available at*: https://www.npr.org/local/305/2021/11/15/1055789888/d-c-extends-program-to-dispatch-more-911-mental-health-calls-to-social-workers#:~:text=D.C.%20is%20extending%20a%20pilot%20program%20that%20calls%20on%20the,news%20of%20the%20program's%20extension; Sam P.K. Collins, *D.C. Students Voice Demands for More Mental Health Services,* The Washington Informer, February 2, 2022, *available* at: https://www.washingtoninformer.com/d-c-students-voice-demands-for-more-mental-health-services/. Melissa Millar and Amber Rieke, *Re-Routing Behavioral Health Crisis Calls from Law Enforcement to the Health System,* DC Health Matters Collaborative, May 2021, *available at*: https://www.dchealthmatters.org/content/sites/washingtondc/ReRouting_Crisis_Response_white_paper_May_2021.pdf.

[50] Provided by CLC partners the DC Behavioral Health Association.

[51] Centers for Medicare and Medicaid Services. Market Basket Data. Online. Available 3/21/2022: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData. The reported index levels for the Medicare Economic Index for Quarter 4 of 2016 was 1.208 and the forecast for Quarter 1 of 2023 is 1.403. To calculate the gap between Q4 of 2016 and Q1 of 2023, requires taking the forecasted index level for Q1 of 2023, 1.403 and dividing that by Q4 index level, 1.208, which is equal to 1.161 and then multiplying that by 100 to get 116.1 and then finally subtracting by 100 to get the percentage point which gives you 16.1%. *See* Market Basket Definitions and General Information, *available at*: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/info.pdf.

ATTACHMENT 5

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
WITNESS LIST – FY23 BUDGET OVERSIGHT HEARING
1350 PENNSYLVANIA AVE., N.W., WASHINGTON, D.C. 20004

COUNCILMEMBER VINCENT C. GRAY, CHAIRPERSON
THE COMMITTEE ON HEALTH

FY23 BUDGET OVERSIGHT HEARING ON

NOT-FOR-PROFIT HOSPITAL CORPORATION AND UNITED MEDICAL CENTER BOARD OF DIRECTORS

THE DEPARTMENT OF HEALTH CARE FINANCE

AND

THE OFFICE OF THE DEPUTY MAYOR FOR HEALTH AND HUMAN SERVICES

MONDAY, MARCH 28, 2022, 10:00 A.M.
REMOTE HEARING VIA WEBEX
STREAMED LIVE ON YOUTUBE AT TINYURL.COM/FISCAL23

WITNESS LIST

Not-for-Profit Hospital Corporation and UMC Board of Directors

Panel 1 – Public Witnesses

1. Wala Blegay — Staff Attorney, DC Nurses Association (DCNA)
2. Roberta LeNior, RN — President UMC-DCNA

Panel 2 - Executive Witnesses

3. Angell Jacobs — Chair, United Medical Center Board of Directors
4. Marcela Maamari — Interim CEO, United Medical Center

The Department of Health Care Finance

Panel 3 - Public Witnesses

5. Caroline Kenney	Managing Director of Public-Private Ventures, Urban Atlantic
6. Mary Procter	Public Witness
7. Tamara Smith	President and CEO, DC Primary Care Association
8. Luisa Furstenberg-Beckman, MPH	Produce Prescription Program Manager, DC Greens

Panel 4

9. Claudia Schlosberg	Chair, Workforce Development Subcommittee, DC Coalition on Long Term Care
10. Ian M. Paregol	DC Coalition of Disability Service Providers
11. Judith Levy	Coordinator, DC Coalition on Long Term Care
12. Claudia Balog	Lead Researcher, 1199SEIU United Healthcare Workers East - Maryland/DC Region

Panel 5

13. Mark LeVota	Executive Director, District of Columbia Behavioral Health Association
14. Damon King	Director of Policy Advocacy, Legal Aid Society of the District of Columbia
15. Mandar Bodas	Research Scientist at the Fitzhugh Mullan Institute for Health Workforce Equity, The George Washington University Milken Institute School of Public Health
16. Selene Lara	Community Health Worker, La Clínica del Pueblo

Panel 6

17. Mark C. Miller	State Ombudsman, Office of the D.C. Long-Term Care Ombudsman

18. Mary Cabriele	Director of Workforce Programs, Academy of Hope Adult PCS
19. Veronica Sharpe, MHSA	President, District of Columbia Health Care Association
20. Susan Hargreaves	Administrator, The Lisner-Louise-Dickson-Hurt Home; DCHCA Board Member
21. Samaria Washington	Director of Regional Operations, BridgePoint Healthcare

Panel 7

22. Rob Downing	Carding Group, LLC; Downing & Company
23. Kate Coventry	Senior Policy Analyst, DC Fiscal Policy Institute

The Office of the Deputy Mayor for Health and Human Services

Panel 8 - Public Witnesses

24. Kate Coventry	Senior Policy Analyst, DC Fiscal Policy Institute
25. Jesse Rabinowitz, MSW, LGSW	Senior Manager of Policy and Advocacy, Miriam's Kitchen

Panel 9 - Executive Witness

26. Wayne Turnage	Director, Department of Health Care Finance Deputy Mayor for Health and Human Services, Office of the Deputy Mayor for Health and Human Services

Committee on Health

Budget Hearing

DISTRICT OF COLUMBIA NURSES ASSOCIATION

TESTIMONY, March 22, 2022

The District of Columbia Nurses Association (DCNA), an affiliate of the National Nurses United, AFL-CIO, is a full-service professional organization and labor union solely dedicated to representing health care professionals in the District of Columbia. With approximately 2,000 members, DCNA advances the health care profession by fostering high standards of practice, promoting the economic and general welfare of employees in the workplace and lobbying District officials regarding health care issues. DCNA represents approximately over 150 registered nurses employed by the United Medical Center (UMC).

My name is Wala Blegay and I am the staff attorney for DCNA. I am here to discuss UMC failure to respond or delay in response from UMC Human Resources (HR) department for all grievances and inquires. The UMC HR department only has two staff members for an entire hospital. Some of the HR staff are not trained to handle

labor issues and have revealed are not knowledgeable in responding to grievances and labor issues. Our nurses have not be paid their 2022 raises despite the contractual language in support of the nurses.

The nurses deserve better treatment. As the hospital is preparing to wind down, we must remember that the hospital is not yet closed. We hope that the hospital will continue to properly staff the units and provide proper support to the nurses. The nurses work tirelessly with limited staff and support. They deserve proper attention to any contract matters from the HR Department. Thank you.

Walakewon Blegay, Esq.

Staff Attorney & Labor Specialist, DCNA

DISTRICT OF COLUMBIA NURSES ASSOCIATION

Budget Hearing

United Medical Center

TESTIMONY March 27th, 2022

My name is Roberta F. LeNoir and I am an Emergency Room nurse at United Medical Center (UMC). I am the president of the District Columbia Nurses Association (DCNA)/UMC unit. I have been a nurse at UMC for over thirty (30) years. I have been committed to providing quality care to the residents who live in Wards 7 and 8. I represent over 250 nurses at UMC.

I have given testimony many times to the Council over the years imploring this committee to recognize the needs of UMC. There are conditions present now which prevent us from fully performing our professional responsibilities and assuring the best possible outcomes of care for our patients. It is difficult for us at UMC to believe that black lives of residents in Ward 7&8 really matter. I have testified to every known deficiency and lack creating an impossible environment to practice safely. Yet this entire body leaves to chance this slow-moving disaster. Nurse practice is in jeopardy every single day, you put your license on the line.

The conditions of work are so harsh now, nurses now believing the city will never respect this hospital for the services it provides, are now leaving in large numbers. Human resources has one person working in the entire department. This means that our contract is constantly being disregarded. Negotiated raises and differentials are not being instituted. The nursing staff is weary; they have worked in this disparate condition without respect or recognition for far too long.

The Control Board instituted by this Council cares more about meeting financial goals rather than providing compassionate care and assuring a safe working environment.

The new hospital system will be ready in 2024 along with Urgent Treatment Centers now. However, you have patients that are in need now, who still call this hospital their medical home. This should be a humane transition . We should be working together to transition to a new hospital system. Let the legal record show that UMC/ Control Board is operating this hospital that is detrimental to patients and nurses alike as well as other healthcare professionals. The following persistent conditions exist.

1. Lack of adequate supplies to provide ongoing safe care. These are system variances including computers to bedside blood pressure monitors.
2. Inability to promote a healing environment and provide compassionate care, the foundation of nursing practice.
3. High rate of agency nurses who lack experience and familiarity with needs of the population. Some units up to 80% of staff is agency. Agency nurses are often paid up to $100 per hour.
4. Lack of adequate nursing administrative support to promote safe, efficient, and compassionate care.
5. Refusal by administration to follow negotiated contract language costing the city excessive money in Unfair Labor Practices.

In conclusion, the nurses at UMC have been abandoned, time and time again. The question becomes, what are your expectations of us currently? It is evident that we don't merit total and complete consideration in your limited accommodations of the needs of this population. The nurses and other staff at UMC deserve more, we have weathered multiple disasters and somehow kept this place afloat. We ask that the Council provide appropriate oversight and institute measures to improve the conditions of work and practices to assure respect of our contractual agreements.

Respectfully submitted,

Roberta F. LeNoir, RN

Fiscal Year 2023 Budget Oversight Hearing on the Not-for-Profit Hospital Corporation (UMC)

Before the
Committee on Health
Council of the District of Columbia

The Honorable Vincent C. Gray, Chairman

March 28, 2022, 10:00 a.m.
Virtual Meeting Platform

Testimony of
Angell Jacobs
Chair, Fiscal Management Board
Not-for-Profit Hospital Corporation and
Deputy Chief Financial Officer and Chief of Staff
Office of the Chief Financial Officer

Fitzroy Lee
Acting Chief Financial Officer
Government of the District of Columbia

Good morning, Chairman Gray and members of the Committee on Health. I am Angell Jacobs, Chair of the Fiscal Management Board (Board) for the Not-for-Profit Hospital Corporation, more commonly known as United Medical Center or UMC. I am pleased to appear before you today with Interim CEO Marcela Mamaari and Chief Financial Officer, Lilian Chukwuma to discuss UMC's Fiscal Year (FY) 2023 Budget.

The FY 2023 budget supports the hospital in fulfilling its mission of providing quality medical care to our residents, while acting as responsible stewards of our revenues and resources. When I appeared before you during the performance oversight hearing, I described some of the challenges that UMC has faced during FY 2022, including inadequate staffing in the emergency department and a high rate of ambulance diversion. Since that time, improvements have been reported in both staffing and patient activity, and ambulance diversions are now at zero. The hospital's operator continues to implement the savings initiatives outlined in the Operational/Wind Down Plan. As a result, we expect to end FY 2022 with a balanced budget, despite a recent reduction in our Disproportionate Share (DSH) payment.

The successful completion of the savings initiatives this fiscal year should also help to stabilize the hospital in FY 2023 and allow us to end the budgetary year in balance with the proposed $15 million operating subsidy.

Thank you for the opportunity to participate in today's hearing. I will now turn to Interim CEO Marcela Mamaari, who will provide testimony on the FY 2023 budget, after which we would be happy to answer any questions that you or the Committee may have.

ATTACHMENT 6

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
WITNESS LIST – FY23 BUDGET OVERSIGHT HEARING
1350 PENNSYLVANIA AVE., N.W., WASHINGTON, D.C. 20004

COUNCILMEMBER VINCENT C. GRAY, CHAIRPERSON
THE COMMITTEE ON HEALTH

FY2023 BUDGET OVERSIGHT HEARING ON

THE DEPARTMENT OF HEALTH (DC HEALTH)

MONDAY, APRIL 4, 2022, 10:00 A.M. – 6:00 P.M.
REMOTE HEARING VIA WEBEX
BROADCAST LIVE ON DC COUNCIL CHANNEL 13
STREAMED LIVE AT WWW.DCCOUNCIL.US AND ENTERTAINMENT.DC.GOV.

WITNESS LIST

Public Witnesses

Panel 1

1. Dr. Andrea Boudreaux, MPH	Executive Director, Children's School Services, Children's National
2. Tininka Rahman	Project Director, HealthySteps, Children's National
3. Sarah Barclay Hoffman	Director of Policy, Early Childhood Innovation Network
4. Leah Castelaz	Children's Law Center

Panel 2

5. Fernanda Ruiz, MSW	Home Visiting Director, Mary's Center
6. Dr. Maria Marquez	Medical Director, Mary's Center
7. LaDon Love	Executive Director, SPACEs In Action
8. Carrie Stoltzfus, MPH	Executive Director, Food & Friends

Panel 3

9. Alexander Justice Moore	Chief Development Officer, DC Central Kitchen
10. Lauren Shweder Biel	Executive Director, DC Greens
11. Kimberly Crawford	Training & Outreach Coordinator, DC Coalition Against Domestic Violence (DCCADV)
12. Melissa Delia, MD	DC Action

Panel 4

13. Jarred Bowman	Early Childhood Policy Analyst, DC Action
14. Nisa Hussain	Early Childhood Program Manager, DC Action
15. Peter Wood	ANC 1C03
16. Eric Colchamiro	Director of Government Affairs, Alzheimer's Association - Maryland and the District of Columbia

Panel 5

17. Dean R. Brenner	Alzheimer's Association - Maryland and the District of Columbia
18. Sal Selvaggio DDS	Public Witness
19. Dr. Jessica Boyd	CEO & President, Unity Health Care
20. Jacqueline D. Bowens	President & CEO, DC Hospital Association

Panel 6

21. Hannah Garelick	Community Organizer, Jews United for Justice
22. Mark C. Miller	State Ombudsman, Office of the D.C. Long-Term Care Ombudsman
23. Shane Sullivan	Harm Reduction Coordinator, HIPS
24. Tamara Smith	President and CEO, DC Primary Care Association

Panel 7

25. Felix Hernandez	Advocacy and Fatherhood Program Manager, Mary's Center
26. Yocaira Perez	Mary's Center
27. Ginger Ellis, SFSW	Mary's Center
28. Maria Martinez	Mary's Center
29. Flor Mendez	Mary's Center

Panel 8

30. Morena Amaya	Mary's Center
31. Nuvia Melgar	Mary's Center
32. Noemi Villalta	Mary's Center
33. Leydi Hernandez	Mary's Center

Panel 9

34. Wala Blegay	Staff Attorney, DC Nurses Association
35. Radha Muthiah	President and CEO, Capital Area Food Bank
36. Donna Banzon	Director of Healthy Food, Martha's Table
37. Lon'Dras Bradley	Market Operations Manager, Martha's Table

Panel 10

38. Sharlene Juste	Program Manager for Student Life, New York University - Washington DC Campus
39. Sean A Pernell, MAT	HPE Plummer ES
40. Gabby Cole	Student, Banneker High School
41. Clint Ngwa	Student, Phelps ACE
42. Raea Jordan	Student, Banneker High School

Panel 11

43. Michelle Tiller	Student, Banneker High School
44. Eleanor Catherino	Student, Jackson-Reed High School
45. Avajane Lei	Student, School Without Walls
46. Danika Howard	Student, BASIS

Panel 12

47. Reagan Dunham	Washington AIDS Partnership and LGBTQ+ Budget Coalition
48. Ruqiyyah Anbar-Shaheen	Director of Early Childhood, DC Action
49. Danielle Hamer	Policy Associate, DC Fiscal Policy Institute
50. Camille Range, MPH, RDN	Public Witness

Panel 13 - Executive Witness

51. LaQuandra S. Nesbitt MD, MPH	Director, Department of Health (DC Health)

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Testimony Before the District of Columbia Council
Committee on Health
April 4, 2022

Public Hearing:
Budget Oversight Hearing
District of Columbia Department of Health

Leah Castelaz
Policy Attorney
Children's Law Center

Introduction

Good morning, Chairman Gray, and members of the Committee. My name is Leah Castelaz, and I am a Policy Attorney at the Children's Law Center.[1] I am testifying today on behalf of Children's Law Center, which fights so every DC child can grow up with a stable family, good health, and a quality education. With nearly 100 staff and hundreds of pro bono lawyers, Children's Law Center reaches 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year. CLC is a member of the Early Childhood Innovation Network (ECIN),[2] the Under 3 DC Coalition,[3] and the Home Visiting Council.[4]

I appreciate this opportunity to testify regarding the Mayor's proposed FY2023 budget for DC's Department of Health (DC Health). Many of the children we work with – children in the foster care system or receiving special education services – have faced multiple adverse childhood experiences resulting in complex trauma and need access to high-quality health services to achieve stability. Children require timely access to appropriate mental health services, like early prevention and intervention services and behavioral health providers, to help meet their social, emotional, and developmental needs.[5] Investing in children's physical and mental health at a young age can strengthen families[6] and create a foundation for DC children to have a healthy, productive future.[7]

These investments are particularly important in light of the pandemic. National research has revealed significant negative behavioral health effects in children and

families since the start of the pandemic.[8] One national survey found that 14 percent of parents reported that their children's behavioral health had worsened during the pandemic.[9] Additionally, parents have reported the toll the pandemic has taken on their own behavioral health citing increased depression, anxiety, and substance use.[10] The worsening behavioral health of children and families, however, can be mitigated by providing adequate, timely, and appropriate access to behavioral health services.[11] As the District emerges from the pandemic, there is a need to invest in behavioral health supports and resources starting with the District's youngest residents and their families.

Although the Mayor's proposed budget for FY2023 does not cut funding for early childhood prevention and early intervention behavioral health services, it unfortunately does not provide any new investments in these areas either, including the HealthySteps program.[12] Further, the proposed FY2023 budget is unclear as to what, if any, investments DC Health will make to address behavioral health care workforce shortages – an ongoing issue that has only been exacerbated by the increased demand for behavioral health services caused by the pandemic.

We are fortunate that the District's financial recovery from the pandemic is looking much better than expected. According to the latest projections from the Office of the Chief Financial Officer (OCFO), the District will take in approximately $506 million more in revenue for FY2022 than was anticipated when the Council approved the FY2022 budget in August 2021.[13] This is in addition to the over $570 million excess

surplus from FY2021.[14] Projected revenues for each year of the upcoming financial plan are also higher than previously anticipated.[15] OFCO estimates that FY2023 revenues will be 3.9 percent higher than FY2022 revenues – an increase of nearly $360 million dollars.[16] Given this unanticipated additional revenue and the projected financial strength of the city, the Council is well-positioned to prioritize much-needed investments in our health system that will improve access for children and families to quality services like HealthySteps.

My testimony focuses on two critical areas of investment in behavioral health that we urge be added to the DC Health Budget. We ask the Committee to commit:

- **An additional $300,000 in recurring local dollars for the HealthySteps program to allow the program to expand to an additional site.** Increasing public investments in the District's HealthySteps program will increase access to enhanced pediatric primary care services in communities where they are needed the most.
- **Funding for three additional FTEs for the Health Professional Licenses Administration to increase the number of licensing specialists reviewing social work and professional counseling licenses in the District**. Increasing the number of licensing specialists specifically for social work and professional counseling would decrease processing time for behavioral health licenses and increase the workforce flow of behavioral health professionals into the District.

HealthySteps Needs Additional Funding to Expand Access to Services

HealthySteps is an evidence-based national program model that provides infants and toddlers with social-emotional and development support by integrating child development specialists into primary care.[17] HealthySteps in the District embeds Family Services Coordinators (FSCs)[18] and HealthySteps Specialists (HSSs)[19] within the primary care setting to engage with families at each routine pediatric visit from birth to three years of age. FSCs and HSSs support primary care providers, address both the physical and mental health of their patients and patients' families, and provide guidance and referrals to families who need additional services. HealthySteps is currently in three sites funded by DC Health through local dollars.[20] In FY2022, DC Health anticipates adding two sites at Unity Health Care, bringing the total number to five HealthySteps sites in Wards 7 and 8 by the end of FY2022.[21]

Although the Mayor's proposed FY2023 budget provides funding to continue the three existing HealthySteps sites and two anticipated HealthySteps sites, it does not include the new investments needed to establish additional sites that reach all the children and families originally envisioned in the Birth-to-Three for All Act of 2018 (Birth-to-Three). Birth-to-Three calls for HealthySteps sites to be established in Wards 5, 7, and 8.[22] HealthySteps is currently in the process of expanding to its fourth and fifth site in Wards 7 and 8, but there are no plans in FY2022 to add to a site in Ward 5 as envisioned in Birth-to-Three.[23]

Wards 5, 7, and 8 face the highest poverty rates in the District.[24] Children and families in these Wards experience disproportionate barriers to economic security and health care.[25] While the effects of poverty on families and children are extraordinarily complex, there has been significant research that draws a strong link between living in a low-income household with an increased risk for behavioral health problems for both children and adults.[26] Despite this well-established link, children and families living in poverty are some of the people least likely to be connected with high-quality behavioral health care.[27] Living in poverty causes both a need for behavioral health care and a wide range of challenges for children and families to be able to access that care.[28] The obstacles Ward 5, 7, and 8 children and families face include lack of readily accessible services within the respective Wards,[29] stigma around receiving services,[30] and the affordability of services.[31]

Integrated behavioral health care models, however, have shown significant promise in improving behavioral health access and outcomes for children and families residing in the contexts of poverty.[32] HealthySteps is designed to provide additional supports and resources for low-income families by improving access to behavioral health services in a setting in which children and families frequent the most, such as their primary care pediatrician for well-child visits.[33] Embedding behavioral health professionals in the primary care setting through the HealthySteps program allows for

increased integration of care, earlier identification of behavioral health issues for both child and caregiver, and greater connection to community supports and resources.

Location of services is a major factor as to whether families can access behavioral health treatments, supports, or resources they may need. Traveling far distances for doctor's appointments is a burden many low-income families cannot afford to take on.[34] Lack of options for public transportation, long travel times via public transportation, and inability to take off work for the unreasonably long amount of time required to attend doctor's appointments are all examples of barriers to access that low-income families face when accessing health care.[35] To overcome obstacles to access, children and families need to be able to access health care within their own community including valuable behavioral health programs like HealthySteps.

For these reasons, we urge the Council to commit an additional $300,000 in local recurring dollars in the FY2023 budget to enable the HealthySteps program to open an additional site in Ward 5, as envisioned by Birth-to-Three.[36] By increasing the budget to build additional HealthySteps sites more children and families will gain access to essential behavioral health services.[37]

The Health Professional License Administration Needs Additional FTEs to Mitigate Behavioral Health Workforce Shortages

As we testified to during several performance oversight hearings, a significant obstacle to our clients accessing critical services is the lack of behavioral health care providers in the District.[38] Our clients consistently report being unable to find providers

offering the services they need – or if they manage to find a provider, the waitlist for an appointment is prohibitively long. The inability for our clients to find behavioral health providers or access providers without long wait times is a symptom of the District's insufficient behavioral health workforce. It is therefore important that FY2023 budget include strategic investments designed to increase DC's behavioral health care workforce.

One such investment is for the District to increase the number of licensing specialists who review applications for social work and professional counseling licenses. The wait time to be licensed in the District can vary depending on numerous factors, including the individual applicant and the professional board.[39] During the waiting period for a license to be issued or denied, new behavioral health professionals and those licensed in other jurisdictions transferring into DC cannot work. Because professionals cannot work without a District license, slow licensure approval or delays in approval have an impact on professionals entering the behavioral health workforce. For some, they may ultimately decide not to complete licensure if it is delayed for too long because even if qualified, they have a more urgent need for employment and income.[40] Otherwise-qualified health professionals are then removed from the pool of the District's behavioral health workforce due to the inefficiencies of the District's health professional licensing process.[41]

An area of particular concern, as raised by our partners in the provider community, is the wait time experienced by those applicants whose license is not initially accepted by the licensing board. In these cases, the applicant applied, the appropriate board reviewed the application, and determined that the application was either incomplete, missing a document, or the board had further questions for the applicant, etc. The applicant must then go back to remedy any outstanding issues before the board will review the application again, and hopefully this time approve them for a license.

In order to address application issues, applicants typically reach out to a licensing specialist for their respective board to receive help to address gaps or errors in the application. Based on reported experiences by providers to our partners the current number of licensing specialists to help aid those applying for licenses in the District is insufficient. Currently, social work and professional counseling each have two FTEs for licensing specialists.[42] But as it stands, applicants are unable to get in touch with the licensing specialists in a timely manner to have questions answered, seek clarity on documentation requirements, or speak with a specialist to identify any incomplete sections of the application.

Increasing the number of FTEs for licensing specialists within the Health Professional Licenses Administration would allow for greater capacity to work directly with the applicants who are not initially accepted. If licensing specialists can more

quickly help applicants by answering questions and providing information, the applicant will, in turn, be able to quickly remedy any outstanding issues preventing their application from being approved. Once a completed application is sent to the licensing specialists, they will be able to approve it in a timely manner, especially if the licensing specialist was able to help make sure any and all outstanding issues were addressed. The more licensing specialists, the more capacity the board has to address application deficiencies and approve licenses. This will decrease the wait times experienced by behavioral health professionals seeking licenses in the District and increase the number of those professionals entering the workforce.

The proposed FY2023 budget increases the Health Professional License Administration by $3.6 million, but only increases FTEs by 1.2.[43] The Health Professional License Administration, however, administers almost 70,000 health professionals in the District and supports 19 professional boards.[44] It is unclear how DC Health intends to spend the $3.6 million or the distribution of the additional FTEs. We ask the Council to seek clarity during today's hearing as to how the budget will be distributed amongst the Health Professional License Administration and specifically inquire if there are any increases to licensing specialists to process social work and professional counseling licenses. Further, we ask the Council to ensure funding for three additional FTEs to help expedite the licensing procedures in the District for social work and professional counseling to increase the behavioral health workforce.

Conclusion

Thank you for the opportunity to testify today. I am happy to respond to any questions the Committee may have regarding any of the topics covered by my testimony above.

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[1] Children's Law Center fights so every child in DC can grow up with a loving family, good health, and a quality education. Judges, pediatricians, and families turn to us to advocate for children who are abused or neglected, who aren't learning in school, or who have health problems that can't be solved by medicine alone. With nearly 100 staff and hundreds of pro bono lawyers, we reach 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year. And we multiply this impact by advocating for city-wide solutions that benefit all children.

[2] "The Early Childhood Innovation Network (ECIN) is a local collaborative of health and education providers, community-based organizations, researchers, and advocates promoting resilience in families and children from pregnancy through age 5 in Washington, DC. During this critical period of brain development, children are deeply affected by their experiences and environment. ECIN's approach affirms the tremendous opportunity to promote and ensure healthy development of young children." See Early Childhood Innovation Network (ECIN), About ECIN, *available at*: https://www.ecin.org/.

[3] The Under 3 DC Coalition aims to increase access to quality, comprehensive early childhood services and other supports for infants and toddlers and their families in DC, and ensuring that health, education, early learning and human services systems work in a coordinated fashion to improve outcomes for young children. See Under 3 DC, Why Under 3, *available at*: https://www.under3dc.org/.

[4] The DC Home Visiting Council includes advocates, community-based providers, and agency leaders, including DC Health leadership. The Council works to strengthen home visiting in the District by building a cross-sector network of support for programs, advocating for resources and funding for programs' stability and growth, and collaborating to address systemic challenges to implementation of home visiting services. See DC Home Visiting, DC Home Visiting Council, *available at*: https://www.dchomevisiting.org/.

[5] Prevention and Early Intervention Network, *Prevention and Early Intervention in Child Health Services: The foundations of a healthy adult life are laid in early childhood*, April 2018, *available at*: https://www.pein.ie/wp-content/uploads/2018/04/PEIN-Child-Health-Policy-paper-FINAL-Apl-18.pdf; Centers for Disease Control and Prevention, Improving Access to Children's Mental Health Care, December 2, 2021, *available* at: https://www.cdc.gov/childrensmentalhealth/access.html.

[6] The National Collaborative for Infants and Toddlers, Building Momentum for Prenatal-to-Three, July 2021, *available at*: https://www.thencit.org/resources/new-messaging-building-momentum-for-prenatal-to-three.

[7] *Id.*

[8] Children's National, *Covid-19 And Children's Behavioral Health In The District Of Columbia: The Pandemic's Impact On Child Behavioral Health Outcomes And The Behavioral Health Care System*, June 2021, *available at*:

https://childrensnational.org/-/media/cnhs-site/files/advocacy-and-outreach/child-health-advocacy-institute/covid19-and-childrens-behavioral-health-in-dc.pdf?la=en. U.S. Surgeon General's Advisory, *Protecting Youth Mental Health,* 2021, *available at:* https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf; *AAP, AACAP, CHA declaration of a national emergency in children's mental health.* American Academy of Pediatrics, *available at:* https://publications.aap.org/aapnews/news/17718/AAP-AACAP-CHA-declare-national-emergency-in.

[9] Patrick, S. W., et al., *Wellbeing of parents and children during the COVID-19 pandemic: A national survey. Pediatrics,* 146(4), (2000), *available at:* https://doi. org/10.1542/peds.2020-016824; *See also* Children's National, *Covid-19 And Children's Behavioral Health In The District Of Columbia: The Pandemic's Impact On Child Behavioral Health Outcomes And The Behavioral Health Care System*, June 2021, *available at*: https://childrensnational.org/-/media/cnhs-site/files/advocacy-and-outreach/child-health-advocacy-institute/covid19-and-childrens-behavioral-health-in-dc.pdf?la=en; Rachel Garfield and Priya Chidambaram, *Children's Health and Well Being During the Coronavirus Pandemic,* KFF, (2020), *available at*: https://www.kff.org/coronavirus-covid-19/issue-brief/childrens-health-and-well-being-during-the-coronavirus-pandemic/.

[10] Children's National, *Covid-19 And Children's Behavioral Health In The District Of Columbia: The Pandemic's Impact On Child Behavioral Health Outcomes And The Behavioral Health Care System*, June 2021, *available at*: https://childrensnational.org/-/media/cnhs-site/files/advocacy-and-outreach/child-health-advocacy-institute/covid19-and-childrens-behavioral-health-in-dc.pdf?la=en; Jake Hart and Wen-Jui Han, *COVID-19 Experiences and Parental Mental Health*, Journal of the Society for Social Work and Research, Volume 12, Number 2, (Summer 2021), *available at*: https://www.journals.uchicago.edu/doi/abs/10.1086/711613?journalCode=jsswr; Kenneth A. Dodge, Ann T. Skinner, et al., *Impact of the COVID-19 pandemic on substance use among adults without children, parents, and adolescents*, Addictive Behaviors Reports, Volume 14, (December 2021), *available at*: https://doi.org/10.1016/j.abrep.2021.100388.

[11] Jackie Mader, *We know how to help young kids cope with the trauma of the last year – but will we do it?,* The Hechinger Report, October 25, 2021, *available at:* https://hechingerreport.org/we-know-how-to-help-young-kids-cope-with-the-trauma-of-the-last-year-but-will-we-do-it/.

[12] Mayor's Proposed FY 2023 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Health [HC0], p. E-37 to E-63.

[13] On September 30, 2021, the Office of the Chief Financial Office (OCFO) released the September 2021 Revenue Estimates Letter, which reported that for the May 2021 Revenue Estimate used for the FY2022 Budget was adjusted to $8,580.1 Billion. On February 28, 2022, the OCFO reported the February 2022 revenue estimate for FY2022 was reported as $9,086.7 Billion. Therefore, the revenue used to set the FY2022 budget as compared to the current revenue estimate is a difference of $506.6 Million ($9,086.7-$8,580.1 = $506.6). *See* Government of the District of Columbia, Office of the Chief Financial Officer, *Re: September 2021 Revenue Estimates,* September 30, 2021, *available at*: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/Sept_2021%20Revenue%20Estimate%20Letter.pdf; Government of the District of Columbia, Office of the Chief Financial Officer, *Re: February 2022 Revenue Estimates,* February 28, 2022, *available at*: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/February%202022%20Revised%20Revenue%20Estimates%20for%20FY%202022%20-%202026.pdf.

[14]Government of the District of Columbia, Office of the Chief Financial Officer, *Re: February 2022 Revenue Estimates,* February 28, 2022, *available at*:

https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/February%202022%20Revised%20Revenue%20Estimates%20for%20FY%202022%20-%202026.pdf.

[15]Government of the District of Columbia, Office of the Chief Financial Officer, *Re: February 2022 Revenue Estimates,* February 28, 2022, *available at*: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/February%202022%20Revised%20Revenue%20Estimates%20for%20FY%202022%20-%202026.pdf.

[16] Government of the District of Columbia, Office of the Chief Financial Officer, *Re: February 2022 Revenue Estimates,* February 28, 2022, *available at*: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/February%202022%20Revised%20Revenue%20Estimates%20for%20FY%202022%20-%202026.pdf.

[17] HealthySteps DC ensures access to behavioral health services in a setting child frequent, their pediatric primary care practice. Children are more likely to go to their primary care provider due to scheduled well-child visits, thus a primary care provider is well positioned to detect the early onset of behavioral problems. However, a primary care provider may not have the knowledge or skill set to address developmental, behavioral, social, and emotional needs of a child. *See* HealthySteps, *Our Model, available at*: https://www.healthysteps.org/what-we-do/our-model/.

[18] Family Service Coordinators provide dedicated case management and care coordination for families through the support of DC residents with lived experience navigating systems. Early Childhood Innovation Network, *Innovation Spotlight: HealthySteps DC,* May 2019, ECIN Newsletter, *available at*: https://www.ecin.org/newsletter-may-2019.

[19] HealthySteps Specialists can deliver clinic-based mental health visits with families to address critical needs in areas such as maternal depression, grief and loss, and child behavior management. Specialists can also answer questions about behavioral health as well as facilitate the development of attachment, self-regulation skills, and family resiliency. Early Childhood Innovation Network, *Innovation Spotlight: HealthySteps DC,* May 2019, ECIN Newsletter, *available at*: https://www.ecin.org/newsletter-may-2019.

[20] DC Health FY21 Performance Oversight Responses, response to Q40, *available at*: https://dccouncil.us/wp-content/uploads/2022/02/dohpoh.pdf.

[21] DC Health has expanded the HealthySteps program to three pediatric primary care locations using local funds since FY19. There are currently two Unity Health Care sites, East of the River Health Center and Minnesota Avenue Health Center, and one Children's National, Children's Health Center Anacostia. According to Unity Healthcare's website, they have pediatric offices in Wards 1, 7, and 8. Although DC Health has not released an RFP or official plans for the FY22 expansion of HealthySteps, the Agency has indicated that two new sites will open under Unity Healthcare. See DC Health FY21 Performance Oversight Responses, response to Q40, *available at*: https://dccouncil.us/wp-content/uploads/2022/02/dohpoh.pdf. Per the current structure of Birth-to-Three, which creates Ward boundaries for expansion, HealthySteps FY22 expansion with Unity Healthcare is currently limited to Wards 7 and 8. See Find Unity Healthcare Providers, Pediatrics, *available at*: https://www.unityhealthcare.org/find-a-health-care-center?k=&s=pediatrics.

[22] DC Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[23] DC Health FY21 Performance Oversight Responses, response to Q40, *available at*: https://dccouncil.us/wp-content/uploads/2022/02/dohpoh.pdf.

[24] DC Action, DC Kids Count, Ward Snapshots, *available at*: https://dckidscount.org/.

[25] *Id.*

[26] Stacy Hodgkinson, Leandra Godoy, et al., *Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting,* Pediatrics, January 2017, doi: 10.1542/peds.2015-1175. *See also* Evans

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[27] Stacy Hodgkinson, Leandra Godoy, et al., *Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting,* Pediatrics, January 2017, doi: 10.1542/peds.2015-1175.

[28] Stacy Hodgkinson, Leandra Godoy, et al., *Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting,* Pediatrics, January 2017, doi: 10.1542/peds.2015-1175. *See also* Ollie Ganz, Laurel E. Curry, et al., *Barriers to Mental Health Treatment Utilization in Wards 7 and 8 in Washington, DC: A Qualitative Pilot Study,* Healthy Equity, (2018), doi: 10.1089/heq.2017.0051. American Academy of Family Physicians, Poverty and Health – The Family Medicine Perspective, *available at*: https://www.aafp.org/about/policies/all/poverty-health.html.

[29] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District,* page 83, December 2021, *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf.

[30] Ollie Ganz, Laurel E. Curry, et al., *Barriers to Mental Health Treatment Utilization in Wards 7 and 8 in Washington, DC: A Qualitative Pilot Study,* Healthy Equity, (2018), doi: 10.1089/heq.2017.0051; *See also A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District,* page 31, December 2021, *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf; Stacy Hodgkinson, Leandra Godoy, et al., *Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting,* Pediatrics, January 2017, doi: 10.1542/peds.2015-1175.

[31] Ollie Ganz, Laurel E. Curry, et al., *Barriers to Mental Health Treatment Utilization in Wards 7 and 8 in Washington, DC: A Qualitative Pilot Study,* Healthy Equity, (2018), doi: 10.1089/heq.2017.0051; *See also* Stacy Hodgkinson, Leandra Godoy, et al., *Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting,* Pediatrics, January 2017, doi: 10.1542/peds.2015-1175.

[32] Stacy Hodgkinson, Leandra Godoy, et al., *Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting,* Pediatrics, January 2017, doi: 10.1542/peds.2015-1175.

[33] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District,* page 72, December 2021, *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf; The Integration of Behavioral Health into Pediatric Primary Care Settings, SAMHSA, 2017, *available at:* https://www.nashp.org/wp-content/uploads/2019/09/The-Integration-of-Behavioral-Health-into-Pediatric-Primary-Care-Settings.pdf; HealthySteps, *Our Model, available at*: https://www.healthysteps.org/what-we-do/our-model/.

[34] TransitCenter Equity Dashboard, *The Washington D.C. Story*, *available at:* https://dashboard.transitcenter.org/story/dc; *see also* Office of Healthy Equity, District of Columbia, Department of Health, Healthy Equity Summary Report: District of Columbia 2018, *available at*: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/HER%20Summary%20Report%20FINAL%20with%20letter%20and%20table_02_08_2019.pdf.

[35] TransitCenter Equity Dashboard, *The Washington D.C. Story*, *available at:* https://dashboard.transitcenter.org/story/dc; *see also* Office of Healthy Equity, District of Columbia, Department of Health, Healthy Equity Summary Report: District of Columbia 2018, *available at*:

https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/HER%20Summary%20Report%20FINAL%20with%20letter%20and%20table_02_08_2019.pdf; Stacy Hodgkinson, Leandra Godoy, et al., *Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting,* Pediatrics, January 2017, doi: 10.1542/peds.2015-1175. *See also* Ollie Ganz, Laurel E. Curry, et al., *Barriers to Mental Health Treatment Utilization in Wards 7 and 8 in Washington, DC: A Qualitative Pilot Study,* Healthy Equity, (2018), doi: 10.1089/heq.2017.0051.

[36] DC Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[37] HealthySteps has been shown to increase healthy and secure relationships between families as well as setting children up for future successes by equipping children with the necessary socialization and cognitive abilities to reduce the likelihood of risk behaviors later. *See* Zero To Three, *Healthy Steps National Evaluation Report,* (2003), *available at*: https://ztt-healthysteps.s3.amazonaws.com/documents/139/attachments/2003_HS_National_Evaluation_Report.pdf?1539967824; Center for Disease Control, *Adverse Childhood Experiences*, (2019), *available at*: https://www.cdc.gov/violenceprevention/aces/index.html; Karoly, Lynn A., M. Rebecca Kilburn, and Jill S. Cannon, *Proven Benefits of Early Childhood Interventions,* Santa Monica, CA: RAND Corporation, (2005), *available* at: https://www.rand.org/pubs/research_briefs/RB9145.html.

[38] Leah Castelaz, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 23, 2022), *available at*: https://childrenslawcenter.org/resources/fy22-oversight-testimony-dc-health/; Tami Weerasingha-Cote, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (January 24, 2022), *available at*: https://childrenslawcenter.org/wp-content/uploads/2022/01/TWeerasingha-Cote_Childrens-Law-Center-Testimony-for-Jan.-24-2022-DBH-Oversight-Hearing_FINAL-1.pdf; Sharra E. Greer, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 28, 2022), *available at*: https://childrenslawcenter.org/wp-content/uploads/2022/02/SGreer_Childrens-Law-Center-Testimony-for-Feb.-28-2022-DHCF-Oversight-Hearing_FINAL..pdf.

[39] DC Health FY21 Performance Oversight Responses, response to Q114, *available at*: https://dccouncil.us/wp-content/uploads/2022/02/dohpoh.pdf.

[40] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District,* page 110, December 2021, *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf.

[41] *Id.*

[42] DC Health FY21 Performance Oversight Responses, response to Q114, *available at*: https://dccouncil.us/wp-content/uploads/2022/02/dohpoh.pdf.

[43] Mayor's Proposed FY 2023 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Health [HC0], p. E-40.

[44] Mayor's Proposed FY 2023 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Health [HC0], p. E-44.

Testimony for

The Committee on Health

April 4, 2022

Submitted By

Fernanda Ruiz

Home Visiting Director

Mary's Center for Maternal and Child Care, Inc.

to

Vincent Gray, Chair

Testimony for 2022 Budget Hearing
Committee on Health
DC Health
April 4, 2022

Fernanda Ruiz
Home Visiting Director
Mary's Center for Maternal and Child Care, Inc
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Good morning, Chairman Gray and Members of the Committee,

Thank you for the opportunity to testify today. My name is Fernanda Ruiz, and I am the Home Visiting Director at Mary's Center, a member of the Under 3DC Campaign and a District resident from Ward 4. In my role I support the Healthy Families America (HFA), Parents As Teachers (PAT), Healthy Start and Nurse Family Partnership (NFP) programs funded by the DC Health and other home visiting models currently implemented in the District through other funding sources.

I am here today to support the proposed FY2023 budget for the Department of Health (DC Health) to continue their investment in the Home Visiting programs at Mary's Center, include funding for the First Time Mothers grant supporting NFP and to request a 15% increase to these grants. Funding for these programs needs to be recurrent and needs to be adjusted to inflation and to the current demands placed on home visitors to support families during the pandemic. These programs have proven to be effective at supporting families and improve maternal child health and early childhood outcomes through the strategy of home visiting[1][2][3].

Home visitors are educated, well trained, dedicated and committed individuals. They are passionate about working with families. 81% of home visitors have a bachelor's degree in human services, child development or another relevant field with our remaining team joining us as District residents with experience in early childhood development, community health and other areas that support our participants. Yet, as many social services jobs, home visiting is a job that is mostly done by women and people of color[4]. Historically, community members that are underpaid. Home visitors find their jobs rewarding and meaningful. However, a rewarding position is only one aspect of what allows us to be engaged in our work; we also need to ensure our compensation matches the importance, skill level and quality that we bring. As an agency that has implemented home visiting for 26 years, we know what is necessary to be effective and

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[1] Data Source: Our Impact (2021). *Healthy Families America*. Retrieved from: https://www.healthyfamiliesamerica.org/our-impact/evidence-of-effectiveness/
[2] Data Source: Proven Results (2022). *Nurse Family Partnership*. Retrieved from: https://www.nursefamilypartnership.org/about/proven-results/1386-2/
[3] Data Source: Evidence Based Research and Results (2022). *Parents As Teachers.* Retrieved from: https://parentsasteachers.org/research-and-quality-improvement-index
[4] Data Source: Home Visitors Experience Report (2021). *DC Home Visiting Council*. Retrieved from: http://www.dchomevisiting.org/uploads/1/1/9/0/119003017/home_visitors_experience_report-final_english.pdf

we know home visiting staff deserve pay that reflects the time and investment that the team has put into their role to ensure the highest quality of care and support to our communities.

Funding and compensation greatly impact participant outcomes and staff retention. We have presented testimony every year outlining the impact of staff turnover, so often due to needing a salary more reflective of their skills and abilities. We've reviewed how lapses in funding impact consistency and continuity of services, including loss of contact with families and loss of trained staff who have built trusting relationships with families. We know that lower pay is correlated to lower staff retention[5].

A variety of reports have shown how inequities in District residents exacerbate infant mortality rates disproportionately[6][7][8][9]. Families come in all shapes and forms. After many years in the field, we recognize the importance of having a robust perinatal and early childhood system. A continuum of support of diverse home visiting programs, that accounts for the small differences among families and allows families to engage in the model that best meets their needs. Mary's Center currently offers four home visiting models and a community health worker case management program. Allowing us to engage families through different phases of perinatal and early childhood years.

Home visiting programs are designed to families with complex needs who are at risk of poor health outcomes due to the accumulation of risk factors they experience. Using a trauma informed perspective, they address the parent's history of trauma, and current or previous challenges related to substance abuse, behavioral health, and/or domestic violence. This skillset makes them well-positioned to support families in these extraordinarily tough times. Home visitors are trained to support families through crisis and today they continue to be the lifelines to many of our families.

NFP is a widely researched and proven evidence-based home visiting model, that supports first-time low-income mothers. DC Council and DC Health made this possible in FY22 through seed funding with a total amount of $150,000 dollars. Mary's Center has secured additional $2.2 million dollars through private foundations and NFP to pilot NFP in the District for three years. The community has received well the NFP program, and we are happy to report to date we have

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[5] Data Source: Home Visitors Experience Report (2021). *DC Home Visiting Council*. Retrieved from: http://www.dchomevisiting.org/uploads/1/1/9/0/119003017/home_visitors_experience_report-final_english.pdf

[6] District of Columbia Department of Health (2018). Perinatal health and infant mortality report. Retrieved from https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20Health%20Perinatal%20Health%20%26%20Infant%20Mortality%20Report_FINAL.PDF

[7] Siddiqi, A., Jones, M. K., Bruce D. J., & Erwin, O. C. (2016). Do racial inequities in infant mortality correspond to variations in societal conditions? A study of state-level income inequality in the U.S., 1992-2007. *Social Science & Medicine*, 164, 49-58. doi: 10.1016/j.socsimed.2016.07.013

[8] DC Fiscal Policy. (2018). *DC's growing prosperity is not reaching Black residents, Census data show.* Washington, DC: Ed Lazere. Retrieved from: https://www.dcfpi.org/all/dcs-growing-prosperity-is-not-reaching-black-residents-census-data-show/

[9] District of Columbia. (2016). *Community Health Needs Assessment*. Washington, DC: Merrill, C., & Searcy, K. Retrieved from: http://www.dchealthmatters.org/content/sites/washingtondc/2016_DC_CHNA_062416_FINAL.pdf

50 mothers enrolled and 16 healthy births to date. We hope to continue to partner with DC Health in offering NFP to more mothers and their children in the District.

Mary's Center continues through our social change model to be committed to the health, education and safety of families in the District. We urge DC Health to continue their investment in prevention services and that we do not remove these essential supports for families of young children. We hope we can build from here to continue our shared commitment to serve families in the District with the goal of improving maternal and child health outcomes. We continue to manage racism, trauma, inequity and loss, let's recognize the importance of maintaining investment in our programs within our system of care towards safe and healthy families that lead to safe and healthy communities.

Thank you very much for your attention and time. I am happy to take any questions.

Testimony for

The Committee on Health

April 4, 2022

Submitted By

Dr. Maria Marquez

Administrative Medical Director

Mary's Center for Maternal and Child Care, Inc.

to

Vincent Gray, Chair

April 4, 2022

Committee on Health
Council of the District of Columbia
John Wilson Building
1350 Pennsylvania Avenue, NW, Washington, D.C. 20004

Good morning, Chairman Gray and Members of the Committee,

Thank you for the opportunity to testify today. My name is Dr. Maria Marquez, and I am the Administrative Medical Director at Mary's Center Fort Totten. I moved to the District in 1995 for my residency and have been a practicing pediatrician in this community for the last 26 years. At Mary's Center, I get to see firsthand the impacts of our Social Change model and efforts to connect participants to not only health care, but also wraparound services that their health and well-being. I am here today to request that the Council invest in an additional HealthySteps program site to support Ward 5 children and families. This would require $300,000 in additional program funding in the FY23 budget.

As you know, HealthySteps is an early development program that is embedded in primary care practices where the majority of participants are enrolled in either Medicaid or DC Healthy Families or are uninsured. The program integrates a licensed child-development health professional in the pediatric primary care setting to help parents adapt to life with a new baby and get connected to infant-toddler resources that can help families thrive.

Evidence demonstrates that HealthySteps can positively impact development, interpersonal relationships, and health.[1] Children involved in HealthySteps are more likely to develop healthy and secure relationships with their families, are likely to stay connected to long-term health care, and demonstrate positive early education indicators, such as expansive vocabularies by 24 months of age.[2,3] The District has three HealthySteps sites that served 1,192 children in FY21. This was a significant increase over the 415 children served in FY20.

- In FY21, DC Pritzker Children Initiative (DC PCI) collected data from the two Children's National HealthySteps sites and one Unity HealthySteps site. Together, these three sites served 1,192 children, which compared to 415 children served by these three sites in FY20, represents a 287% increase in children served between FY21 and FY22.[4]

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[1] Zero To Three. Healthy Steps National Evaluation Report. 2003.
[2] Briggs, R. D., Stettler, E. M., Silver, E. J., Schrag, R. D., Nayak, M., Chinitz, S., & Racine, A. D. Social emotional screening for infants and toddlers in primary care. Pediatrics, 129(2), e377–384. (2012)
[3] Johnston, B. D., MD, MPH, Huebner, C. E., PhD, MPH, Tyll, L. T., MA, Barlow, W. E., PhD, & Thompson, R. S., MD. Expanding developmental and behavioral services for newborns in primary care: Effects on parental well-being, practice and satisfaction. *American Journal of Preventative Medicine,* 26(4), 356-366. (2004)
[4] Data provided by the DC Pritzker Children's Initiative, on file with the Children's Law Center.

- Additionally, I would like to note that I understand that none of the current sites offers services in Spanish, and I believe that the Council should ensure that sites are connected to providers that have the capacity to engage with families in their preferred languages.

The existing sites have clearly scaled up to meet additional needs and it is apparent that District families will benefit from additional HealthySteps sites. As a District pediatrician, I would like to see HealthySteps, and programs like it, available to all families who need it. This absolutely includes the children and families that I work with every day at Mary's Center Fort Totten.

- In 2021, approximately 23 percent of our pediatric participants were uninsured.
- We cared for more than 5400 pediatric participants, and 1,368 of those were between the ages of 0-3, which as you know, is a critical period for child development. Many of my participants are low-income, Black and Brown, and often primarily speak a language other than English.
- In Ward 5 more broadly, approximately 3,926 children under 5 years old living in Ward 5 are Medicaid recipients. Of those children, 66% are Black and 18% of children are Latinx.

In light of the COVID-19 pandemic, many of my participants have had delayed diagnoses and treatments and I have particularly seen an increase in delayed diagnoses of autism. I screen patients almost daily, which is a sharp increase over my pre-COVID experience. We screen children, and then refer them to a developmental specialist for a formal diagnosis. HealthySteps can help us ensure that children have access to early diagnoses and treatments during the early childhood period, which is when they are likely to be most effective. I am deeply concerned about my community and the need to maximize access to early developmental supports like HealthySteps.

With an integrated model of health care, education, and social services, Mary's Center is well positioned to integrate HealthySteps into our current programming. We know that DC recognizes the importance of a robust pediatric and early childhood system. We urge DC Health to expand their investment in HealthySteps, and hope that an additional HealthySteps site can come to Ward 5 in FY23.

Thank you very much for your attention and time. I am happy to take any questions.

SPACEs in ACTION

Thank you members of the committee and Malcolm for your coordination that led to the opportunity for me to speak today.

I am LaDon Love, **Executive Director of SPACEs In Action or SIA**. **SIA** is an executive committee member of the **Under 3 DC coalition**, a core member of the **ECIN Prenatal to Five Capacity Building Collaborative,** and a member of the **Fair Budget Coalition** and the **Just Recovery DC** coalition.

Some of my other roles include me being a *daughter, sister, cousin, aunt, and mom*. A value that I hold close to my heart is *family*. The work that SIA does in DC allows us to connect with individuals who are family leaders. We are a Black, Latin and immigrant membership-based organization that helps our members and leaders reclaim their power as they advocate for the needs of their families and community. Our focus is health equity for all, solving childcare funding issues and economic dignity for families.

We believe that every child who resides in DC is a child of DC. DC must take care of DC's children. Today, let's focus on babies and toddlers or birth to three and the benefits of ***Healthy Steps***.

You can see two videos that we co-created with the *ECIN Prenatal to Five Capacity Building Collaborative* to educate more families about *Healthy Steps*.

- **bit.ly/healthystepses - Espanol/Spanish**
- **bit.ly/healthystepsen - English**

As a mom of a 12-year-old, I wish this program had been available to my family over a decade ago. It was not. But, we do not do this work for instant gratification, although it could be nice. But, we do this work to help the families raising babies and toddlers in DC.

Fact: Black pregnant people, the first 365 days after giving birth, and newborns are more likely to have complications than any other group - nationally and in DC. Those who speak a language other than English are more likely to struggle to get access to services in their first language. We have to reduce the Black morbidity rates due to pregnancy, birthing and living…NOW. And, language linguistics must also be centered when planning the delivery of services.

Healthy Steps offers developmental and family screening, mental health support for parents, positive parent guidance, care coordination, services in languages other than

Submitted by LaDon Love, SPACEs In Action, ladon@spacesinaction.org, cell 301-828-6886

English and more. The program is offered at several location in DC that include - Georgetown Medical Center via a mobile clinic and at Fort Lincoln, Children's Nfational at the Arc and the Big Chair, and through Unity health care at Minnesota Ave and East of the River. It primarily focuses on services the historically underserved Wards 5, 7, and 8. When we find programs like Healty Steps that work, they need to receive a deeper investment and should be expanded to support more families.

My request on behalf of SIA is that the council take action and increase the funding for *Healthy Steps* by $300,000 and ensure that the funds are reoccurring. We cannot afford to ignore the needs of DC families or our most vulnerable future voters - DC's babies and toddlers.

Submitted by LaDon Love, SPACEs In Action, ladon@spacesinaction.org, cell 301-828-6886

Statement of Carrie Stoltzfus, Executive Director, Food & Friends, before the DC Council Committee on Health

April 4, 2022

Good morning Chairman Gray and members of the Committee. I am Carrie Stoltzfus, the Executive Director of Food & Friends. As always, I'd like to begin by thanking you, Mr. Chairman, and the Committee on Health, for your continued support of our mission to improve the lives and health of DC residents living with serious illnesses such as cancer, kidney failure, HIV/AIDS, and other conditions that limit their ability to provide their own nourishment. We are also grateful for our partnership with Dr. Nesbitt and the staff of DC Health.

The support of DC Health has helped us deliver more than 617,000 freshly prepared, home-delivered, medically tailored meals and groceries to more than 2,100 District residents in 2021 who have complex health needs. We have seen from our own work and from peer-reviewed studies in other cities that tailored nutrition provided to those with multiple serious illnesses not only addresses food insecurity, but also improves health outcomes while reducing healthcare costs in these vulnerable populations.

Food & Friends is requesting $1,025,000 in funding from the Community Health Administration, raising our request from the $825,000 we received in FY22 to $1,025,000, to support increased food access, and 36,000 additional meals, for the most vulnerable DC residents—those living with serious illnesses who are in need of medically-tailored meals and often unable to leave the home. In the 5 years since we have last requested an increase in our CHA funding, our services to District residents have grown by 50%.

This $1,025,000 request represents only 15% of what Food & Friends will spend taking care of DC residents this year, yet this funding is critical. Robust support from DC Health enables us to leverage the city's commitment four-to-one with funding from private sources. Our CHA grant is more important than ever before as we continue to provide almost 15,000 more meals per month than we did before the pandemic.

We have continued to meet the needs of our neighbors during the pandemic, not only growing the number of residents we care for, but expanding eligibility to meet the needs of additional conditions such as cystic fibrosis. We also launched a Care Transitions program that enables us to pre-enroll individuals while they're still in the hospital in order to begin service within 48 hours of discharge. We haven't missed a day of service throughout the pandemic, ensuring that our most vulnerable neighbors are able to shelter safely at home while their nutritional

needs are taken care of. We have also deepened our partnerships with Medicaid managed care providers, providing an additional opportunity for clients to access our services.

Food & Friends' clients are acutely ill and often unable to take advantage of other nutrition programs or shop at a grocery store. A healthy food system must include support for those who are primarily homebound and have complex nutritional needs. Our clients become involved with us when they are out of other options, and we take that responsibility seriously. Throughout the pandemic, we didn't miss a day of service to our clients, ensuring they were able to shelter safely at home while their nutrition needs were taken care of.

We also enthusiastically endorse the proposals presented by the Fair Food for All DC Coalition, as well as B24-0419, the No Senior Hungry Omnibus Amendment Act of 2021 and B24-0702 - Non-Profit Certified Business Enterprise Amendment Act of 2022, acknowledging the role of non-profits in the local economy. Our emergency food providers have filled a critical need in the community during the pandemic, and the city's investment in these programs will enable us to emerge stronger and healthier than we were before.

Food & Friends will continue to meet the challenges of feeding those who are medically vulnerable, as we have for the past 34 years. We appreciate the Council's support of our mission before, during, and after the pandemic. I am happy to answer any questions, and I look forward to a continued partnership with you Mr. Chairman, the D.C. Council, and D.C. Health.

Fair Food for All DC Coalition
FY23 Budget Update and Call to Action

The District of Columbia faces persistently high rates of food insecurity. We cannot afford to underfund the District's highly effective, efficient, and community-driven food access programs. While the FY23 budget largely seeks to return to 2019's investments in food access, the needs in our community will not revert to pre-pandemic levels without more decisive investment and action.

- The number of DC residents relying on SNAP benefits has grown from 94,000 to 140,000 – **a 49% increase**
- 37% of the city's Black children have experienced food insecurity during the pandemic
- Joyful Food Markets are increasing student engagement by 16%, reaching up to 8,500 Ward 7 and 8 schoolchildren
- Home-delivered, medically tailored meal production has grown by 20% since FY19
- Healthy Corners store sales have increased by up to 200% thanks to SNAP incentives

Produce Plus (FRESHFARM)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$1,200,000	$1,200,000	$1,401,934	$1,170,934	$1,500,000	**$329,066**

Home-Delivered Meals (Food & Friends)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$975,000	$825,000	$825,000	$820,000	$1,025,000	**$205,000**

Healthy Corners (DC Central Kitchen)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$500,000	$500,000	$750,000	$500,000	$1,000,000	**$500,000**

Joyful Food Markets (Martha's Table)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$1,504,271	$1,500,934	$1,825,000	$1,500,934	$1,825,000	**$324,066**

Distribution Efforts (Capital Area Food Bank)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$0	$0	$1,000,000	$0	$500,000	**$500,000**

Commodity Supplemental Food Program (Capital Area Food Bank)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$379,400	$410,000	$309,232	$410,000	$410,000	**$0**

Produce Rx (DC Greens)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$250,000	$250,000	$500,000	$500,000	$500,000	**$0**

We hope our partners on the Council will help close these remaining budget gaps, totaling **$1,858,132**. With your support, our integrated, data-driven healthy food access solutions will contribute to a more just recovery, overcome rising costs of food and other essentials, and address unacceptable health disparities.

CAPITAL AREA FOOD BANK · d.c. central kitchen · dcgreens · D.C. Hunger Solutions – Ending hunger in the nation's capital · FOOD & FRIENDS – Delivering hope, one meal at a time · FRESHFARM – nourishing our food future · Martha's Table

Committee on Health
DC Health Budget Oversight Hearing
April 4, 2022

Honorable Chairperson Gray and Members of the Committee on Health,

Thank you for convening today's hearing. My name is Alexander Moore and I am testifying on behalf of **DC Central Kitchen**. We are proud to partner with DC Health in implementing the award-winning **Healthy Corners** program. Our work to transform small corner stores into robust, reliable access points for nutritious foods has become a public health and economic lifeline. With the number of District residents relying on SNAP benefits growing by 49% in the past two years – to more than 140,000 of our neighbors – the need to make healthy, affordable food options available in every DC neighborhood has never been more urgent.

This Committee's support has helped Healthy Corners become a national model for empowering SNAP customers to double their painfully limited purchasing power with special incentives for fruits and vegetables. Our SNAP Match benefit allows 15,000 residents to afford more of the healthy food they need and want when costs for food and other essentials are rising at an astounding rate. This is especially critical for low-income seniors who receive the minimum SNAP benefit of just $30 a month and may struggle to travel long distances to full-service grocery stores.

Healthy Corners and SNAP Match are doing just what they are supposed to, and more. **SNAP customers are voluntarily spending 18% more of their own money on fruits and vegetables** than they were when SNAP Match began. Corner stores are clamoring to join this program and in response, we are doubling the number of SNAP Match-participating retailers to more than 30 stores this year. It can be hard for our partner businesses to join hearings like these, so if you visit any of our social media accounts today – @dcck on Twitter, @dccentralkitchen on Facebook and Instagram – you'll see an amazing video featuring Healthy Corners store owners talking about how SNAP Match is changing their businesses and communities in powerful ways.

This is the type of progress this Committee has always wanted to see. But because of the benefit's soaring popularity, we are on pace to fully exhaust the Federal funds for these point-of-sale incentives at the end of 2022, a full year early. The proposed budget maintains Healthy Corners funding at the same level it has received since 2019, and DC Central Kitchen is grateful for that continued investment. But it's not 2019 anymore. With residents' reliance on SNAP Match benefits at DC corner stores at an all-time high, we cannot afford to lose this resource when Federal funding is exhausted. I'm here to ask for your help in identifying an additional $500,000 in FY23 funding exclusively for SNAP Match benefits that will go directly to low-income shoppers and put food on their tables.

Healthy Corners is just one of several homegrown food access programs operated by the Fair Food for All DC Coalition and supported by DC Health that have become national best practices. Collectively, we work to ensure that seniors, children, residents battling serious illness, and families struggling to make ends meet can access the nutritious food they need with dignity. The proposed budget largely resets our programs' funding levels to 2019, which is likely to force difficult choices about which food insecure

residents we can serve and where. We are not immune from the same inflationary pressures on food, staff, and fuel facing our residents, but our relative scale, efficiency, and evidence-based models make these initiatives uniquely effective investments in the health and well-being of our community. Attached to our testimony is an overview of our respective programs' funding levels as well as more information on Healthy Corners and SNAP Match. We respectfully call on Council to help identify the $1.85 million we need to fully fund these vital efforts at a crucial time for more than 100,000 food insecure residents.

Thank you for the opportunity to testify today and I am happy to answer questions.

THE HEALTHY CORNERS PROGRAM AND SNAP MATCH: A HOMEGROWN WIN/WIN

1. With support from DC Health, DC Central Kitchen aggregates, prepares, and delivers fresh and frozen fruits and vegetables to small corner stores in low-food-access communities at discounted rates. We provide stores with free infrastructure (fridges, shelves), signage, technical assistance, marketing support (e.g. Metro ad buys), and educational events to drive foot traffic and sales.

2. Stores add a modest mark-up to ensure profitability. Any customer can purchase any product, but thanks to **SNAP Match**, SNAP customers who includes a fruit or veggie in their SNAP-eligible purchase can earn up to $5 in additional produce incentives. As of 2021, WIC customers can redeem their benefits at participating stores thanks to the WIC Expansion Act.

3. Customers can access healthy, affordable foods right on their own block, 7 days a week. Store owners gain new revenue and are rethinking their business models, emphasizing health and freshness. The District brings additional WIC and SNAP dollars to DC at a time of rising food insecurity, while becoming a national model for healthy corner store innovation.

In 2018, DC Central Kitchen (DCCK) won the first US Department of Agriculture (USDA) grant in the nation to focus on providing produce incentives to SNAP customers at corner stores. This '**SNAP Match**' pilot at 18 participating retailers in Wards 5, 7, and 8 quickly produced a **162% increase in sales**. Consumer demand for SNAP Match benefits was so strong we spent down a 3-year, $500,000 USDA grant – 100% of which can *only* support direct consumer benefits without a cent towards DCCK's operating costs – in less than 2 years. That left the waitlist of corner stores wanting to join the program largely unmet. In 2020, DCCK won another $500,000 USDA grant with the goal of increasing the number of participating SNAP Match retailers to 34 or more stores citywide.

This innovative solution is working. **SNAP customers are voluntarily spending 18% more of their own money on fruits and vegetables** than they were when SNAP Match began. Redemption rates for our SNAP incentives are 28 percentage points higher than typical farmers' market programs, underscoring the unique accessibility of our partner stores, the elevated need in the communities we serve, and the desirability of our diverse line-up of value-added, fresh cut items that make healthy eating easier on-the-go. These healthy products also sustain **living wage jobs** for DC Central Kitchen culinary graduates with histories of incarceration, homelessness, and chronic unemployment. However, given the benefit's soaring popularity, we are on pace to fully exhaust Federal funds at the end of 2022, **another year early**.

The pandemic has **grown the number of DC residents on SNAP from 94,000 in January 2020 to more than 140,000 today – a 49% increase**! SNAP is a lifeline, but if healthy food is not available in the neighborhoods where SNAP participation is the highest, we risk further undermining the health of communities most impacted by COVID-19. SNAP Match adds vital purchasing power for our most vulnerable households and makes healthy food a viable proposition for small DC retailers.

We know SNAP Match works, but DC is once again at a disadvantage. Given our singular focus on serving DC, we are not able to effectively compete for larger state-level USDA grants of $1+ million that could help stretch and secure the SNAP Match benefit. At the same time, SNAP and its recipients are often vilified for political reasons on Capitol Hill. Relying on Federal funding for this innovative and progressive produce incentive could prove risky after the mid-terms and beyond. We respectfully ask the DC Council to protect Healthy Corners' SNAP Match benefit by increasing the annual allocation to DC Health for Healthy Corners from $500,000 to $1,000,000. This $500,000 increase will be **dedicated to SNAP Match customer incentives**, putting funds right in the hands of food insecure DC residents as they select nutritious fruits and vegetables at their neighborhood corner stores – **a timely win/win for public health and our local economy**.

Fair Food for All DC Coalition
FY23 Budget Update and Call to Action

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We hope our partners on the Council will help close these remaining budget gaps, totaling **$1,858,132**. With your support, our integrated, data-driven healthy food access solutions will contribute to a more just recovery, overcome rising costs of food and other essentials, and address unacceptable health disparities.

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FY23 Budget Update and Call to Action

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- 37% of the city's Black children have experienced food insecurity during the pandemic
- Joyful Food Markets are increasing student engagement by 16%, reaching up to 8,500 Ward 7 and 8 schoolchildren
- Home-delivered, medically tailored meal production has grown by 20% since FY19
- Healthy Corners store sales have increased by up to 200% thanks to SNAP incentives

Produce Plus (FRESHFARM)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$1,200,000	$1,200,000	$1,401,934	$1,170,934	$1,500,000	**$329,066**

Home-Delivered Meals (Food & Friends)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$975,000	$825,000	$825,000	$820,000	$1,025,000	**$205,000**

Healthy Corners (DC Central Kitchen)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$500,000	$500,000	$750,000	$500,000	$1,000,000	**$500,000**

Joyful Food Markets (Martha's Table)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$1,504,271	$1,500,934	$1,825,000	$1,500,934	$1,825,000	**$324,066**

Distribution Efforts (Capital Area Food Bank)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$0	$0	$1,000,000	$0	$500,000	**$500,000**

Commodity Supplemental Food Program (Capital Area Food Bank)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$379,400	$410,000	$309,232	$410,000	$410,000	**$0**

Produce Rx (DC Greens)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$250,000	$250,000	$500,000	$500,000	$500,000	**$0**

We hope our partners on the Council will help close these remaining budget gaps, totaling **$1,858,132**. With your support, our integrated, data-driven healthy food access solutions will contribute to a more just recovery, overcome rising costs of food and other essentials, and address unacceptable health disparities.

CAPITAL AREA FOOD BANK · d.c. central kitchen · dcgreens · D.C. Hunger Solutions – Ending hunger in the nation's capital · FOOD & FRIENDS – Delivering hope, one meal at a time · FRESHFARM – nourishing our food future · Martha's Table

DC Health FY23 Budget Hearing
April 4, 2022
Lauren Shweder Biel
Executive Director, DC Greens

Thank you for this opportunity to share thoughts and perspective on the FY23 budget. As you know, I'm the Executive Director of DC Greens, a nonprofit that advances health equity by building a just and resilient food system in the District. However, I am here today as a member of the Fair Food for All DC Coalition, which includes the District's major emergency food security providers: Capital Area Food Bank, DC Central Kitchen, DC Hunger Solutions, DC Greens, Food & Friends, FRESHFARM, and Martha's Table.

As you are well aware, the food insecurity rates in the District have sky-rocketed since the start of the pandemic. There has been a 49% increase in the number of residents relying on SNAP benefits (from 94,000 to 140,000 residents). We also know that these SNAP benefits are woefully inadequate to meet the food security needs of our city. Until we as a city Give SNAP a Raise, we must take steps to meet the growing needs.

However - despite the crush of food insecurity that our residents are experiencing, **the FY23 budget returns food security funding back to FY19 levels.**

It is proven fact that food insecurity contributes to to chronic illnesses, violence, educational attainment and so much more. With so much on the line for health equity, it is past time that we recognize that food security <u>must be meaningfully supported by city investments</u>. This budget leaves the work of feeding residents to the whims of the philanthropic sector - a choice the District makes at its own peril.

The Fair Food for All DC Coalition is asking for a total enhancement of roughly $1.8 million to bolster the tireless work of our emergency food providers. We have shared the breakdown of this request with your staff and are happy to follow up with more detail, but - again - these funds are necessary for organizations like Capital Area Food Bank, DC Central Kitchen, Martha's Table, FRESHFARM and Food & Friends to meet the food security needs of District residents in FY23.

Until the city meaningfully invests in food security by Giving SNAP a Raise, we need the safety net of emergency food providers. And we need the city to be a stronger financial partner in this critical work.

Council of the District of Columbia

Committee on Health

Councilmember Vincent Gray, Chairperson

FY2023 Budget Oversight Hearing:

Department of Health

April 4th, 2022

Submitted written testimony:

DC Coalition Against Domestic Violence

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Washington, DC 20005

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www.dccadv.org

The DC Coalition Against Domestic Violence (DCCADV or The Coalition) is the federally recognized statewide coalition of domestic violence (DV) service providers in the District of Columbia. The Coalition is a membership organization that provides training and technical assistance, conducts outreach and education, and advocates for trauma informed policies that address domestic violence in the District of Columbia. DCCADV's members include domestic violence housing, legal service, and culturally specific organizations serving: Black, Latino, Asian and Pacific Islander, immigrant, and LGBTQ+ survivors of domestic violence. Our members also serve teens and youth, survivors formally incarcerated, and survivors who are Deaf and Deaf/Blind. DCCADV is also a member of the Fair Budget Coalition, and we strongly support the Fair Budget FY23 budget priorities and recommendations. We believe the city needs to make investments across multiple issue areas to make meaningful steps toward addressing historical racial and economic inequalities. We are calling for Council to perform an act of justice.

A driving force behind the mission of the Coalition is the understanding that intimate partner and sexual violence continue to be a major public health concern for DC residents of all ages. This is especially true for youth whose lives have been detrimentally uprooted as we navigate challenges posed by the COVID-19 pandemic. According to the 2022 Teen Dating Violence Awareness Month Action guide, 1 in 3 teens in the United States will experience physical, sexual or emotional abuse by a dating partner before they become adults.[1] Furthermore, in a 2020 survey by the Office of the State Superintendent of Education, 1 in 10

[1] Office of Victim Services and Justice Grants. (2022, February). OVSJG 2022 Teen Dating Violence Awareness Month Action Guide. Retrieved from https://www.loveisrespect.org/wp-content/uploads/media/sites/3/2022/01/2022-TDVAM-Action-Guide_R02..pdf

DC high school students reported experiencing physical dating violence.[2] We also know that 39% of women living in DC have experienced sexual violence, physical violence, and/or stalking perpetrated by an intimate partner, and 50% of women have experienced psychological aggression by an intimate partner.[3] Young women and girls between the ages of 16-24 are at the greatest risk for experiencing dating violence[4] and relationship abuse. Nationally, more than half of women and men who have been physically or sexually abused or stalked by a dating partner first experienced abuse between the ages of 11-24.[5]

Youth teen dating and sexual violence victimization can have severe impacts on quality of life and youth deviancy. Experiencing dating and sexual violence is associated with negative physical and mental health consequences, such as higher risk of chronic illness, the development of post-traumatic stress disorder, and risky sexual behaviors.[6] Additionally, middle and high school students were more likely to miss school and receive lower grades when they reported feeling unsafe.[7] In addition to negative mental health symptoms, youth exposure to violence is associated with a higher risk of intimate partner violence (IPV) victimization in adulthood.[8]

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[2] Stein, P. (2020, February 25). 10% of D.C. high-schoolers say they experience dating violence. the city wants to change that. The Washington Post. Retrieved from https://www.washingtonpost.com/local/education/10percent-of-dc-high-schoolers-say-they-experience-dating-violence-the-city-wants-to-change-that/2020/02/24/0b551032-5710-11ea-ab68-101ecfec2532_story.html

[3] Source: S.G. Smith, et al., The National Intimate Partner and Sexual Violence Survey: 2010-2012 State Report (2017)

[4] Dating violence is a pattern of abusive and coercive behaviors where a partner exerts power and control over someone they are dating or involved in some type of relationship. The abuse can be physical, emotional and/or sexual.

[5] Breiding, M.J., Chen J., Black, M.C. (2014). Intimate Partner Violence in the United States 2010. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[6] Preventing Multiple Forms of Violence: A Strategic Vision for Connecting the Dots. (2016). Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[7] Centers for Disease Control and Prevention. (2021, March 5). Preventing teen dating violence |violence prevention | injury Center|CDC. Centers for Disease Control and Prevention. Retrieved February 18, 2022, from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/teendatingviolence/fastfact.html

[8] Children exposed to violence. Office of Juvenile Justice and Delinquency Prevention. (n.d.). Retrieved from https://ojjdp.ojp.gov/programs/children-exposed-violence

Responses to combat these detrimental effects have included efforts of secondary prevention, aiding survivors after violence has already occurred by providing case management, legal, medical, mental health and housing services. Service providers at these agencies are struggling to meet the demands of an overwhelmed system of care as a result of the COVID-19 pandemic. Since the pandemic began, intimate partner and sexual violence program staff have reported experiencing more personal and professional stressors, perceived a decrease in client safety, and lacked resources needed to help survivors and themselves. The strain placed on these agencies stem from reductions in overall service capacity and the shift to a remote service provision.[9] It's important to note that these are compounding stressors that affect the quality of these services in addition to pre-COVID occupational stressors such as burnout, low pay and exposure to secondary traumatic stress (STS).

To transform our culture and end intimate partner violence, funding strategies that increase resiliency for providers and survivors and reduce risk factors to victimization are paramount. As noted by DC Health in their recent Community Health Needs Assessment, injury and violence prevention is one area in which the District has seen no change, and is, in fact, getting worse.[10] We recognize that the work to reduce and prevent violence does not happen overnight. DC Health has made an important commitment by recognizing intimate partner and sexual violence as a public health issue.

[9] Wood, L., Schrag, R. V., Baumler, E., Hairston, D., Guillot-Wright, S., Torres, E., & Temple, J. R. (2020). On the Front Lines of the COVID-19 Pandemic: Occupational Experiences of the Intimate Partner Violence and Sexual Assault Workforce. Journal of Interpersonal Violence. https://doi.org/10.1177/0886260520983304

[10] DC Community Health Needs Assessment, Executive Summary 2019; Retrieved from https://ourhealthydc.org/dc-chna/

We are grateful to work with DC Health and our community-based partners through the Sexual Violence Prevention Community of Practice (SVPCoP). Over the last year, we have been able to provide valuable training to address forms of teen dating and sexual violence such as technological abuse and reproductive coercion. Additionally, we developed a Youth Sexual Violence Prevention toolkit for caregivers in the District which equips parents and guardians with valuable local resources for youth. Moving forward, we plan to continue working to identify state-level indicators of sexual violence and to create and facilitate training on topics related to youth sexual violence prevention for school personnel to support the mandates of the School Safety Omnibus Act of 2018. To ensure these preventative efforts are deployed widely across the District, significant investments and resources must be made if we want to break generational cycles of abuse and allieviate the burden currently placed on service providers.

The development of inter-agency collaborations that promote advocates' safety and wellbeing during on-going public health crises, such as the COVID-19 pandemic, will help support intimate partner and sexual violence survivors[11] as well as providers. Establishing and maintaining these collaborative relationships has been a major challenge due to the burnout participating providers have been facing over the last two years. Work strain has made it difficult for providers overwhelmed with current service provisions at these agencies to support survivors and are in need of additional funding to support secondary prevention services for case management, advocacy and information for youth in the District. In order to bring focus

[11] Garcia, R., Henderson, C., Randell, K. *et al.* The Impact of the COVID-19 Pandemic on Intimate Partner Violence Advocates and Agencies. *J Fam Viol* (2021). https://doi.org/10.1007/s10896-021-00337-7

back to violence prevention, funding must also be made available to allow staff to allocate time to primary prevention initiatives, such as the SVPCoP. This funding will also support the continued implementation of the School Safety Omnibus Act of 2018, allowing for collaboration and facilitation of prevention education for school staff, faculty and students.

It is for these reasons that the DC Coalition Against Domestic Violence asks the Council to fund $350,000 to DC Health for a healthy relationships campaign in DC schools. This campaign will include a training program for School-based Mental Health Providers on intimate partner violence and local resources this fall, planning support to help individual schools build a Teen Dating Violence Awareness campaign in February, and funding for a student-lead and designed poster campaign. These efforts will engage youth in the discussion about what healthy relationships look like, sound like, and feel like and what to do if you find yourself in an unhealthy situation and help prepare school staff to support students with trauma informed and person-centered tools.

Rape Prevention and Education Funds

The Coalition has worked closely with DC Health staff in the Family Health Bureau within the Community Health Administration (CHA) over the past three years. The goals of the Family Health Bureau are to coordinate and bring together programs and organizations that serve children and adolescents throughout the District, and to provide education, support, and resources to improve and promote health for all residents. The health and sexuality education sessions and violence prevention programs within the CHA are a few of the only primary

prevention[12] initiatives to explicitly address intimate partner and sexual violence. These programs are exclusively funded through the federal CDC Rape Prevention and Education (RPE) program, that is administered by DC Health. RPE grantees work collaboratively with diverse stakeholders, including state sexual violence coalitions, educational institutions, rape crisis centers, community organizations, and other state agency partners to implement state/district wide prevention efforts.

DCCADV receives RPE dollars from DC Health and we are excited to continue to work with our DC Health partners and other sub-grantees to enhance DC's violence prevention work. However, as noted by DC Health, in the 2019 Community Health Needs Assessment, "o*ur efforts in the areas of Injury and Violence Prevention and Mental Health need to be redoubled to reverse negative trends."*[13] While DC has made significant local investments (through the Safer Stronger DC initiative[14]) in responding to community-based violence, there is little to no local funding dedicated to sexual assault and dating violence primary prevention efforts.

Currently, with the support of DC Health, we have been able to assist Beta Omega Social Services (BOSS) with the implementation of the Expect Respect curriculum with students ages 12-17. This curriculum begins to fill the gap in primary prevention by focusing on educating high school students about safety, social support and skills for healthy relationship building. Despite the limitations to implementation due to the COVID-19 pandemic, BOSS has been able to

[12] Primary prevention is an intervention that takes place before any health effects occur. When applied to domestic and dating violence, primary prevention education works to prevent relationship violence from occurring by teaching youth to understand and develop safe and healthy relationships. Effective violence prevention programming creates a baseline understanding of the specific behaviors and characteristics of teen dating violence, and teaches the skills necessary for healthy and respectful behaviors.
[13] Id 10
[14] Id 10

facilitate group sessions in 3 schools in the District with positive evaluatory outcomes. To date, BOSS has reached over 140 students ages 12-17 with this curriculum. The success of this implementation thus far and the pending expansion of group facilitation into other high schools in DC speaks to the need for increased resource allocation toward primary prevention initiatives to combat dating and sexual violence before it occurs. As we continue to work to provide additional training opportunities to support the School Safety Act, we must be prepared for potential disclosures of youth violence and support agency capacity to provide services desired by survivors. This means increasing funding to secondary prevention services that would further streamline the referral process and improve current resource shortages facing intimate partner and sexual violence service providers.

Additionally, it is paramount to recognize that investments in equity are methods of sexual violence prevention among adolescents. DC Health recognizes that "racism rather than 'race' better explains racial disparities."[15] According to the DC Health 2019 Community Health Needs Assessment, "Black and Latinx students were nearly three times more likely to have experienced dating violence than White students."[16] Addressing such disparities in sexual violence prevention begins with equitable community investments that allow for both primary and secondary prevention efforts to be best receivable by minority communities. This includes allotting funding for culturally specific sexual assault and dating violence prevention efforts to bridge the gaps caused by systemic racism. With these investments, we will be able to curb the pipeline of victimization and create positive outcomes for youth as well as the District.

[15] Id 10
[16] Id 10

Conclusion

DCCADV urges the DC Council to provide DC Health with the resources they need to respond to the new and unprecedented challenges of intimate partner and sexual violence and ensure that providers are supported in their efforts to combat this public health crisis. DC must recognize that primary prevention allows us to curb the violence before it occurs. Through a preventative lens, we will be able to address the rise in youth and family violence and strains on service providers during the on-going COVID-19 pandemic. DCCADV believes intimate partner violence is preventable, and we will continue to seek sustainable resources to support programming, policy initiatives, and community awareness about IPV prevention in the District of Columbia. We are committed to being DC's leader in efforts to stop violence before it starts. We hope that District leaders, across governmental agencies, will join us. Thank you, Chairperson Gray, for the opportunity to testify.

Testimony of Nisa Hussain
Program Manager of Early Childhood, DC Action
Department of Health
Committee on Health: Budget Oversight Hearing
Fiscal Year 2023
Council of the District of Columbia

Good morning Councilmember Gray and members of the Committee on Health. Thank you for the opportunity to address the Council as it conducts this budget oversight hearing for the Department of Health. My name is Nisa Hussain and I am the Early Childhood Program Manager for DC Action and Chair of the DC Home Visiting Council.

DC Action uses research, data, and a racial equity lens to break down barriers that stand in the way of all kids reaching their full potential. Our collaborative advocacy initiatives bring the power of young people and all residents to raise their voices to create change. Through our signature coalitions, Under 3 DC and the DC Home Visiting Council, we empower families and communities. We are also the home of DC KIDS COUNT, an online resource that tracks key indicators of child and youth well-being.

Today, my remarks will focus on the Department of Health's (DC Health) early childhood home visiting programs, which the agency both funds directly and through MIECHV funding. In particular, DC Health administers the Healthy Families America, Parents as Teachers, and Nurse Family Partnership programs at Mary's Center, the Mothers Rising program at Mamatoto Village, the Healthy Families America program at Community of Hope, and the Parenting Support Program at Georgetown University. DC Health also receives some funding from CFSA for administration of a Parents as Teachers program, which I have addressed in my testimony at the CFSA budget hearing.

I would like to focus my testimony on the importance of increasing investments in home visiting programs in the FY23 proposed budget to continue supporting DC's families. We are asking for a 15% increase to all current home visiting grants at DC Health and CFSA to align with the rising inflation rates, address the home visiting workforce shortages, and enable programs to adapt to the increased demands to their workforce during this pandemic. This 15% increase is a $369,150 enhancement to the existing DC Health home visiting budget.

Chairman Gray, thank you for championing home visiting programs as part of the early childhood system and the Birth-to-Three law these past years. We are also grateful for DC Health's continued leadership and partnership on the Home Visiting Council. Lastly, we appreciate the Council's past support of home visiting programs. It is imperative that these programs receive sufficient funding to continue strengthening and sustaining the long-term relationships that make their work so effective.

Home visiting is an essential early childhood and family support strategy

Home visiting is a valuable, preventative, and evidence-based strategy that supports the healthy development and well-being of children, expectant parents, and families. These voluntary and free programs pair families with a trained home visiting professional, who builds trusted relationships over time to address family and child needs including kindergarten readiness; healthy birth outcomes; maternal and child social, emotional, and physical health; and family economic security[1] DC's home visiting programs primarily serve Black and brown families who are among those hit hardest by the health and economic impacts of the COVID-19 pandemic for the last several years.

Home visiting is an essential early childhood strategy that plays a unique role in the early childhood system: due to their relationship-based approach, home visitors have the ability to guide families towards resources and DC's broader system of services they may otherwise not have access to. Whereas medical (or other program) interactions may be more brief, home visitors have a more holistic understanding of a family's circumstances and can refer them to services they need.

Home visitors also coach parents to reach self-sufficiency by learning new skills, addressing their challenges, and working towards their personal goals[2]. Parents that enroll in these programs have the desire to care for their young children with confidence. With the support of a trusted home visitor, they can carry out their parenting journey feeling empowered and capable. As a result, children can benefit from a more stable home environment and receive the care they need to meet their highest potential.

The extra support for caregivers has been especially important for the target populations - selected based on their unique needs - served by DC Health-funded home visiting programs. For example, Georgetown University's Parenting Support Program is the primary home visiting

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[1] Avellar, S. and Supplee, L., 2013. Effectiveness Of Home Visiting In Improving Child Health And Reducing Child Maltreatment. [online] Pediatrics. Available at: https://pediatrics.aappublications.org/content/132/Supplement_2/S90>

[2] https://pubmed.ncbi.nlm.nih.gov/27044687/#:~:text=Home%20visiting%20intends%20to%20address%20poverty%20in%202,services%20such%20as%20adult%20education%20and%20job%20training.

program that supports caretakers with intellectual or developmental disabilities. The programs administered by Community of Hope, Mamatoto Village, and Mary's Center all focus on expectant parents or families with children under 3 and are able to offer tailored support based on the family's situation, such as homelessness, health care access injustice, and more. Mary's Center's new Nurse Family Partnership (NFP) program also supports first-time, low-income mothers and began its three year pilot of the evidence-based NFP home visiting model in DC in FY22.

Home visiting programs continue to support families during COVID-19

As we enter our third year of the COVID-19 pandemic, DC families continue to overcome endless challenges around financial challenges, child care affordability, and anxieties around the many decisions impacting their children's safety. These are challenges that are added to the existing hardships that many home visiting families were already experiencing.

As a result of these compounded challenges, families relied on the support of their home visitors. Home visitors quickly adapted to the new guidelines and 100% of programs pivoted to a virtual setting and found new ways to maintain these trusted relationships[3]. Most commonly, home visitors found themselves delivering basic supplies (food, diapers, technology, etc.) to houses or centers, utilizing video or phone calls to conduct their regular visits, and directing participants to relevant resources or services that the District provided for COVID-19 relief. The adaptability of programs allowed an uninterrupted continuity of care to the families who needed it the most.

As reported to the Home Visiting Council, 55% of home visiting families experienced an increased need for mental health and domestic abuse resources in 2021[4]. Programs also reported an increase in basic needs like rent assistance, supplies, and food. These combined challenges, plus the effects of social isolation, can all contribute to amplified levels of stress in the home, increasing the risk for child abuse and neglect[5]. As mentioned, home visiting is an effective tool to prevent these outcomes since home visitors coach parents to cope with these negative stressors and continue positive parenting practices especially during crisis.

While programs have effectively transitioned to a safer virtual setting, they are still facing challenges meeting the needs of families who have been hit disproportionately hard by this public health emergency. Programs reported a struggle to maintain consistent engagement and active participation from families, due to competing priorities. 87% of programs observed challenges around their participants' experience and access to technology or WiFi during their virtual visits. Programs are also seeing families facing increasingly urgent needs and emergencies, so home visitors are spending more time and resources to address those needs

[3] http://www.dchomevisiting.org/uploads/1/1/9/0/119003017/2021_hv_annual_report.pdf
[4] http://www.dchomevisiting.org/uploads/1/1/9/0/119003017/2021_hv_annual_report.pdf
[5] https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a1.htm

before the usual home visiting curriculum. These new set of challenges for programs have weighed heavily on the home visiting workforce these past two years.

More investment in these programs is needed to provide home visitors the support and any additional resources they may need to continue serving families in such a heightened state.

Increase funding for DC Health home visiting programs to reflect their important work and help them meet the evolving needs of families

Home visiting grants have not increased for several years, even as caseloads have changed and as inflation has risen rapidly over time. With less room for increased compensation, high cost of living rates, and growing levels of stress for the workforce, it is no surprise that home visitor turnover rates continue to rise alongside these changes[6].

Additionally, programs have used extra time, resources, and creativity to meet the heightened needs of families during this public health emergency without any funding increases. Programs are seeing more families in crisis than ever before. Home visitors are not only working hard through more urgent situations with families, but also using extra resources to meet these evolving needs. During this hearing, programs will share their perspectives on how difficult operating with flat funding has been, especially during a pandemic, and how additional funding could address their workforce challenges.

A 15% increase to home visiting program grants would catch program grants up with inflation since they were first issued, address the challenges of flat funding, and also enable programs the flexibility to meet the needs of their workforce and their home visiting families. A $369,150 enhancement to the existing DC Health grant amount for home visiting programs would better reflect the hard work of these valuable programs.

Overall, home visiting is a unique and critical strategy that invests in families and as a result, invests in the well-being of the wider community of the families. Now is the opportunity for DC Council and DC Health to reciprocate that investment in their home visiting programs by increasing funding for all home visiting grants.

If the District wants to invest in the well-being of their communities, starting with its youngest residents, increasing funding for preventative programs like home visiting is a worthwhile choice. The Mayor's proposed decision to enhance MPD's budget by $30 million while valuable family and youth-serving programs like home visiting stay stagnant is disappointing since we know these family support programs have longer term value to addressing the current challenges in our communities. We hope that the DC Council takes the next steps to revise the FY23 budget to better reflect how we want to support our communities facing the highest

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6 http://www.dchomevisiting.org/uploads/1/1/9/0/119003017/home_visitors_experience_report-final_english.pdf

barriers.

We implore the Council to prioritize home visiting programs for the DC community and find additional funds to allow these critical programs to continue serving families. This is an important investment in DC Health's goals to support the health and well-being of expectant parents and families with young children.

Thank you for the opportunity to testify. I welcome your questions.

My name is Sal Selvaggio, and I am representing Northwest Neighbors Village, and the Iona Citizen Advisory Group.

Before my retirement as a dentist, where I practiced in DC for 35 years, I saw in my patients the challenges that caring for an aging parent presented. I witnessed firsthand how, in the dental office setting, having a **trained** healthcare aide to assist in the care of that parent made a difference in the welfare for both parent and child. It takes **training** to know how to **safely** transport and seat in a dental chair a patient with dementia. It takes **training** to know how to properly provide oral care for that patient in their home so they can maintain their health and not be prone to infections.
This expertise is needed for **any** healthcare appointment and follow up care.

You have heard testimony about similar situations, and I'm sure you are well aware of the challenges we now have, and will **continue** to have, in caring for our elderly. However, I would like to emphasize that the shortage of healthcare workers will not **only** affect our aging population, but will have downstream consequences for our **entire** community, **regardless** of age. Let me present you with a few scenarios:

You may need to be admitted to a **hospital** for an urgent procedure. However, you are told that your procedure will need to be **delayed** until a hospital bed becomes available. A number of potential beds are being occupied by patients who can't be released because they require professional post hospital **homecare**, and, even though homecare agencies have been contacted, no one is available…

Or

You have had an **accident** and are receiving care in a rehab facility. You find that you need help getting to the bathroom or to take your

medicine, however **no one** is answering your call button. The facility is short staffed, and everyone is too busy helping someone else. They'll get to you…when they can….

Or

You are taking care of your elderly **parent** in your home the best you can, but you have a **job** and a **family**. You need a healthcare aide to work in your home so you can make a living, and at the same time keep your beloved parent safe and comfortable. Finding a steady, available aide is **difficult** because of the high turnover rate that plagues that workforce.

I have had all these scenarios happen to my family members or friends.
Our current Covid crisis has **exposed** and **worsened** the onset of our healthcare workforce shortage, as it has for many other societal issues.

The key to **alleviating** this problem is to provide wages that are **competitive**. Only by doing so can we create educational pipelines for potential workers who will be willing to take on these jobs.

Being a healthcare worker is hard, emotionally and physically. They care for us when we are at our most vulnerable. We ask from them their compassion and competence.
Having to struggle to just pay rent and put food on the table should be a burden that our society must recognize as being **morally unjust**, and we must work to solve this for the good of these workers, and for the health and welfare of our community.

Thank you for this opportunity to provide my testimony, and I'm happy to answer any questions if you have any.

UNITY HEALTH CARE

Healthier You. Healthier Communities.

TESTIMONY OF

Dr. Jessica H. Boyd
President & CEO
UNITY HEALTH CARE

Regarding the

Department of Health FY23 Budget

On

April 4, 2020

Good afternoon Chairman Gray and the Members of the Committee on Health. My name is Dr. Jessica Henderson Boyd. On January 1, 2022, I had the privilege of becoming the new President and CEO of Unity Health Care, Inc. (Unity), having previously served as Unity's Chief Medical Officer since November 2019. Before joining Unity, I served as a management consultant for McKinsey & Co. and the Cystic Fibrosis Foundation, and before that worked in community health for almost a decade in Baltimore, Maryland.

I am thrilled to be here today to testify on the proposed FY2023 budget for the Department of Health. Thank you for this opportunity, Mr. Chairman, and for your years of tireless leadership on behalf of better health outcome for District residents and your support for community health centers and for Unity.

Before I begin the heart of my testimony, I would like to take an opportunity to extend my deep appreciation to my predecessor, Vincent Keane, for his three decades of dedication and advocacy in support of health care equity and access to care for low-income residents. Mr. Keane was the chief architect who transformed Unity from a small organization, providing healthcare in homeless shelters and on the streets, to the District's largest provider of primary medical and dental care for low-income residents. I am humbled and excited by the opportunity to build on his legacy and that of the entire Unity team.

Today, Unity Health Care:

- Operates 9 community health centers, 12 medical sites at homeless shelters, and 2 school-based health centers across the District;
- Serves nearly 100,000 patients each year (approximately 450,000 patient visits per year), making Unity the healthcare provider for 1 in 7 District residents;
- Employs approximately 1,000 compassionate health professionals throughout the city; and
- Provides award-winning healthcare at the D.C. jail.

We want to thank Mayor Bowser for her steady leadership and continued commitment to funding the District's public health care infrastructure. The FY23 proposed budget includes more than $4.36 billion for this effort, including the Department of Health, the Department of Behavioral Health, and the Department of Health Care Finance, which facilitate access to quality health care for more than 317,000 District residents. In addition, we owe the Mayor and her team, and in particular Dr. Laquandra Nesbitt, our collective gratitude for the manner in which they have managed the COVID-19 pandemic over the past two years. They ensured that providers and residents of the District had the tools and resources available to mitigate the impact of COVID and partnered with many organizations including Unity to ensure the underserved had access to lifesaving prevention and treatment.

The unpredictability of this public health crisis makes budgeting a difficult task, as new initiatives must yield to existing commitments. Notwithstanding these challenges, the Mayor's FY23 budget includes several enhancements that we enthusiastically support, including:

- $31 million for new permanent supportive housing vouchers and other initiatives to end chronic homelessness;
- $31 million in renovations of the District's permanent and temporary supportive housing and shelter services;
- $4.5 million to expand school nursing services at additional school health services programs in public and public charter schools;
- $2.8 million to enhance programs and services at the 801 East Shelter;
- $2.6 million to provide greater community connection and wellness through technology by distributing personal tablets to seniors; and
- $500,000 in free dental services to seniors.

Each enhancement represents the promise of improved health outcomes for District residents. Unity is particularly excited about the above-mentioned FY23 enhancements as they support many of our priorities. We are excited to support the many impactful initiatives on housing including the enhanced resources identified for new permanent supportive housing

vouchers and additional resources for medical respite. Our experience in partnering with DHS to reduce the impact of COVID on unhoused individuals has highlighted the positive impact of housing on health care. The distribution of personal tablets as another example will enhance access to telehealth services for low-income District seniors in Wards 7 and 8, which was a need identified in our 2021 year-long study on the subject, conducted in collaboration with Johns Hopkins Medicine. We also fully support the mayor's initiatives around maternal health including cash assistance to new mothers which will positively impact many of our patients and ensure a healthy start for our youngest residents.

Importantly, these investments are coming on the heels of the recent groundbreaking for the new Cedar Hill Medical Center on the campus of St. Elizabeths, which is scheduled to open in fall 2024. We are convinced that this $375 million investment will improve the health outcomes of District residents, particularly those residing in Wards 7 and 8.

As the Members of the Committee deliberate on the Mayor's proposed FY23 budget, we ask that consideration be given to a few additional priorities, including the need to fund additional respite care services for the District's underserved, particularly women, and the importance of continuing to invest the District's Loan Repayment Program for health care providers in Health Professional Shortage Areas and Medically Underserved Areas.

Thank you again, Mr. Chairman, for the opportunity to share Unity's perspective on the Mayor's FY23 budget. I would be happy to answer any questions that you and Member of the Committee might have.

Testimony before the
Council of the District of Columbia

Committee on Health

FY23 Budget Oversight Hearing
for the
DC Health

* * *

Presented by

Jacqueline D. Bowens

President & CEO

April 4, 2022

Greetings Chairman Gray and members of the Committee on Health, my name is Jacqueline D. Bowens, and I am the President and CEO of the District of Columbia Hospital Association (DCHA). I appreciate the opportunity to present testimony on DC Health's FY23 budget.

DCHA has been the unifying voice of the District's hospitals for 44 years. We represent the interests of our members who provide care to residents from all eight wards and are committed to providing high-quality care to everyone that walks through their doors.

It is worth repeating that DC Health's support for residents and providers throughout the pandemic has been incredible. Dr. Nesbitt and her team, including Dr. Sharon Lewis, Patrick Ashley, and Terri Thompson to name only a few, have done a wonderful job.

As we look towards FY23 and the future, we see the important investments being made by the Mayor in the Department of Health to meet workforce needs, address equity and advance health outcomes in the District.

When it comes to the health care workforce, continued investment in loan repayment is essential to the continued recruitment and retention of qualified providers in the city. Additionally, DC Health has joined the DC Health Care Workforce Partnership as a member. The Partnership was established with the support the Council, Councilmember Elissa Silverman and the Workforce Investment Council and is entering its second year. It has a primary goal of bringing employers, training providers, support organizations and government partners around the same table to establish a sustainable pipeline and career paths for health care workers

across the entire industry. DC Health's collaboration on this initiative is instrumental to our successes because of the role the various professional boards play in approving curriculum and requirements for licensure, certification or registration.

When it comes to licensure, we are grateful for the continued partnership with the Health Regulation & Licensure Administration. Its continued work to streamline the licensure process is very much appreciated. Recognizing the amount of work and the number of licenses the licensing staff is processing, we recommend the Committee use certified fund balances across the various special purpose licensure funds to authorize the hiring of at least fifteen licensing support FTEs on a recurring basis to improve the customer experience. The needs go across all boards from Nursing and Medicine to the behavioral health and allied boards. Health Licensing Specialists

are critical to the process and have to balance processing applications, taking calls, and providing in person assistance. We believe additional staff can improve the overall flow and process.

I do want to recognize Ms. Melondy Franklin at the Board of Nursing. She has been an invaluable help in our efforts to support applicants and our members.

The continued investment in perinatal quality is crucial in the District's ongoing work to improve health outcomes for mothers and babies during pregnancy and after birth. DCHA in collaboration with DC Health continues to convene the Perinatal Quality Collaborative to support the Department's efforts on making lasting changes that allow mothers and babies to thrive.

Thank you for the opportunity to testify and I am happy to answer any questions.

Budget Oversight Hearing for the Department of Health
Committee on Health
Councilmember Vince Gray
April 4, 2022
Testimony of Hannah Garelick
Jews United for Justice

Thank you, Councilmember Gray and members of the committee. My name is Hannah Garelick and I am a community organizer with Jews United for Justice, a local grassroots organization that mobilizes thousands of Jews and allies in DC to fight for social, racial, and economic justice. As always, thank you Councilmember Gray for your continued work and championing of the Birth-To-Three Law. We were deeply disappointed to see the Mayor's lack of funding investments in family health support programs like Healthy Futures and HealthySteps in her budget. Today, I will focus my testimony on the need to invest at least an additional $300,000 into HealthySteps. As a member of the Under 3 DC Coalition, JUFJ asks that you now take on the responsibility to ensure these vital health support programs see an increase in funding in the FY23 budget.

Jewish tradition teaches us the value of "*Ki shama Elohim el kol ha'na'ar ba'asher hu sham: For the Holy One heard the voice of the child who was there*."[1] Our tradition tells us that just as the Holy One listened to each of us, so too should we listen to the experiences of those who are experts in their own lives – of the children, parents, and educators. Those who are involved in the growth and development of young children should have the resources and training to listen and support the voices of young children.

Every family, regardless of wealth, race, or zip code, deserves the opportunity to have the access to resources they need to thrive and live joyfully in the District. In order to achieve that, all families should be able to access services that meet their families' physical and mental health needs. HealthySteps integrates licensed child development health professionals in pediatric primary care settings to help parents adapt to life with a new baby, and get connected to infant-toddler resources that can help families thrive. This vital investment of an additional $300,000 for HealthySteps will make that possible for more families in the District.

As you know, the past two years have only exacerbated physical and mental health challenges for so many in our city. Those who have historically been left behind, especially Black and Brown people and communities, have disproportionately felt the impacts of the pandemic.

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[1] (Genesis 21:17)

HealthySteps along with the other proven health support programs detailed in the Birth-to-Three Law can meet the needs of families so they can have more successful outcomes. Working with skilled professionals in the HealthySteps program, families are able to receive the social-emotional support they need to help their children grow.

By enhancing the HealthySteps program budget by at least $300,000, more children and families will gain access to essential child development services that are embedded in their pediatric wellness visits. These funds will allow the Department of Health to expand these vital services to one additional site in Ward 5, 7, or 8 in the District.

In addition to the $300,000 for HealthySteps, JUFJ and the Under 3 DC Coalition are asking for an increase in funding for Healthy Futures by $700,000 and an increase for DC Health's Home Visiting programs by $369,150 to be in line with caseloads, workforce shortages, and inflation. As we are informed by our Jewish traditions, listening to the voice of the children, parents, and educators, we must invest in the resources and training to make these programs available to more families in the District. Thank you for the opportunity to testify today.

Testimony Submitted to the Committee on Health

By D.C. Long-Term Care Ombudsman For the District of Columbia

Budget Oversight Hearing for DC Health April 4, 2022

Greetings Chairman Gray and Members of the Committee on Health. I am Mark Miller, D.C. Long-Term Care Ombudsman with Legal Counsel for the Elderly (LCE). Thank you for the opportunity to provide this testimony on behalf of the 9,000 District residents receiving long-term care services and supports (LTCSS) in nursing homes, assisted living residences, community residence facilities, and in their homes through the District's Elderly and Persons with Physical Disabilities (EPD) Medicaid Waiver Program.

The Ombudsman Program is part of the Department of Aging & Community Living Service Network and is charged by federal and D.C. law with representing the interests of some of the District's most vulnerable citizens. Our mission is to promote and help ensure the highest quality of life and quality of care for these individuals.

In FFY 2021, the Ombudsman Program handled 278 complaints, resolving 76% of those issues to the satisfaction of the care recipients or complainants. This resolution rate is well above the national average. Issues involved quality of life, quality of care and residents' rights.

Better Oversight Requires More Surveyors

The Ombudsman Program supports additional funding for the Department of Health's Health Regulatory & Licensing Administration (DC Health/HRLA) so they can effectively protect residents by ensuring compliance with federal and District regulations, including conducting federally required standard surveys of nursing homes, and responding to resident complaints. CMS acknowledges that since the pandemic, when annual surveys were halted for more than a year, many complaints and problems went unidentified and unaddressed. This resulted in catastrophic declines in the physical and mental health of residents, including the deaths of 224 residents of District nursing homes. Nationally, there was a 77% increase in the use of anti-psychotic medications. Survey agencies continue to struggle to keep up, stretching the time between surveys, making surveys more predictable, and having to divert resources to respond to complaints in a timely manner. While DC has the highest staffing standard in the country, 4.1 hours of nursing care per resident per day, this standard is not self-enforcing. To ensure residents are receiving the care they need, and for which the District pays, and to crack down on the inappropriate use of anti-psychotics, and hold providers accountable, we need more surveyors.

The Long-Term Care Needs Study Update

Chairman Gray, we appreciate your work and support, and that of the Council, to pass and fund the ***Study of Long-Term Care Facilities and Long-Term Care Services Act*** (22-561) in 2019. The study was completed last year. Unfortunately, it has not yet been made available to my Office nor to the public. We understand that the internal review process takes time, however it would have been helpful to see the findings and

any recommendations prior to the development of the Mayor's budget so that any recommendations that require a fiscal investment by the city could have been considered for inclusion. Still, we would like to see the results and determine if they confirm what we know anecdotally, that long-term care services lag behind the current and projected needs of our residents. On a positive note, the District of Columbia is making great progress in creating affordable assisted living resources. Affordable Assisted Living not only allows nursing home residents to transition to a more independent setting, it also delays or prevents nursing home placement for those persons already in the community who need supervision and support, but how can longer live in their own homes. Currently, HRLA is without a program manager for Intermediate Care Facilities Division, which oversees this critical resource.

Finally, we look forward to continuing to work with Dr. Lewis and her team to identify and address the numerous problems, both individual and systemic, encountered by residents living in D.C.'s nursing homes and assisted living facilities.

Thank you for your ongoing advocacy on behalf of the District's vulnerable residents and for the opportunity to share testimony on behalf of the Ombudsman Program and the residents we serve. I am pleased to answer questions you may have.

Submitted by Mark C. Miller
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DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

To: The Honorable Vincent Gray, Chair, DC Council Committee on Health
Members of the Committee on Health
From: Patricia Quinn, VP of Policy and Partnerships, DC Primary Care Association
Re: Budget Hearing for DC Department of Health
Date: April 4, 2022

The DC Primary Care Association (DCPCA) works to build a healthier DC by sustaining community health centers, transforming DC care delivery, and advancing racial and health equity. Our strategic focus areas include:

- Value-based reimbursement
- HIT innovation for health centers
- Cross-continuum stakeholder relationships
- Equity-oriented programs and innovations
- Health center infrastructure and operations

Our collaborators in this work include community health centers, serving almost 1 in 4 District residents in every ward of the city; District government agencies including DC Health; as well as other providers in the DC health ecosystem. We appreciate the opportunity to provide testimony regarding the budget of the District of Columbia Department of Health (DC Health.)

DC Health has proved itself ready and able to move quickly, decisively, and in concert with health associations and health care providers to protect the District's health system. Decisions made and reinforced over the past two years such as those that permitted waiver of licensure requirements for those already licensed elsewhere, that accelerated opportunities for telehealth, and that expanded existing roles and scope helped to stabilize the system and ensure access to care for those most in need. DC Health has carefully balanced the needs of health care providers without diminishing safety or quality. DCPCA is grateful to the Department of Health for prioritization of health care workers for COVID vaccines, and for the clear message to the workforce requiring vaccinations. We pledge to do all in our power to ensure that the health care workforce in the District of Columbia is among the most protected from COVID-19 infection.

DCPCA's robust partnership with DC Health spans across preventative care, emergency preparedness, infectious disease, chronic disease, maternal-child health, workforce, licensing, and health equity. As we emerge out of 2 years of pandemic health care--including COVID-19 testing, treatment, and vaccination--and into a third year of unknown challenges, we do know some things for certain. We know that health care providers have born unprecedented burdens, including life-altering impacts to their physical and emotional health. We know that our health centers are struggling to recruit, hire, and retain the high-quality team members essential for our city to make progress toward health equity. And we know that we can improve the pathways and on ramps for entering health careers, and for obtaining licensure in the District of Columbia.

As we head into a third year of intensifying demands on health centers and the communities they serve, we will need flexible resources and policies that support new ideas and innovations to ensure we have a sufficient, well-supported workforce. We continue to support streamlined reciprocity and transparent data on timelines, so that the Department of Health is appropriately resourced to ensure that those providers in the licensure pipeline move expeditiously through the process.

The most frequent challenge our member health centers express when attempting licensure is a lack of information about the reasons for delay or bottleneck. In an effort to improve communication and response to licensure questions and issues, DCPCA supports an increase in the number of Health Licensing Specialists at DC

Health. With a larger team, DCPCA hopes DC Health would have capacity to quickly identify and notify those applicants who need to correct an issue with their licensure application.

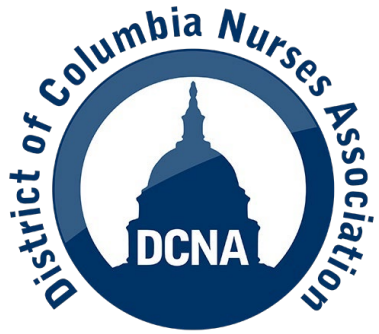
In our performance oversight testimony, DCPCA recommended an "all-hands" meeting to identify viable pathways to meet workforce needs in the short and long term, including some outside-the-box ideas and investments. DC Health is planning such a convening later this month, bringing together health care associations and using a data-driven approach to unprecedented workforce challenges. We wholeheartedly embrace DC Health's perspective that we can achieve much when we leverage and strengthen our partnership and collaboration.

In addition to the above-mentioned workforce efforts, DCPCA wishes to alert Health Committee members to some changes at the federal level that could have ramifications for the District. While health centers are deeply committed to providing care to patients regardless of ability to pay, centers are still required by federal regulation to make every attempt to be paid, either by insurers or patient self-pay (based on a sliding scale related to income.) Previously, the US Department of Health and Human Services established a fund to which health centers and other providers could submit claims for COVID-19 testing and treatment that they provide to uninsured patients. For health centers, this meant they did not have to present uninsured patients with a bill for any COVID-related treatment provided.

The resources for that uninsured patient fund have been exhausted, and Congress has not allocated funds to replenish it. Although the District has the second highest rate of insurance coverage in the US, our member health centers do continue to see patients who are uninsured. Additionally, the expected end to the federal public health emergency in the coming months will also end the continuous coverage provisions. Providers and advocates are bracing for a considerable increase in the number of District residents who will lose coverage, even if only temporarily. Again, health centers will continue to see patients, regardless of their ability to pay, but we are concerned that lack of insurance coverage may have a chilling effect on residents' willingness to seek needed COVID testing and care.

DCPCA appreciates the many investments in public health and health equity. Equity investments of note include the return of funding for Senior Dental services and continued funding for the Office of Health Equity (OHE.) The OHE and the many prevention-focused programs within the Community Health Administration that target behavioral, physical, and social drivers of health provide critical momentum toward a District where every resident has a fair shot at a full health life.

Our health system emerges from two years of pandemic response battle-scarred, yet resilient. DC Health played the most important role in our survival and resiliency. Collectively, we learned we can evolve to meet unprecedented needs with never-imagined speed. We learned that often the most important people staffing our health system are not CEOs or MDs, but those closest to our patients, providing community connection and trust. We learned that we can act in bold ways to combat practices that interfere with patient-centeredness, from the care we provide, to the policies we develop, to the workforce we build. Most certainly, we learned that robust and committed partnership between DC Health, health providers, public health advocates, and communities deeply impacted by inequity is our best chance to be prepared for the next public health challenge, and to thrive.



DISTRICT OF COLUMBIA NURSES ASSOCIATION

COMMITTEE ON HEALTH

Department of Health Budget Hearing

TESTIMONY April 4, 2022

My name is Wala Blegay and I am the staff attorney for the District of Columbia Nurses Association (DCNA) and we represent the nurses in the school health program. We are a full-service professional organization and labor union solely dedicated to representing health care professionals in the District of Columbia. With over 2,100 members, DCNA advances the health care profession by fostering high standards of practice, promoting the economic and general welfare of employees in the workplace and lobbying District officials regarding health care issues. We are lobbying for full funding for a nurse in every school for 40 hours a week.

We fought in 2017 for the passage of the Public-School Health Services Amendment Act, but it is subject to appropriation. To date, the Public-School Health Services Amendment Act has not been fully funded. Nurses are forced to float to two or three schools weekly which impacts continuity of care. Nurses have a difficult time gaining relationships with the school staff and parents since they are not in the school often due to floating. Since the COVID-19 pandemic commenced, the duties of the

nurses have increased, adding COVID-19 tasks in addition to their care management, and this task has become overburdensome and difficult to manage when a nurse has to float from one school to another.

DOH is aggressively increasing responsibilities of nurses by increasing documentation while the numbers of students with care substantially increases. The students' needs have increased because of stressors related to the pandemic. These roles must be incentivized to attract experienced practitioners to accomplish unrealistic tasks set by DOH. A nurse in every school is crucial, along with licensed assistive personnel to provide conscientious support and surveillance. The nurses are impaired in their ability to adequately respond to the needs of our students.

We ask the DC Council to consider the following in structuring a budget for school nursing. We need a nurse in every school for 40-hour coverage. A nurse needs to be in the same school for 40 hours a week and nurses should not be floated to two to three schools per week. Nurses need time to develop a relationship with parents, students and school staff which will promote quality care for the students. Assistive personnel, such as health techs, cannot be substituted for a professional nurse. DOH still insist upon giving the techs inappropriate responsibilities without adequate oversight. The nurses need updated computer equipment to facilitate frequent zoom and webcast; most computers do not have cameras or speakers to support technology. This includes a need for data entry personnel to allow nurses to perform professional duties. Nurses also need resources and additional training on the mental health care for our students and family, in the wake of the pandemic. There needs to be ongoing mental health services for nurses as well who are experiencing excessive stressors and burnout.

In conclusion, it is time to fully fund the school nursing program so that we can

have 40-hour nursing coverage in every school. Our nurses work hard every day to protect the health of our youth and they need your support. Thank you.

Sincerely

Wala Blegay, Esq.

Written Testimony Submitted for the DC Department of Health Performance Oversight Hearing
DC Council Committee on Health
Chairman Vincent Gray
April 4, 2022

Donna Banzon, Director of Healthy Food, Martha's Table
dbanzon@marthastable.org, 202-750-8455

Chairman Gray and the Committee on Health, thank you for considering this statement.

My name is Donna Banzon and I am the Director of Healthy Food at Martha's Table, a DC community nonprofit founded in 1980. We support strong children, strong families, and strong communities by increasing access to high-quality early education, healthy food, and family supportive programming.

Since 2015, we've operated the Joyful Food Markets program in partnership with the Capital Area Food Bank and DC Health. Joyful Food Markets are no-cost, pop-up markets held in over 50 schools in Ward 7 and 8. Joyful Food Markets are designed to increase access to fresh fruits, vegetables, and pantry items and to promote healthy eating behaviors among families through recipes, nutrition activities, community resources and more.

Thanks to DC Health's investment in Joyful Food Markets over the past 7 years, we have distributed over **3.5 million pounds of healthy food directly to children and families in Wards 7 and 8**, the majority of whom live in low-food-access neighborhoods**.**

As we continue to recover from the pandemic, we must ensure school families have access to nutritious food they need to fuel their health. I am here to ask the Council to continue your strong commitment to the health of our school families and increase Mayor Bowser's proposed funding for Joyful Food Markets by **$324,066 to total $1.825 million** in FY2023 and beyond. This recurring additional investment would help us increase student engagement by 16%, reaching up to **8,500 total elementary, middle, and high schools students across 53 campuses in Wards 7 and 8.** Increased funding will help us:

- Procure an additional 175,000 lbs of fresh fruits, vegetables, and pantry items each year; Over 800,000 lbs of food will go directly to school families each year
- Increase staff capacity as well as marketing, outreach, and engagement efforts to reach more families in Wards 7 and 8
- Better leverage technology to track data and collective impact

The program is making a real difference in the lives of families.

- A parent reported: "The Joyful Food Market was a wonderful blessing during the pandemic. I wouldn't have made it without JFM."
- A school social worker shared: "The free, high quality produce provides both nutrition for our school community, and also builds trust that school is a place where people's needs are valued and cared for."

Lastly, Martha's Table is a proud member of the Fair Food for All DC Coalition, a network of nonprofit partners working together to help build a more just and equitable food system. We respectfully ask the Council to unite behind our collective efforts by supporting the Coalition's platform.

On behalf of Martha's Table, I thank DC Health and this Committee for the years of strong partnership and collective impact as we support thousands of families who are experiencing food insecurity. We hope that DC Health and the Council continue to support the growth of the Joyful Food Markets program. Thank you for the opportunity to testify.

Fair Food for All DC Coalition
FY23 Budget Update and Call to Action

The District of Columbia faces persistently high rates of food insecurity. We cannot afford to underfund the District's highly effective, efficient, and community-driven food access programs. While the FY23 budget largely seeks to return to 2019's investments in food access, the needs in our community will not revert to pre-pandemic levels without more decisive investment and action.

- The number of DC residents relying on SNAP benefits has grown from 94,000 to 140,000 – **a 49% increase**
- 37% of the city's Black children have experienced food insecurity during the pandemic
- Joyful Food Markets are increasing student engagement by 16%, reaching up to 8,500 Ward 7 and 8 schoolchildren
- Home-delivered, medically tailored meal production has grown by 20% since FY19
- Healthy Corners store sales have increased by up to 200% thanks to SNAP incentives

Produce Plus (FRESHFARM)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$1,200,000	$1,200,000	$1,401,934	$1,170,934	$1,500,000	**$329,066**

Home-Delivered Meals (Food & Friends)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$975,000	$825,000	$825,000	$820,000	$1,025,000	**$205,000**

Healthy Corners (DC Central Kitchen)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$500,000	$500,000	$750,000	$500,000	$1,000,000	**$500,000**

Joyful Food Markets (Martha's Table)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$1,504,271	$1,500,934	$1,825,000	$1,500,934	$1,825,000	**$324,066**

Distribution Efforts (Capital Area Food Bank)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$0	$0	$1,000,000	$0	$500,000	**$500,000**

Commodity Supplemental Food Program (Capital Area Food Bank)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$379,400	$410,000	$309,232	$410,000	$410,000	**$0**

Produce Rx (DC Greens)

FY20 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY23 Request**	Funding Gap
$250,000	$250,000	$500,000	$500,000	$500,000	**$0**

We hope our partners on the Council will help close these remaining budget gaps, totaling **$1,858,132**. With your support, our integrated, data-driven healthy food access solutions will contribute to a more just recovery, overcome rising costs of food and other essentials, and address unacceptable health disparities.

CAPITAL AREA FOOD BANK · d.c. central kitchen · dcgreens · D.C. Hunger Solutions – Ending hunger in the nation's capital · FOOD & FRIENDS – Delivering hope, one meal at a time · FRESHFARM – nourishing our food future · Martha's Table

Written Testimony Submitted for the DC Department of Health Performance Oversight Hearing
DC Council Committee on Health
Chairman Vincent Gray
April 4, 2022

Lon'Dras Bradley, Market Operations Manager, Martha's Table
lbradley@marthastable.org, 202-804-4406

My name is Lon'Dras Bradley, and I am a native Washingtonian, resident of Ward 8, and the Healthy Market Operations Manager for the Joyful Food Market Program. I have been with Martha's Table since 2015, when I joined as a Healthy Market Leader. I joined the Joyful Food Market Program because I believed the role would allow me to support and show up as a leader in my community and provide opportunities for growth and personal development. What I did not know was during my time as a Market Leader, I would learn and experience so much about myself; leadership, what it takes to be vulnerable, and different ways to support our community. The Joyful Food Market program is more than the grocery bag filled with fresh fruits and vegetables. It is the conversations, the music, the dancing, the positive energy that brings people together. It is about community.

A great example of the Joyful Food Markets' impact always brings me back to this one story I will never forget. This experience took place during a food story study we conducted in 2018. The goal of the study was to see how families were using the JFM produce at home - best practices for how to use, store, and prep different fruits and vegetables that we provided each month. - as well as examining the quality of the food and resources given like our monthly recipes. During my first food story study, I got the chance to interview a grandmother who had a granddaughter that attended one of our schools - Rocketship Rise- in Ward 8. During our conversations, she shared so much valuable information with me:

"I'm really grateful, and the food allows me to save money - because I don't get food stamps - and time because I can walk from the school after receiving a bag of produce. The recipes allow me to be creative and make different types of healthy meals for my family that are easy to make. I like to collect the recipes in my kitchen drawer."

The grandmother also shared her appreciation for our program, saying – "I value everything about the program because I get to see all of you (referring to the JFM team members) and see the kids excited to try new things."

This is why I love and believe in the type of work we are doing with the Joyful Food Markets program. I continue to do this work; because, as a community member of Ward 8 myself, I am personally reminded and affected by the lack of access and variety of options to fresh fruits and vegetables. I love this program because we do not only focus on data; we focus on students in Wards 7 & 8, the family, and the whole community.

I believe there is still so much more work to be done. We have the opportunity to reach up to 8,500 students and their families by deepening the program in early childhood education centers, elementary, middle, and high schools in FY2023. I'm here to ask the Council to increase funding for Joyful Food Markets by $324,066 from $1,500,934 to total $1.825 million.

Thank you, DC Health, for your support and partnership. We hope that DC Health and the Council will continue to fully fund the Joyful Food Markets program for children and families in Wards 7 and 8. Thank you for your consideration.

April 4, 2022

WRITTEN TESTIMONY REGARDING CONTINUED FUNDING
OF THE JOYFUL FOOD MARKETS PROGRAM

Submitted by:
Sharlene Juste
Program Manager for Student Life
New York University - Washington DC Campus

Good afternoon,

I have been aware of Martha's Table and its work in the community since I made Washington, DC, my home in 2013. As a young professional, I worked at George Washington University and connected with some colleagues at the university who managed student programs and volunteer events for Martha's Table, and the feedback was always positive.

Fast forward to 2017, when I started in my role at NYU Washington, DC. NYU DC had a newly formed partnership with Martha's Table and the Joyful Food Market program. We adopted the Smothers Elementary School market, which was just a few minutes' walk from my apartment in Marshall Heights at the time. My students and staff couldn't stop raving about how much fun they had while working at the Joyful Food Market and meeting Smothers' students and their families.

My students' enthusiasm inspired me to join them during one of the Joyful Food Market days, and the rest is history. As a volunteer, I worked the cooking demonstration table, making a stir-fry out of the market's provided ingredients with Smothers students, providing samples, and handing out recipe cards to families. It was the first time I felt like DC was really home, and I connected with my community. My students replenished items on the market tables, and some dressed up in fruit and vegetable costumes and danced with the children and families. It was great fun while providing fresh produce and grocery items to children and families in a manner most convenient for parents and caregivers during school pickup.

I thought about how great a program like Joyful Food Markets would have been during my childhood growing up in the Bronx, NY, in a busy working-class family with three siblings. My mother said as much when I told her about my day at the Joyful Market

back then. It was wonderful to reconnect with Martha's Table and JFMs in the summer of 2021 and revive this great partnership and experience. NYU DC has adopted the market at Achievement Prep this academic year, and it has been a blast!

It's been an opportunity for NYU DC students and staff to connect with the DC community outside of the downtown area and learn about regional food security issues, environmental justice issues, etc., that affect DC residents every day. We also have the privilege to connect with a vibrant community; NYUDC students probably wouldn't have the same opportunity at their internships on The Hill or at think tanks downtown. Through our JFM partnership, NYU DC students get introduced to Go-Go and other DC cultural staples while learning how to interact with people of all ages and backgrounds. It's hard to describe how valuable this exchange of kindness and community is for both volunteers and community members.

Over the last few months, I have heard many times from Achievement Prep parents about how much they appreciate their Joyful Food Market and how it helps them provide healthy meals between their planned supermarket runs. I've witnessed children and parents get excited about their favorite fruits or vegetables offered at the market that day. I've seen Achievement Prep students try a new fruit or vegetable and deliver their hilarious unfiltered feedback while parents and volunteers encourage them to keep trying new things; either way, it goes with the taste test. It's still so much fun to be a part of this critical service to the children and families of our community.

This exchange of kindness and community are fundamental reasons to keep the JFMs fully funded to ensure that families in our community, including Wards 7 and 8, have access to healthy meals.

Many thanks to all on the committee for your time.

TESTIMONY

Good afternoon Chairman Gray, Committee on Health, and constituents. My name is Reagan Dunham, and I am speaking to you today as a representative of the Washington AIDS Partnership, the LGBTQ Budget Coalition, The Way Home Coalition, and community members who seek to end homelessness in the District. **On behalf of the DC LGBTQ+ Budget Coalition and LGBTQ community, I seek your support.** The Coalition submitted a request for Mayor Bowser to allocate $500,000 to the Mayor's Office of LGBTQ+ Affairs to support housing capacity grants that will protect homeless LGBTQ residents but we found out last week that unfortunately, the request was not fulfilled.

1 in 100 D.C. residents is experiencing homelessness on any given night, and nearly 10% of unhoused adults identify as LGBTQ. Close to 40% of unhoused youth, ages 18-24, identify as LGBTQ. Currently, there are no LGBTQ service providers on the city's list of certified permanent supportive housing programs. This means that even when unhoused LGBTQ+ residents seek shelter, they are unable to find the culturally-competent services they need and deserve. Housing programs across the board are seeing budget cuts of up to 15%, rending them even less able to provide housing support to our community members.

Through the Mayor's Office of LGBTQ+ Affairs, the DC LGBTQ Budget Coalition requests $500,000 in funding for the Washington AIDS Partnership to pilot a housing-first public-private initiative to advance LGBTQ+ health. As the largest private funder of LGBTQ-focused programs in the greater Washington region, longtime leader of Washington, D.C. public-private health partnerships, and collaborator in Mayor Bowser's Plan to End HIV, the Partnership is well suited to serve as the grantmaking authority, expediting intermediary, and manager of this initiative.

In 2017, the Partnership privately funded its first LGBTQ housing service organization. Five years later, it has expanded efforts to now fund, monitor, and assist four such organizations. The Partnership will work with the Mayor's Office of LGBTQ+ Affairs to use requested funding, in conjunction with funding from private funders, to execute the following activities:

- Identify 4-6 LGBTQ community-based organizations best suited to pilot the housing-first health initiative.
- Administer grants to these organizations and provide them with funding to support housing and wraparound case management services.
- Monitor performance and help collect data that will help grantees address homelessness, chronic illness, and HIV transmissions among LGBTQ residents.
- Convene community-based organizations (CBOs) to help them integrate their collective resources and streamline policy advocacy.
- Coordinate an external evaluation of each CBO's efficacy.

An Advisory Board study found that providing housing to people experiencing homelessness in D.C. can save taxpayers money – as much as $20,000 per person in the system. **It is imperative that the FY2023 budget includes a markup of the requested $500,000 in capacity grants to the Mayor's Office of LGBTQ Affairs.** We are confident we, the network of LGBTQ service providers and advocates, can get the work done. All we are asking is that we have the funding to allow us the capacity to do so. **We are looking for the ability to create impact, and we are hopeful we can count on you to support us meet our goal.**

Testimony of Ruqiyyah Anbar-Shaheen
Director of Early Childhood Policy and Programs, DC Action
Coalition Director, Under 3 DC
Committee on Health: Budget Oversight Hearing Fiscal Year 2023
Council of the District of Columbia
April 4, 2022

Good morning, Councilmember Gray and members of the Committee on Health. Thank you for the opportunity to address you today. My name is Ruqiyyah Anbar-Shaheen and I am Director of Early Childhood Policy and Programs for DC Action, Coalition Director of Under 3 DC, and a member of the Early Childhood Educator Equitable Compensation Task Force.[1]

DC Action uses research, data, and a racial equity lens to break down barriers that stand in the way of all kids reaching their full potential. Our collaborative advocacy initiatives bring the power of young people and all residents to raise their voices to create change. Through our signature coalitions, we empower families and communities. We are also the home of DC KIDS COUNT, an online resource that tracks key indicators of child and youth well-being.

My remarks today are more broadly directed to the Committee on Health and focus on early childhood educator benefits, as described in the Birth-to-Three Law.

Ensure access to affordable benefits for early educators, as intended by the Birth-to-Three for All DC law

Thank you, Councilmember Gray for your leadership on early childhood education over the past few decades and for introducing and championing the Birth-to-Three law. We also thank you and your colleagues - in particular Councilmembers Allen, Lewis George, Henderson, Nadeau, Silverman, Robert White, and Trayon White - for voting for a permanent revenue source to fund early educator compensation in the District. This investment is historic and leads the nation as an example of how states can invest in building equitable and sustainable systems that right historical wrongs. In particular, it is an important step in correcting the devaluation of the work of the primarily Black and brown women who care for and educate our society's youngest learners.

As we eagerly await the Council's review and codification of the Early Educator Equitable Compensation Task Force's final recommendations, I'd like to bring your attention to the issue of benefits for early educators. While the Task Force was only charged with developing pay recommendations, we recognized the critical importance of benefits in compensation for early educators. DC Action urges the DC Council to review the recommendations for provision of benefits - and particularly health care benefits - and work with the appropriate agencies and members of the early learning community to develop next steps. We must not let the matter of benefits for early educators fall by the wayside.

[1] https://lims.dccouncil.us/downloads/LIMS/47312/Signed_Act/B24-0285-Signed_Act.pdf

The Birth-to-Three Law clearly defined compensation to include base salary and fringe benefits We know that salary and benefits - including health care, paid time off, and retirement benefits - are critical to staff retention, and to supporting teachers' ability to care for their families and invest their careers in early education.[2]

Increasing pay is an important step in increasing the equity of our early learning system, but doing so without accounting for the impact of higher pay on early educators' ability to participate in publicly financed health care would be short-sighted and could ultimately be detrimental to educators. It's also contrary to the intent of increasing pay to early educators. Some educators could see pay increases that could bump them out of eligibility for public health insurance programs, or out of eligibility for some premium subsidies. These changes could ultimately mean that educators break even with higher pay and higher premiums, or actually see a reduction in pay by losing publicly financed subsidies.

Data are currently limited on the benefits early educators receive through their employers, and suggest that employer-provided benefits are not the norm in the early learning sector. There may be a number of factors contributing to these circumstances. We understand that employer knowledge of benefits options, capacity for benefits provision, and cost of benefits are likely significant contributors. The District must select a strategy or a combination of strategies that address these barriers and ensure that early educators truly benefit from the compensation program, as intended.

Finally, pay supplements through the Pay Equity Fund in FY 22 are likely to have implications for publicly subsidized health care for educators with the lowest salaries (prior to supplements). In particular, educators participating in the Alliance or Medicaid face cliffs that could outpace pay supplements if they have to compensate with premiums on the private market or if they face unexpected health care costs without benefits. It is critical that educators have an abundance of language-accessible information in a diversity of formats about these implications, so that they can make the best possible decision for themselves and their families.

Thank you for the opportunity to testify.

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[2] Hamer, Danielle. *Testimony at the Performance Oversight Hearing of the DC Education Agencies on Early Childhood Educator Compensation. DCFPI. 2022.* https://www.dcfpi.org/all/testimony-at-the-performance-oversight-hearing-of-the-dc-education-agencies-on-early-childhood-educator-compensation/

Independent Research. Poverty Solutions. Better DC Government.

Testimony of Danielle Hamer, Policy Associate
At the Budget Oversight Hearing on the Committee on Health
Office of the Committee of Health, DC Council
April 4, 2022

Chairman and members of the Committee, thank you for the opportunity to testify. My name is Danielle Hamer, and I am a policy associate at DC Fiscal Policy Institute (DCFPI). DCFPI is a non-profit organization that shapes racially-just tax, budget, and policy decisions by centering Black and brown communities in our research and analysis, community partnerships, and advocacy efforts to advance an antiracist, equitable future. DCFPI is a member of Under 3 DC, a coalition committed to securing a strong start for every infant and toddler in DC.

DCFPI commends the Mayor for preserving the nearly $72.9 million in the Early Childhood Educator Pay Equity Fund (PEF) dedicated to raising early education compensation to achieve parity with DC Public School (DCPS) teachers in her fiscal year (FY) 2023 budget. This investment is a crucial first step in strengthening DC's child care system and recognizing the long-undervalued work of a mostly Black and brown early care workforce.

My testimony encourages the DC Council to include health care as a crucial part of the compensation plan, and to guard against benefits cliffs as early educators begin to receive their pay supplements. These are crucial steps to ensuring that early educators have access not only to fair wages, but essential health care benefits.

Council Must Recognize that Fully Parity in the Birth-to-Three Law Includes Health Care

Last month, the Task Force submitted recommendations on program design for the PEF, including a short- and long-term funding mechanism, a new salary scale for early educators based on educators' role, credentials, and experience, and implementation steps for the District to follow. DCFPI urges the Council to recognize that full parity in the Birth-to-Three Law includes health care and other benefits. As such, you should ensure that these benefits are included in the compensation plan, whether it be in FY 2023 or later in the financial plan. In the law, parity for early educators means compensation equivalent to the average base salary and fringe benefits of an elementary school teacher employed by DCPS with the equivalent role, credentials, and experience. Benefits include health care, paid time off, and retirement.[1] While proposing a plan for fringe benefits was not part of their charge, the Task Force's report provides suggestions for ensuring educators can retain and/or access health care benefits and are connected to resources to understand how compensation may affect their benefits.

Higher pay and affordable health care work hand in hand to fairly compensate early educators.

Excluding health care benefits as part of the compensation program would not only violate the spirit of the Birth-to-Three law, but it could cause some workers to be worse off in the end if their total wage increase fails to outstrip any increased cost in health care coverage that they face due to higher wages. Higher costs could be a result of losing Medicaid eligibility or facing a higher premium through employer-sponsored insurance or through the marketplace. The proposed base salary levels for all assistant teachers ($39,250) and lead teachers ($48,216) are higher than the Medicaid income threshold for single workers without children ($27,000) and single workers with one child ($37,700); other workers could lose eligibility depending on their family size and credentials.

Whereas DCPS provides health care coverage directly and uniformly to teachers, some early education providers cannot afford to provide health care coverage to their employees. There is a mix of experiences across the sector, with some workers having employer-provided insurance, Medicaid, or subsidized insurance through the marketplace. Council should assess mechanisms available for ensuring all early educators have affordable health care coverage, including a direct grant to employers to help offset the cost of insurance or potentially a direct subsidy to the employee through the marketplace. The Task Force report suggests that District leaders explore creation of targeted marketplace subsidies for child development facilities and for individual child care staff.[2] This idea aimed at meeting full parity would require additional public investment.

SNAP Design and Recent DC Earned Income Tax Credit Expansion Should Leave Most Workers Receiving Higher Compensation Better Off

Higher wages for early educators could also cause some workers who are currently receiving food assistance through the Supplemental Nutrition Assistance Program (SNAP) to see reduced benefits or be cut off from the program. Unlike Medicaid where the benefit cliff is substantial, SNAP is designed more like a curb than a cliff: for every additional dollar a SNAP recipient earns, their benefits decline gradually, by only 24 to 36 cents. This means that for most SNAP households, the program continues to serve as an income support—making it easier for families to afford food—as they earn more and gain financial stability.[3] Most workers should be better off under the proposed salary increases given this dynamic, particularly since the median wage for this workforce ($31,950) is above the SNAP income eligibility for a family of three ($28,548).

Similarly, the Earned Income Tax Credit (EITC) is more like a curb once a worker earns above $20,000, with the EITC value decreasing by about 21 cents for every new dollar earned until they are no longer eligible. For the median worker currently earning $31,950 and living in DC, there is no scenario in which the wage increase to the proposed base salary for an assistant teacher and teacher at any credential level fails to be larger than income lost from the EITC program. And for those who see a declining EITC value due to the phase out design, DC's recent substantial expansion of its EITC from 40 percent to 70 percent next year (and to 100 percent by 2026) will serve as an additional complementary buffer. Moreover, those working part-time with incomes below $20,000 are more likely to see the biggest net gain from higher wages and the expanded DC EITC since the value of the credit is largest below that income.[4]

Roll Out of Higher Compensation to Early Educators Must Guard Against Benefits Cliffs

The Council should ensure that OSSE implements a plan to notify educators about the ways in which their work and income supports might be reduced by higher wages or require participating employers to provide that notice to their workers. The Task Force report provides recommendations to connect educators to resources, proposing that OSSE works with partners to identify existing potential counseling resources. The Council should set aside funding to help early learning professionals better understand potential public benefits and health care disruptions they may experience. This funding could support small grants to direct service providers who can advise early educators about potential benefit cutoffs or reductions, or at minimum, support the production of materials on potential benefit cliffs and the local counseling resources available.

The Council should also ensure that OSSE chooses the frequency of payment for the short-term supplemental payments—such as a one-time lump sum or monthly and quarterly payments—that leads to the fewest disruptions in health care coverage for these workers.

Thank you for the opportunity to testify, and I am happy to answer any questions.

[1]District of Columbia, "Birth-to-Three For All DC Act of 2018," page 12.

[2] Washington State recently implemented legislation that provides marketplace subsidies specifically for early educators. Learn more here: https://www.opportunityinstitute.org/blog/post/coming-this-fall-brand-new-program-will-help-an-estimated-40000-child-care-workers-afford-health-insurance/

[3] Center on Budget and Policy Priorities, "Policy Basics: The Supplemental Nutrition Assistance Program (SNAP)," June 2019.

[4] Maryland and Virginia also have state EITCs, but they are lower than DC's expansion at 45 percent and 20 percent respectively.

Testimony of Camille Range, Public Witness
FY23 Budget Oversight Hearing: Committee on Health
April 4, 2022

Good afternoon, Councilmember Gray and members of the Committee on Health.

My name is Camille Range. I am testifying today as a Ward 8 resident, homeowner, and health professional. By day, I am my community's registered dietitian through my employment at Martha's Table. By night, I am completing the final months of my doctorate in Urban Leadership and Entrepreneurship from the University of the District of Columbia.[1] I have been testifying at the DC Budget & Performance Hearing over last five years and it is insightful to reflect on how my recommendations, research, and experience as public health scholar.

This year, I would like to use my testimony to bring awareness to no-cost opportunities for collaboration with limitless financial, social, and sustainable impact. Specifically, I would like to draw the attention to the intersection of health, agriculture, and our environment. As we broaden our understanding on the impacts of food insecurity to nutrition security, we are learning the importance of the communication of services and nutrition and health education. Furthermore, we are learning about the need for human-capacity to support these consumer demands and systems leadership.

This direction was reaffirmed by United States Secretary of Agriculture Tom Vilsak's remarks last month at Teachers College at Columbia University.[2] There, he announced the four new pillars the USDA will use to address nutrition security including prioritizing equity and "developing, translating, enacting, and enabling nutrition science through partnerships to get to "ordinary" individuals."[2] In my prediction, nutrition education through WIC and SNAP-Ed is the primary program federal funding will increase in the future implementation of this new framework.

Because the District of Columbia does not have a Department of Agriculture, we will not be able to fully access the millions of dollars in future funding. Nonetheless, our efforts should be innovative and aggressive to acquire federal and District funds to provide adequate nutrition and health education and services.

Currently, the University of the District is the one of the major recipients and acts as a quasi-agency between the District of Columbia and US Department of Agriculture. Primary funding streams include 1) DC SNAP-Ed, managed by DC Health Community Health

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[1]University of the District of Columbia. Ph.D in Urban Leadership and Entrepreneurship. https://www.udc.edu/causes/phd/

[2]USDA Actions on Nutrition Security. United States Department of Agriculture. March 17, 2022. https://www.usda.gov/media/live

Administration and 2) through direct relationship-building through UDC CAUSES (College of Agriculture, Urban Sustainability and Environmental Sciences).

The following are recommendations to restore and reimagine funding allocation to leverage these organizations to provide culturally relevant nutrition education services to the residents of the District of Columbia:

Immediately fund the ongoing DC nutrition education services assessment in partnership with Howard University and Office of Planning. There is currently no funding to support this informative and vital research. Given the potential future use of research results for both leadership and residents, DC Health and Office of Planning partner to allocate at least $100,00 to support the research methods. Furthermore, this research is currently being conducted by a black woman, mother, and doctoral student. This is tangible example of how the District can utilize funds to support evidence-based recommendations while empowering a diversified health professional workforce.

Restore and secure SNAP-Ed funding allocation to the UDC CAUSES Center for Nutrition, Diet and Health. Prior to the 2014 Farm Bill, SNAP-Ed funding was distributed to state departments with funds reserved to be administered through land-grant extension programs. Recent legislation now allows state departments more authority and flexibility allocate SNAP-Ed funding. Therefore, UDC must now compete with other sub-grantees for a portion of their previous awards. Previously, the Center for Nutrition, Diet and Health receive approximately $750,00/annually and now receives approximately $400,000/annually.

Explore a memo of understanding and secure local funding of $1M to support the collaborative efforts of University of the District of CAUSES Urban Leadership & Program and the Office of Health Equity. This doctoral program is the first of its kind in the nation and housed at the only urban, historically black land-grant university. Therefore, it presents exponential potential to improve urban health and environmental outcomes while diversifying the workforce and research of the District's food, environment and health systems. Funds can be used to support educational costs, collaborative research projects and community participation to develop inclusive solutions to promote health equity.

Reimagine how agencies such as the Department of Health, Parks & Recreation and Energy & the Environment can leverage partnering with UDC CAUSES to secure federal funding through the US Department of Agriculture. Given the absence of a municipal-

level agricultural office, District agencies must be innovative and diligent in their commitment to cross-agency collaboration, advancing racial and health equity and improving nutrition security.

Examples include funding opportunities from the USDA National Institute of Food & Agriculture (NIFA) to support socially disadvantaged farmers, to grow and educate residents on specialty crops (fruits, vegetables, nuts, etc.) native to their culture,

and leverage youth employment programs to advance education and workforce development programs. Most NIFA funding opportunities require proof of cost-matching to apply for additional funding. Hence, the opportunity for benefitting DC agencies to contribute to collaborative research and program development and implementation.

I am happy to discuss these recommendations and research to expand to the partnership with UDC CAUSES. I am committed to serving as a model, leader, and advocate for how innovative collaboration can promote health outcomes in the communities of color by the residents of these communities.

Thank you for your time and attention to my testimony today. I wish you all wellness and safety throughout the remainder of your week.

Advocacy 2022

Flor Mendez

My name is Flor Mendez, I have been in the Home Visiting Program for 4 years.

The program has been a great help for me both in my self-learning and in my learning as a mother. The program has helped me grow and learn to be independent on a professional level and the ability to better understand my son. I have always received all the help I need from the program.

I have many memories of when I began as a participant in the Home Visiting Program. When I began, I was experiencing difficult situations with my health, with my relationships and emotions. Now I am in a different place from when I began, and I hope to be even better when my time in the program comes to an end. These difficult situations that I overcame now are only a bad memory.

My Family Support Worker es my favorite person, my friend, a very special person in my life, someone that motivates me and has helped me in my worst moments because she has always been with me, helping me out of restlessness and giving me emotional support and thanks to this support, I have been able to move forward in many areas in my life. My professional relationship with my Family Support Worker has been beautiful and it has strengthened with time. I thank her for all the support she has given me over the years, and I have learned much from her. My Family support Worker has helped me find housing, to achieve my goals.

The greatest benefit of participating in the Home Visiting Program has been learning many things to help my son develop. I have learned to talk more with my son, to teach him new skills, to take time to read books and to discover the talents and skills that my son has. Also, the program has helped motivate me to look for work and as a family, we have learned many things.

I want to ask you, the Member of DC City Council to continue supporting the Mary's Center Home Visiting Program because it would affect me a lot and the other families if the program is to end. Please do not take away this support.

Budget Hearing 2022

Leydi Hernandez

Hello, thank you councilmembers and committee, for the opportunity to testify. My name is Leydi Hernandez and am a program participant of the HFA Home Visiting program at Mary's Center. My experience in the program has been good and has impacted my life because I have had support when I have some anxiety or doubt an if my Family Support Worker didn't have the information, she would look for it and send it to me. The program has helped me resolve circumstances that would have taken a lot out of me to solve by myself.

On a personal level, I have felt support and the program has helped me resolve situations with my children because the topics that we talk about in home visits are informative. The topics that we talk about empower and help me grapple with situations when I was lost. The topics of child development teaches us to give our children a positive upbringing.

The main benefit of participating in Mary's Center Home Visiting Program has been to have support when I need it. To have someone that can help me in situations where I have felt distressed. Being in the program, I feel that I have someone to turn to when difficult situations arise. All that I have learned will benefit my children and they have been benefitting since I joined the program.

If I find that the program is going to end, I would ask why and I would ask you, the Members of the Council not to do it because there are families that receive different supports and it would impact the families to not have this program as a resource and help. Also, I would ask to look for a way to give the program more money because the families can get help from the program and keep moving forward and more money means the ability to include more families that that feel the need to have a Family Support Worker.

My Family Support Worker is responsive, we have all our visits, and she is punctual. She always lets me know ahead of time when she is not going to be able to have a visit and she always gives me the contact information of her coworker or someone who can help me in case there is an emergency while she is out. For example, she has given me information about places to receive mental health therapy.

With my Family Support Worker, I have felt trust, respected and she always respects the decisions I make. Sometimes I have talked to her about my religious beliefs, and she has always taken my opinion in a respectful way. I trust her because we have been working together for many years. This trust has helped me tell her many things when I wasn't felling ok.

Ms. Leydi Hernandez has been in the Home Visiting Program since November 2014.

3/11/22

Letter from Mrs. Nuvia Melgar

Hello, thank you councilmembers and committee, for the opportunity to testify. My name is Nuvia Melgar and am a program participant of the HFA Home Visiting program at Mary's Center. My participation in the Home Visiting Program has been a different experience because I have never been in a program like this before. It is important to participate because there are things that you don't know and thanks to the program, you can learn. All the supports the program gives are important, they have helped me on a psychological level and with more concrete supports.

On the personal level, I learned many things that I didn't know. For example, how to understand my baby, and to know how to interpret my daughter's emotions, to understand more easily what she wants or needs especially because she is still young and isn't speaking. I always remember what my Family Support Worker has told me when I am trying to understand what my baby wants or needs.

When I didn't know where to start, the Home Visiting Program gave me many resources. For example, my Family Support Worker referred me to DC CARES to get economic support, to Capitol Hill Pregnancy Center to obtain baby items, also she has helped with getting health insurance and to obtain the birth certificate and social security card for my baby.

With my Family Support Worker, I feel that my confidence has grown and now I feel different than when I started. Now I feel comfortable because my Family Support Worker is a helpful, excellent, and responsible person. I appreciate the support she has given me since I was pregnant with my baby. I am very thankful for all the members of the Home Visiting program because they help families so much.

The major benefit of participating has been all the support that my family and I have received and because of this, I think it would not be a good idea for the program to end. Because it is important and a lot of help. The ideal situation would be to extend the program for more time so that families can stay in the program longer.

Nuvia Melgar, participant in the Home Visiting Program since May 2021

Testimony to the Committee on Health
For the Budget Oversight Hearing for DC Health
Clint Ngwa
Youth Advocate, Young Women's Project
March 29, 2022

Hello, thank you for the opportunity to testify today. My name is Clint Ngwa and I live in ward 5 of D.C. I am 16 years old. I'm a rising senior at Phelps ACE HS. After high school, I plan to go to college and major in aviation in hope to become an international airline pilot. Before I joined YWP, I was ignorant about major everyday topic that relate to sexual health, but the Youth Health Educator program has educated me and has given me the opportunity to be able to talk about these topics, educate and advise other individuals, and spread the knowledge. I chose to testify today because I feel the need to express the fact that if the funding is restored there will be a greater spread of sexual health awareness and knowledge than there is today.

The Youth Health Educator Program is important because there is a rise of STIs in DC. This program helps reduce it because youth health educators work to pass out safer sex materials such as condoms and educate peers about anything sexual health related. Most teens get information from the internet or from their friends. Most teens do not feel comfortable talking to or asking adults about sexual topics because sex is already a taboo topic. This program gives knowledge to teens and empowers us, teens, to tell our peers. I attend Phelps ACE HS; we have an elective health class that only touches the basis of sexual health. We need a comprehensive curriculum because sexual health is more than just sex. It's about healthy relationships, consent, boundaries and so much more. YHEP teaches us comprehensive sexual health so funding the program allows for us to address the problem. Without YHEP, teens are getting their information from unreliable sources and do not know where to get resources from.

Being a sexual health educator taught me has me a lot from sexual topics such as STIs, consent, healthy relationships to helping me develop my workforce skills. I run into people who do not feel comfortable reaching out or since the pandemic, people have become socially anxious so having that sociable skills allows me to break the ice. I am able to use those skills to meet new people every week when I am passing out condoms, giving out clinic referrals and answering my peers' questions. My school isn't implementing enough measures and resources for sexual health education and no resources for condom distribution. Sometimes, condoms can be found in the nurse's office, but the office is always locked, and the condoms are always put away. Since the school year started, I have given out more than 900 condoms. I have also educated about 60 peers directly with my classroom presentation. During my classroom presentation, I educated peers and even teachers about the different types of condoms and how they should be used, how-to put-on condoms and how to store them correctly.

Our work at YWP has provided sexual health awareness to many youths around DC and provided resources for safe sex. YHEP has also created jobs for youth in DC. With our grant being cut last year, our program had to downsize from 100 to 40 youth health educators

meaning that we do not have enough youth at DC schools to do this important work. Youth health educators are a tight group, and we deserve the opportunity to strengthen our skills. With peer education and youth employment, YHEP is working on all fronts to combat the stigma around sexual health but also empowering DC youth to be more knowledgeable and to transform our communities. I see this when I see my friends share the information, I share with them to others. I also see it when I see recurring people ask me for condoms each week or month. The work that I do is priceless.

Without a doubt, youth health educators are integral to addressing the city's sexual health problems. DC youth are counting on you to restore $200,000 in the FY23 DOH Budget to support the Youth Health Educator Program. Youth health educators work 3 hours a week, earn $15/hour, and receive extensive training in sexual health, advocacy, public speaking, and professional development. Thank you for your time and I hope for your continued support in the future.

Advocacy Letter 2022

Hello members of the Council,

My name is Ginger Ellis. I am a Senior Family Support Worker with Healthy Families America, DC. I have been employed at Mary's Center since 2012. As a Senior Family Support Worker, my role is to ensures that each child is safe, healthy, and ready for school by age five by providing intensive home visiting services to overburdened parents. Additional responsibilities include taking a leadership role to support the HFA Program Supervisor, including training new Family Support Workers; coordinating outreach and program events; acting as a representative for the program at community events; and providing temporary support to Family Support Workers in the absence of the HFA Program Supervisor.

More funding for programs and higher pay for staff leads to many positive outcomes: it means less staff turnover which creates more stability for participants. When Family Support Workers stay in their role and longer, families have more consistency it allows more trust to be built and strengthens the relationship. We use the parallel process where if a participant and FSW have a strong relationship, it can provide a model for strong relationships within the family and within the community.

People in this role love the work but aren't getting paid enough to stay in the work. FSWs provide more quality work if they don't feel burnt out and overburdened. Turnover increases feeling overburdened. When FSWs leave, it is not easy to rebuild trust with participants. Sometimes the FSW is the only consistent relationship in a participant's life. Part of the Family Support Worker role is to encourage participants to seek out support systems in their lives, but that can take time.

Family Support Workers support families with their goals including seeking employment that pays well to be able to support and take care of their own families. We talk about money management as part of employment goals. But it is just as important to have work-life balance to create strong families and therefore strong communities. Some families we work with say they must work two jobs. I can think of one particular family: she was working two jobs which caused her home life to be stressful. The mom was unable to be present for homework time with her kids, mealtimes, or school activities and the kids started to act out. The mom was at work most of the time and was unable to spend as much quality time as she would have liked with her kids. I talked with her through the pros and cons to determine how she wanted to move forward. Make enough money to care for her family? Or strengthen her relationship with her kids? She determined two jobs weren't worth the time she was missing with her children and the emotional stress it was causing the family. Therefore, the participant ended her employment with one job and sought TANF support again.

We want the same for ourselves; to be paid fairly for the impactful, life-changing work we do and a healthy work-life balance. Therefore, we are asking for a 15% increase in program funding: to ensure consistent home visiting services to strengthen families and communities.

March 24, 2022

My name is Morena Amaya, today I want to address the DC council members so they can continue to support the Home Visiting programs and increase their funds. I want to speak about the importance of this program and how it has impacted me personally. This program has helped me in so many ways. I started the program when my son was 2 months old. I was not sure what the program was about. Now that I am in the program, it has helped me and my community in many ways. When my son was a month old, my father got robbed and assaulted. I did not know that it would cause me to have PTSD. It was bad that I did not want to leave my house since it happened right outside my house. I found myself finding support in my home visitor, and I ended up having to take therapy because my family support worker and I decided that it was best for me. I also got information about resources that provided free therapy in case I needed it after my sessions ended and if I did not have anyone to speak to. At the time I had a friend who was on the waiting list to get therapy, it was taking longer than expected and she needed it ASAP. I remembered the resources I had previously gotten from my Family support worker, and I gave it to her. Now she is doing so much better and all because of some information I got from the program. I realize that with this program I am constantly getting help and resources, and I am also able to support others in my community with the tools and information I receive. Another way I have been supported throughout my time in the program was when I was unemployed, even though I was unemployed, I still had bills to pay and had to buy items for my son. My family support worker told me about the help the government gives to people, like SNAP and TANF. I had negative connotations with it. I was thinking I will be seen as a weak person and not be able to get the help I needed. My family support worker was able to connect me to someone and she helped me apply and receive my benefits. I did not expect to get accepted, but Once I got the money, I was able to support my mom with some of the home expenses and groceries. My mom was happy because she was able to get many foods item she wanted. She went in every aisle and was able to get anything she wanted. I was unaware of how much she was struggling to get food for us, and the fact that she was limiting the amounts of food she could buy weekly, but once we had the extra help, we realized how exciting it was to buy food and not worry if we could afford it. Another thing the program has helped me is that it has made me feel like I am an amazing mother no matter what I do. Every week, I have a check-in with my family support worker, and I can ask any question I have. My family support worker would answer my doubts and give me activities to help with my child’s development. My family support worker is so helpful, informative, and also understanding. With this program, I feel every mom should be a similar program. It has helped when I've been feeling overwhelmed and feel like I am doing a bad job. My family support worker has made me feel better and reassured me that I am doing a good job. This program also helps with voices of the past. It teaches mothers that going with a different path from the past does not make us a bad mother and just helps our child be even better than before, and that as a mother I am making the decisions that I think are best for him. It teaches us that we should be proud of how far we have come with our child, and we can count on our family support worker if we need anything. I believe this is a program that should be everywhere, it does an amazing job helping mothers.

Hello, thank you councilmembers and committee, for the opportunity to testify. My name is Noemi Villalta and am a program participant of the HFA Home Visiting program at Mary's Center. The program has been very beneficial to me. It gives me positive results on a personal level and a family level. On the personal level, it has benefited me in a positive way because I can manage or I am learning to manage my emotions in a positive way, and similarly I can guide my children in a calm way so that it can amplify their calmness and happiness so they can pass it onto others.

During my time participating in the Home Visiting Program, I have learned to control my emotions, I grew as a person and I learned how to help my children not lose control. I learned to help my children manage their anger and calm themselves. I continue to learn to manage my feelings because sometimes our daily routines cause us to forget, and my Family Support Worker helps us remember that this is important. Also, I learned that emotionally we can feel bad, but also we can rise up stronger, learning to be more helpful to others and to value family more. We have been more united as a family, communicating more often. Before my husband worked a lot and I have learned to communicate better with my children and my husband.

My Family Support Worker has helped me to get medical insurance and my children get medical insurance. My Family Support Worker helped connect me with people who would help me to figure out and solve some situations with confusing medical bills. My Family Support Worker has helped me contact agencies that have given me items for my children. She has helped me contact agencies that have provided therapy to my children. I didn't know about these resources and supports, and the Family Support Worker helped me, giving me information and connecting me with Strong Start and Early Stages.

My relationship with my Family Support Worker has been friendly and confidential because I have lived through tough family, personal, and relationship situations. I went through a very unpleasant health situation that emotionally impacted me and my family. My FSW has helped me with this process because she suggested therapy. She is confident, my friend, who listens to my sorrows. Before, she helped me a lot, but this year she provided a deeper support and has made my situation more bearable. My Family Support Worker is engaging and generous with my family.

I would like the Members of the Council to explore the possibility to expand the budget for the Home Visiting Program so that they can continue helping many families in need because families have suffered emotionally and economically due to Covid. The Family Support Workers provide a lot of support, and I would like the program to continue and for more families to be able to receive these services. Please help the program continue to function. This program teaches us how to help our children so that they can learn to manage their emotions. Just talking with someone is support, it is like a mirror that allows us to reflect and remember not to forget to be parents and to pay more attention to our children. Sometimes we forget because we have a lot to do. This program is beneficial for many families that need it.

Noemi Viallta has been a participant of the Mary's Center Home Visiting Program for 7 years.

Hello council members, thank you for the opportunity to testify today. My name is Yocaira Perez, and I am a family support worker at Mary's Center. I first entered the Family Support worker role working with families who were transferring from one FSW (Family Support Worker) to another. Some had a similar background history, who remind me of my family. I recognized that the support families receive would have been welcome when I was growing up navigating similar situations. The support I provided to my family when I was growing up is the support I currently provide to the families in the Home Visiting Program. This is one of the many reasons why I relate to the families I work with.

A typical day for me starts off by preparing a to-do list for each family I have scheduled for that day. I know that the visit I'm prepared to have can change depending on the needs of the family. Often in a scheduled visit, I may have depression screens or Ages and Stages Questionnaire surveys to check in on the mental wellbeing of a mother and her baby's developmental milestones. However, if a mother's emotions are dysregulated, I pause what I'm prepared for to accommodate and address the mother's immediate needs. I'll eventually come back to the agenda items with the mother or may have to set up another meeting to do so. After a session with a family, I take some time to reflect and self-regulate because often, some sessions come with very intense conversations and emotions that if unprocessed will impact my well-being. I also must write notes to make sure that I capture and document what the Participant and I worked on during that visit.

During COVID, there are extra steps to take to support a family. What used to be home visits in person pre-pandemic we must now deliver virtually. If a family is not tech savvy, taking the time to help the participant work through zoom or other virtual platforms is vital to catching a family. I had to accommodate a family's schedule to make sure that we could meet. In the last year the challenge of virtual learning created barriers for a parent to have a home visit with me. There is a lot to do with the little time a mother can give me. We coordinate with doctors' offices, and appointments to support family access to medical care. We support families with applying for food stamps, insurance, WIC, and other public benefits. When a family has a need for diapers, hand sanitizer, masks, food, I make a referral to food banks, connections to other resource providers or drop-off the diapers myself. In the current setting drop-offs only happen after I've developed a strong relationship with the family. During covid, the drop off may be the very first time I meet with a family versus how home visiting used to look like. This adjustment means that the conversations I have before a drop off are the only opportunities I get to build a strong rapport with them. Having a strong rapport with a family means that they trust me enough to ask me for support when they need it.

Last year, a participant I worked with testified to the council about our Home Visiting program. She expressed how our partnership as Parent and Family Support Worker impacted her life for the better. I reached back out to see how she was doing and informed me that she has a 1-year plan to start applying and enrolling back in school. She has taken the information from her time in the program and applied it to her life every day and has kept herself motivated to achieve her goals.

As a family support worker, I stay in this role because I know I am an extra support to the families, which has a positive impact for both of us. The relationships I develop with families are so strong that it motivates me to continue. The workload and the pay do not equal each other. Seeing the amount of work that we do and the roles that we play makes me feel like the work I am doing is not being valued properly by grant funders. Sometimes I must flex my schedule to accommodate a Mom's Saturday availability, especially if a mom works all day or works two jobs and gets home late. I am telling you that the work I do, the impact I have, and the pay I receive is not proportionate. DC should increase grant funds by 15% to account for inflation as a starting point to begin to adequately pay Family Support Workers like myself. Increasing investments in Home Visiting would increase Home Visitor retention rates and positively impact participant engagement.

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Council of the District of Columbia

Committee on Health

Budget Oversight Hearing:
Department of Health (DC Health)

Testimony of Andrea Boudreaux, PsyD, MPH, MA, FACHE

Children's National Hospital
Monday, April 4, 2022

Good morning, Chairman Gray and members of the Committee, my name is Dr. Andrea Boudreaux, and I am the Executive Director of the Children's School Services Program at Children's National. Thank you for the opportunity to present testimony at the DC Department of Health FY 23 Budget Oversight Hearing. For over 20 years, Children's School Services (CSS) has been providing school health services for DC Public Schools (DCPS) and DC public charter schools. CSS is a school health organization comprised of dedicated health professionals, nurses, and health technicians who work diligently each day to provide the highest quality of health care services to students, families and the communities we serve with compassion, commitment, and a sense of connection on the campus of our schools. Today, I want to take this opportunity to highlight some of the outstanding contributions of Children's School Services and the need for continued investment in the District.

Ensuring all health needs are being met is critical in maximizing the well-being, safety, and care coordination for students. With this program, the District is making an important investment in the health of our children. Our school nurses partner with the schools to ensure: students are immunized; students with asthma, diabetes, and emotional/behavioral health challenges are getting the care they need during the school day and are connected to the care they need to optimize their chronic illnesses; students with disabilities receive the care they need and have the equipment needed to provide that care; and students who are experiencing health related absences are getting support to access appropriate care. We thank Mayor Bowser for including $4.5M for expanding school nursing health services and additional school health services in public and public charter schools, and we strongly support the Council allocating additional funding to support the implementation of B22-027, the Public School Health Services Amendment Act of 2017. The continued investment is essential to improving supports for students in and out of the classroom. The needs of the students across the District are not restricted to the just 3 days a week that some schools have support, but are consistent throughout the week. The school nurse is a critical member of the community. S/He forms bonds with the students, their families, and other community partners. Consistent coverage would benefit us all. While we navigate the nursing shortage and fiscal gap, we still work to ensure that the students in our care have the resources they need. Until we have the fully

staffed team, we have implemented an AOM protocol in which we train lay persons in the school to safely administer medication to students when a nurse or health technician is not on the campus. We are on track to have 700 AOMs across the District going into the new school year. During my 6 week-long tour of every health suite across the District, many needs were identified. Food insecurity, homelessness, poverty, and a host of other needs are glaring in the school, and for many students we are their sole provider of health care services. Funding for more expansive coverage will undoubtedly improve the health outcomes of the students across the District. While the commitment of our nurses is strong, many come from outside the District to provide care to our students. In addition to the AOM coverage discussed earlier, the nurses also leave one campus to administer complicated medication to students in need. The burden of finding parking at a number of our schools in the middle of the day is also a significant challenge. Funding parking permits for our nurses would show the District's gratitude and acknowledge their importance in the care delivery of our most vulnerable residents. While OSSE currently allows for undesignated epinephrine to be supplied to every school for use in an emergency, the need for other rescue medications is also very real. Several of the students, particularly in Wards 5, 7, and 8 do not have the albuterol or glucagon for rescue in an emergency. Our case managers work closely with the family and physicians to ensure that the student has the medication orders and provider access, but we also request funding for rescue meds including Narcan in the health suites to respond to emergencies.

As we testified over the past two years, the impact of the COVID-19 pandemic on children and adolescents has been great. CSS continues to work closely with community providers to address chronic health disparities like asthma, diabetes, and behavioral health. Social determinants of health are top of mind in all that we do at CSS. At Children's National, we have seen increases in behavioral and mental health needs as well as severity of presentation with mental health illnesses, eating disorders and child maltreatment. We have also seen increased food insecurity among our families and increased rates of obesity and diabetes among our patients. The return to in-person instruction was important for the academic development of children in DC but also for their physical and emotional health as well. The

long-term impact of COVID-19 on the health of our students is yet to be seen but we note the ongoing work of the CSS team to improve health outcomes.

As we look forward to the next school year, we continue to build trust in the community of teachers, parents, and students around the safety of immunizations, as well as the comprehensive care that can be provided between the health suite and community providers. Through our partnership with Children's National Mobile Unit, we have seen a 40% reduction in the number of schools with 70% compliance. We will continue to partner with our Children's National Mobile Unit, as they address immunizations, social determinants of health, and unnecessary absences. CSS also continues to expand our reach through Children's National Telehealth, which offers consultative coverage to all schools with a CSS health suite. This consultative coverage is an expansion of services and allows for provider-to-provider real time support for the health suite staff. Twelve pilot schools were identified to help better support their needs, and we hope to expand the implementation of this pilot across the District. We are working to address behavioral health by providing training and support to our staff through the creation of the CSS Behavioral Health team. We look forward to engaging more closely with the Department of Behavioral Health to utilize resources identified to address mental, behavioral, and emotional needs of the students.

We thank DC Health for their continued emphasis on improving the health and wellbeing for children and adolescents in the District. As the Council considers additional funding for school nursing services, please consider that a continued commitment to addressing the health needs of students and schools can result in real improvements in promoting health equity. Children's National and Children's School Services are the bridge between health and education and continue to be a health safety net for so many families and communities in need. We are poised to continue to be a part of the community and public health apparatus, connecting families to services so that all children in the District have an opportunity to reach their greatest potential. Children's School Services with our over 20 year of service to the District and Children's National with its over 150 years, understand the unique needs of the communities we serve. Thank you for the opportunity to testify and I'm happy to answer any questions you may have.

Testimony to the Committee on Health
For the Budget Oversight Hearing for DC Health
Danika Howard
Youth Advocate, Young Women's Project
March 29, 2022

Good afternoon, Chairman Gray and members of the Committee on Health. Thank you for the opportunity to speak today in front of all of you. My name is Danika Howard and I live in ward 6 of DC. I am currently a junior at BASIS DC, and though college is a few years away, I still have plans to attend a liberal arts university and potentially major in a social science or English Lit. I have been at YWP since the beginning of this school year, and it has truly been the most rewarding and enjoyable job I've had. I became a peer educator because I wanted to provide access to sexual health knowledge and materials to my classmates that I knew they weren't receiving from my school. I am testifying today to share the work that I've been doing as a peer health educator and to encourage you to restore funding to the Department of Health FY2023 budget that will support sexual health education and condom distribution in high schools.

The YHEP program is so crucial in the district because the best people to spread information and impact the youth in our schools are fellow teenagers. When these students are being educated by their peers, it creates a more comfortable environment for them to be vulnerable and honest about issues they may want to discuss or learn about. Most schools' sexual health programs lack extremely important details about consent, pleasure, healthy relationship dynamics, LBGTQ+ sex safety, and YHEP makes sure to emphasize those topics when educating students. At my school, we never received a comprehensive sexual health course despite being told we would receive one at the end of 9th grade and still lacks any proper sex ed course or resource area for students to consolidate in. When schools do not teach their students proper sex ed, students are at risk of not only STIs and unwanted pregnancy, but ignorance around safe sex in general. YHEP exists to make up for the absence of proper education DC schools give their students and gives arguably better information due to the lack of emphasis on practicing abstinence. Along with providing condoms, YHEP educates students on the importance of pleasure through using lube, specialized condoms, and LGBTQ+ contraception. We also help students access clinics near them to get tested for STIs, pregnancy, or for information from a professional.

Teaching my peers about sexual health is very important to me because I believe that knowledge is power and liberating the youth by helping them understand their bodies will only benefit them positively. Throughout my time as a YHEP, I learned that many of peers had lots of fears and insecurities surrounding sex and intimacy, many of which were shared with me so I could understand and potentially offer information. For this very reason, I believe that the YHEP program is extremely important in DC schools because most students probably would not share personal information such as fears to a teacher or trusted adult, and due to this, would likely never be able to talk out their struggles. One of my proudest moments as a Youth Health Educator was when a friend of mine pulled me aside during lunch and told me that she had sex for the first time a few days earlier and because of the information and resources I provided

her, it was an enjoyable experience for both her and her partner. I was so proud of myself at that moment because it was proof that my job was actually benefiting people. The fact that I not only helped provide condoms to my peers but helped make sex comfortable and a positive experience was such a gratifying thing to hear. Some of my favorite activities that I have done with YHEP was our Valentine's Day project when we made packs of condoms and candy to hand out that week, students loved them! I conducted classroom presentations about Bacterial STIs as well as LARC birth control methods which I delivered to over 100 of my classmates during the span of a few weeks. I educated them on the types of STIs, the symptoms that they cause, and ways to prevent the spread and infection of them, and for my LARC presentation, I educated students on the wide variety of birth control methods that many did not know existed. As of March, I am organizing my Virtual Wellness center focused on pregnancy options for teenagers because I believe that every teenager should know and consider all of the possibilities. This Sexual Wellness Center is very important because it serves as a completely unbias resource that gives information about pregnancy alternatives to youth that does not encourage nor discourage any of the options listed.

My school has been very supportive of my YHEP journey and has been open to the criticism that I have given many of the staff members on the sex ed curriculum. There has been action made to implement a sexual health course in the middle school at BASIS which I think is an excellent idea because many students would benefit from learning this information earlier than high school. One of my classmates, Noemie Durand, is also working at YWP in the Youth Justice Program and was in the YHEP last school year. She was the one to recommend me to the program and helped me apply and I continue to work alongside her at school for any YWP related events. Virtual Wellness Centers would be extremely useful at my school because they give students copious amounts of information all in one place. These wellness centers also provide anonymity, many students still feel slightly uncomfortable coming to a stranger for sexual health advice, and these centers let them still have access to information without having to feel uncomfortable.

I strongly feel that our work done at YWP has impacted so many students across the district because I have seen it firsthand and know how important the YHEP program is for the safety and wellbeing of teenagers. YWP not only helps reduce STI and unwanted pregnancy rates in DC schools, but it informs students about every aspect of safe sex such as consent, communication, and enjoyment. We are asking that the Committee allocate $200,000 within the DOH budget to the specific purpose of sex education, clinic referrals, and condom distribution in DCPS and Charter high schools with a goal of reaching 25 schools and 10,000 youth. Peer educators should be engaged as part of this work to increase effectiveness (since adults are not able to reach youth through social media or text message) and should be paid for their work. Teenagers educating other teenagers is the best way to truly impact DC students because they feel far more comfortable when speaking to someone similar to them as well as safer sharing information without the fear of parents finding out. The information YWP is sharing across the district is so important for teenagers to learn as soon as possible, and our program ensures that every student has the chance to access the information and resources they need to enjoy safe sex. Thank you!

Testimony of Sarah Barclay Hoffman
Children's National Hospital and Early Childhood Innovation Network

DC Department of Health Budget Oversight Hearing
Committee on Health
Council of the District of Columbia
April 4, 2022

Good afternoon Chairman Gray and members of the Committee, my name is Sarah Barclay Hoffman and I serve as a Program Manager with the Community Mental Health CORE at Children's National Hospital and Director of Policy for the Early Childhood Innovation Network. We are also members of the Under 3 DC coalition. Thank you for the opportunity to testify today in support of funding an additional $300,000 for the HealthySteps Demonstration Program, so that more families with infants and toddlers – especially those from historically under-resourced communities – can access the critical health and mental health benefits of this integrated service, and making further critical investments in DC Health's home visiting program.

HealthySteps

HealthySteps is a nationally recognized and evidence-based model that embeds an early childhood specialist – in DC, mental health clinicians – into the primary care practice, to support the wellbeing of children ages birth to three and their families. HealthySteps has a unique focus on development, social-emotional health, as well as the mental health needs of the family, such as the provision of therapeutic interventions if a mother is at-risk or struggling with postpartum depression. Currently, funding from DC Health supports HealthySteps at Children's National and Unity Health Care clinics located in Wards 7 and 8 through the HealthySteps Pediatric Primary Care Demonstration Program in the Birth to Three for All DC law. We anticipate that soon, after implementation of FY22 funding, there will be five HealthySteps locations in Wards 7 and 8 funded through DC Health. We are grateful for DC Health's strong implementation of these programs and the Council's previous investments in HealthySteps. We thank Mayor Bowser for protecting current investments in HealthySteps, and we urge the Council to allocate an additional $300,000 so that HealthySteps can expand to another site. Key reasons include:

- *Multigenerational Approach*: HealthySteps is a multigenerational approach, which is a key reason why this program is so critical. Optimal childhood development depends upon strong and positive relationships between children and their caregivers. Science has shown that experiences, both positive and negative, in the first few years of life, have lifelong effects on physical and mental health, learning capacities, and future economic productivity. Safe, stable, and nurturing relationships from adult caregivers, including parents and caregivers, provide the brain-based foundations for children's health, learning, and positive social interactions in the future. Research also indicates that supportive, responsive relationships with caring adults early in life can prevent or reverse the damaging effects of chronic stressors. Chronic stressors in the absence of protective relationships can lead to a host of adverse mental and physical health conditions. HealthySteps helps to support these positive relationships, including through the provision of direct mental health services for parents in the pediatricians' office and bypassing waiting lists for mental health services. This approach is even more critical as we navigate the effects of the pandemic on young children and their families.
- *Leveraging Trust of Pediatricians and Health Care Reach*: HealthySteps presents an enormous opportunity to effect change for young children and families because it leverages the high trust that parents and caregivers have in their pediatricians, and the strong reach of health care for young children in the District. Even with dips in well-child rates during the pandemic, our city still has a high percentage of young children and their families attending well-child visits, making it an optimal location to invest so infants, toddlers and their families can receive extra support for physical development, mental health and social determinants of health.
- *Continued Need and Demand.* We continue to hear from providers and families that there is strong interest and demand for HealthySteps to continue expanding to more pediatric primary care clinics in the District. For example, we know through outreach and conversation there is demonstrated interest and need in Ward 5. Particularly as young children and families have endured significant stress, and in some instances, trauma, from

the pandemic, now is the time to continue our investment and expansion of this essential program.

We strongly urge the Council to invest an additional $300,000 in local, recurring funds so that another clinic located in Wards 5, 7 or 8 can implement the HealthySteps model, likely supporting hundreds of additional young children and their families every year.

Home Visiting

We also strongly support a 15% increase to existing home visiting grants at DC Health to adjust for inflation since 2019 and to enable programs to adapt to the increased demands on their workforce and resources to support families during this pandemic. Increasing funding amounts for the home visiting programs - many of which have received flat funding since 2019 or earlier - is critical to the well-being of District families they serve. Home visiting programs are a critical component of our birth to three system of services and supports in DC.

DC's home visiting programs have been a vital touchpoint for families to receive long-term personalized support and stay connected to city-wide programs and services they otherwise may face barriers to accessing. Home visitors help build confidence in parents and families during the early years of their child's life and tailor their services to each family's individual needs.

I thank DC Health and the Council for their continued support of infants, toddlers and their families. Thank you for the opportunity to testify today and I'm happy to answer any questions you may have.

Testimony to the Committee on Health
For the Budget Oversight Hearing for DC Health
Eleanor Catherino
Youth Advocate, Young Women's Project
March 29, 2022

Greetings Chairman Gray and the members of the Committee on health. I want to thank you for giving me the chance to testify today. I am Eleanor Catherino, I am 16 and I live in Ward 3. I will be graduating from Jackson-Reed High School (formerly known as Woodrow Wilson) in 2024 and I hope to study psychology and journalism. I see my future to be bright, I wish to be a therapist, which I feel I could be successful in several different branches of this profession, and I want to make my change in the world even if it is small. After being offered the opportunity to become a peer health educator, I enthusiastically took the position and, frankly, it has been so much more of a learning experience than I ever thought it would be. So, I am testifying today to share my insight and experience that I've had in this work and inspire you to restore the funding in the DOH FY23 budget to sexual health education and condom distribution in DC High Schools.

There is a lot I wish to address about my experiences with YHEP, and first it is perhaps worthwhile to reiterate that STI and pregnancy rates in D.C. are high. According to the CDC, youth aged 15-24 make up approximately ¼ of the sexually active population, but account for half of new sexually transmitted infections in the U.S. each year.[1] Before joining this program, I didn't have many opinions on things like sex and resources around it. I certainly felt that youth should get educated and everyone should get the things they need, but past that I didn't pay any mind. By participating in this program, it has caused me to talk to other people and see small glimpses into their lives. It has allowed me to notice how many of peers do not have proper sexual health knowledge. Many have engaged in risky sex with the potential of contracting STIs and/or unplanned pregnancy. Sex is a fact of life and expecting abstinence does not suffice. Proper sexual health education, condom access and access to resources are important for youth to make appropriate sexual health decisions. Youth health educators contribute to safer sex decisions, STI prevention, pregnancy prevention, etc. by providing information about access to safer sex materials, sharing accurate information about safer sexual health practices, and referring people to clinics. Sexual health cannot be shunned or ignored, and education and resources for issues that come with it need to be as available as resources that comes with things like sports, more so in fact. That's why I love my job as a youth health educator. Because it pushes exactly this, it provides youth with the knowledge and awareness of their own sexual health and behaviors. YHEP works to combat negative stereotypes and biases toward marginalized groups, including LGBTQ+ people, creating more positive and inclusive environments in their friend groups, schools, and communities. YHEP empowers teens, like me, to educate our peers in classrooms, hallways, before and after school. Essentially, what I mean is this: youth have the right to know about their own bodies and make informed decisions about their health.

It’s funny how much you hear when you open your ears a bit and talk to different people. Among my peers, there are a lot of misconceptions like “they don't use condoms'', the reference of being “clean” when people mention STIs and talk about the withdrawal method. Before joining YHEP I would have ignored it, and yet now, I can advise them otherwise and correct their misconceptions. I can only hope that they take my words into mind and do what is best. Not only do these words get heard by them, but they also get heard by everyone around them, and something I now pride myself on is that I would have never bothered doing something like this before. In fact, when I get into these conversations with people, others around will ask questions, and when I give condoms out later in the day, I will find that they have given some to friends that needed some, and that they gave some further, reaching more people than I could have ever hoped. It has become pretty clear, at least in my school, that condoms are quite easy to get, people will occasionally walk up and ask me for them of their own accord, and there are even some running jokes about it, and I notice many of my close friends sharing information that I teach.

Jackson-Reed High School is doing an okay job when it comes to sexual health education and condom distribution. It’s pretty clear that administration of the school does not take much interest in the matter, as basically the only mentions of safe sex are in the nurse’s office. There are condoms that anyone can take outside the nurse’s office. Sex education… happens but it could be better. It needs to be better. There are so many ways that could be done to make it better like providing STI testing at schools or actively encouraging talk about sexual health. This is exactly why this program is so important. Youth health educators bridge the gap. Youth health educators are constantly interacting with their peers spreading this information. As of now, with the school year nearing its end, we are working on virtual wellness centers in hopes to continue to educate our peers during the summer break. The sexual health virtual wellness rooms increase youth’s accessibility to sexual health information from anywhere. The sexual health wellness centers will offer rooms on various sexual health topics and focused on specific information like clinics located near our school. The work I’ve done with this group has been fulfilling and has certainly had a good effect on me, and not only that, but I have also seen this work having a good effect on my high school. Teenagers relate and listen to teenagers, and it is far more comfortable and less awkward to hear about sex from someone your age than someone 20-40 years older. They’re willing to say things or ask things they wouldn’t normally ask a teacher, and they’re willing to listen far more than they would sitting at the back of their classroom on a computer with a downloaded VPN, watching YouTube.

And due to this, we ask that the Committee allocate $200,000 within the DOH budget to the purposes of sex education, clinic referrals, and condom distribution in DCPS and Charter high schools with the goal of reaching 25 schools and 10,000 youth. Peer educators are a necessary part of this because, as I’ve addressed before, teenagers are more comfortable with teenagers, and these peer educators should be paid for this work. Sex is inevitable, it is a fact of life, so we need to accept it and help people and it is evident to me that the best way of doing this is through YHEP. Thank you!

Source:
1: DC YRBS Report, 2019 -
https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2019%20DC%20YRBS%20Report.pdf

Testimony to the Committee on Health
For the Budget Oversight Hearing for DC Health
Gabby Cole
Youth Advocate, Young Women's Project

Hello Chairman Gray and Members of the Committee of Health. My name is Gabrielle Cole and I live in ward 1 of D.C. I am a junior at Benjamin Banneker Academic High School and I hope to be a lawyer in the future. I have been a peer educator for the Young Women's Project since 2021. I became a peer educator so that I can spread important information on sexual health and hopefully help teens have a better understanding of sexual health. I am testifying today to discuss the work that I have been doing as a peer educator and I strongly encourage you to restore funding to the Department of Health FY2023 budget that will support sexual health education and condom distribution in high schools.

Sexual health is important because it teaches teens about how to stay safe during sex. Taking sex classes can teach teens different ways to protect themselves against STIs and pregnancy. Sexual health is also about learning your body and understanding it, things that are important as a person gets older. Along with sex, sexual health also is about understanding consent and boundaries which are not only important in sex, but also in everyday life.

At my school, Benjamin Banneker, I have not encountered a sexual health class. I have seen condoms in a classroom once. When I asked other students if they knew about it, no one did, which showed me that the school was not advertising them. Many students in my grade have never had a sex ed class, or only had a "make sure to use a condom" talk in middle school, but nothing in depth. At the start of my work, the majority of the students I encountered could not answer questions like "what are the steps to put a condom on?" or "What are flavored condoms used for?" or "how often should you get tested for STIs." Now with my work, many of my classmates better understand safe sex because youth health educators fill the gaps in school-based sex education. Each term, I am responsible for conducting a classroom presentation. In the fall and spring, I taught over 100 students at Benjamin Banneker about condoms and LARCs. My presentation detailed the different types of condoms, how to put one on, how to safely dispose of condoms, what LARCs are and their benefits over other contraceptives, and how to get LARCs and condoms. YBRS reported that "the use of hormonal forms of contraception such as birth control pills, rings, patches, shots, implants, or IUDs has increased by almost 10% since 2015—from 22.7% in 2015 to 31.8% in 2019.[1,2]" These statistics illustrate the importance of youth health educators increasing their peer's knowledge and awareness of hormonal contraceptives. I am now transferring that presentation into a virtual wellness center room. The Sexual Health Wellness Center is important because it gives students a safe space to learn and explore questions they may have, especially if they are too shy to ask an educator or cannot locate one of us. By having virtual wellness centers, they will have access to needed resources like free condoms, clinics, birth control, and learning about sexual health virtually.

The Youth Health Education Program is important because it helps teens gain an understanding

of sexual health as a whole. This program trains youth on various sexual health topics such as gender and sexuality, anatomy, menstruation, condom usage, pregnancy prevention, and STIs. Us, trainees, then educate our peers, answer their questions, link them to resources and create a safe space to talk about sex. I love learning things I did not know, and everything I learn is not always sex related. I learn about having a healthy relationship, recognizing unhealthy actions and addressing them, how to talk about and respect boundaries, how to care for my mental health and so much more. I especially enjoy being able to also teach others the same thing and watch them make decisions using the information I have given them. YWP has given me the tools, skills and knowledge I need to address my peers and link them to resources. The Young Women's Project develops youth leaders and supports our work to solve community problems. YHEP also provides over 60 jobs for youth in over 10 DC high schools. Youth health educators work as peer educators, employees and advocates who educate peers on safer sex, earn money for their families, and raise awareness with public officials about important issues facing youth. YWP youth health educators work every day to make our city a better place.

Our work at YWP has impacted many young students in different DCPS schools for the better because many students feel comfortable talking to young students like myself, and for those that are not comfortable we adjust for them. We are asking that the committee allocate $200,000 within the DOH budget to the specific purpose of sex education, clinic referrals, and condom distribution in DCPS and Chart high schools with a goal of reaching 25 schools and 10,0000 youth. Peer educators should be engaged as part of this work to increase effectiveness (since adults are not able to reach youth through social media or text message) and should be paid for their work. Sex education is important so that many can stay informed on way to protect themselves and the best way is through our program. Thank you!

Source:

1. DC YRBS Report, 2019 - https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2019%20DC%20YRBS%20Report.pdf
2. DC YRBS Report, 2015 - https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2015%20YRBS%20Report.pdf

Thank you, committee, for the opportunity to testify today. My name is Genia, and I am Nurse Home Visitor for the Nurse Family Partnership Of DC at Mary's Center. I will share with you all that I was a young immigrant mother in the states similar to families that I work with now. I can personally relate to the challenges some of the mothers I work with face, this time around they have me as a support to overcome these challenges. Overcoming the challenges alone, made me want to be someone who could support others who were in similar situations.

The best part about the Nurse aspect of NFP is that I'm walking in as a trusted health professional that a mother will have consistent access to. We get to build a relationship as Mother and NHV that, yes, can focus on some clinical assessments and health education, and further can truly begin to address upstream socio-economic determinants of health. I will not take credit for the successes the mothers I partner with experience and will use this time to talk about some the successes we've seen so far. Sometimes I might support a family fill out a form because the language barrier exists, accompany a client to their housing services intake or access a domestic violence resource, and further demystify some of the challenges of caring for an infant. First time mothers have a steep learning curve, I get to be a support to their learning through providing developmentally appropriate expectations of their child and help them build a healthy parent-child attachment and relationship that helps prevent / avoid delays in care, development, access to the appropriate information and care that the family needs. I'll go further and add that the home visiting strategy helps participants create healthy coping mechanisms of chronic stress, avoid injury, abuse, and neglect of a baby with information on home safety education / babyproofing. One of the little victories I'll share is a teen mother who gave birth to a healthy full-term baby who was connected to childbirth classes and doula services after surviving IPV and housing instability. To those of you who may not know the challenge to deliver a full-term baby while navigating toxic abusive environments, it's a monumental achievement to do so. Another victory, 100% of the mothers in the program have at least initiated breastfeeding to their infants. Which is so much higher than the current DC Rate. Another patient is about ready to have her baby. I met the mother when she was just a year out from exiting the child welfare system, and housing insecure. Currently, she is now about to have a full-term baby and has recently moved into her own apartment with the father and is utilizing disability services that she should have been connected to her whole life but wasn't. These victories are only the beginning of our impact since we haven't even reached a year of implementation. I think the most impact I have as their Nurse Home Visitor is in just being in the mother's corner.

I'm glad that families have the NFP model to overcome the challenges they face. I know that I would have greatly benefited from programs that work to support first-time mothers where they are. As a Nurse Home Visitor, I can meet mothers in spaces they are most comfortable and am able to offer support that goes beyond a medical appointment. Sometimes mothers are seeking information to exit abusive relationships, navigate immigration challenges, obtaining resources and benefits that they are eligible for. The NFP model really works with the science and application of change. This means that I can build trust and rapport with a mother in that safe space, so that when they're ready we can talk about family dynamics to help develop the capacity to address their own challenges and meet their own goals of self-sustainability.

Testimony of Tininka Rahman, Program Director
Children's National Health System and Early Childhood Innovation Network

Budget Oversight Hearing
Committee on Health
Council of the District of Columbia
April 4, 2022

Good Morning Chairman Gray and members of the Committee, my name is Tininka Rahman. I am the Program Manager for the HealthySteps Program at Children's National Hospital and part of the Early Childhood Innovation Network (ECIN). The Early Childhood Innovation Network, initially spearheaded by Children's National and MedStar Georgetown University Hospital, now encompasses a large, local collaborative of health and education providers, community-based organizations, researchers, and advocates that promotes resilience in families and children from pregnancy through age 5 in Washington, DC. As you know, the HealthySteps program is part of the Birth to Three for All DC Act, which improves the comprehensive systems of supports for children's healthy growth and development. I am here today to testify on the benefit of this national model, the impact it is having on families at Children's National, and the continued need for investment in FY 23. Thank you for this opportunity to testify today.

HealthySteps is a nationally recognized and evidence-based model of pediatric primary care that embeds an early childhood specialist into the standard clinic practice to promote family wellness and healthy child development. HealthySteps is currently implemented within two Children's National Hospital primary care clinics within Ward 8. These sites at Children's are staffed by a HealthySteps specialist and a Family Support Coordinator who provide a multitude of services to patients and families at routine pediatric visits on issues such as feeding, behavior, sleep, attachment, caregiver depression and trauma, social determinants of health, and community resource navigation. Data from national evaluations of HealthySteps has shown decreased utilization of the emergency room, reduced usage of harsh parenting practices, and increased receipt of well-child visits and vaccinations.[1] Since the original pilot launched in 2017, HealthySteps has served over 2,625 children. HealthySteps works to facilitate early intervention referrals and medical appointments addressing development, autism, behavioral

[1] Information on national data and evaluations is available at www.healthysteps.org

health and varying supportive services to positively combat psychosocial circumstances. Current collaborations and partnerships have allowed us the ability to connect patient families with services, support and information at a much higher rate including drastically higher success rates with early intervention referral facilitations. By addressing these key health areas from a proactive perspective, we allow for infants and toddlers to develop, live and grow healthier lives while simultaneously reducing the likelihood for further negative diagnoses and health inequities.

The COVID-19 pandemic significantly impacted the way medical services have been provided and how our team normally connects with families during their medical visits. HealthySteps was able to pivot and continue to provide the critical support to families of newborns, providing depression screenings, anticipatory guidance and parenting support adding telehealth and virtual connection models into the options for service delivery. The program implemented a virtual support group for new moms, discussing coping skills to address parental stress and anxiety, covid isolation and over all challenges of surviving a challenging economy, community violence and ever changing school protocols for their older children. For example, HealthySteps was able to provide support for a mom who struggled to navigate the return to school protocols for her 2nd grader while caring for a 4 month-old and navigating her own challenging work environment and keeping COVID free. The virtual support group provided her with information on COVID-19 and steps she could take to keep her family safe while also providing a networking opportunity to connect with other parents. This support decreased her anxiety and provided needed information to make informed decisions.

Early childhood is a critical period for brain development and we know that the resources available to DC families to make the most of this influential health period depend on race, place, and income – an inequity that we must address in collaboration with families, neighborhoods and community leaders. Through identifying solution-based initiatives for other contributing factors that create disparities, we equally emphasize the importance of building cross-sector coordinated systems of care. We are demonstrating that when families partner with HealthySteps, childhood development and family health are immensely elevated as a result of integrated pediatric primary care and connection with other early childhood and family-serving systems.

I commend DC Health on its commitment and investment in young children and their families, especially through its effective implementation of the HealthySteps Pediatric Primary Care Program. Thank you for the opportunity to testify and I'm happy to answer any questions you may have.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Fiscal Year 2023
Budget Oversight Hearing

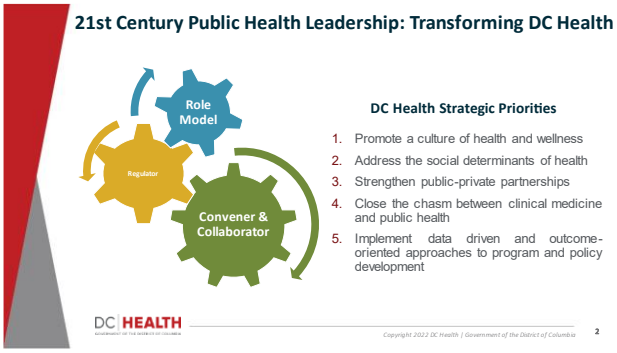
Testimony of
LaQuandra S. Nesbitt, MD, MPH
Director

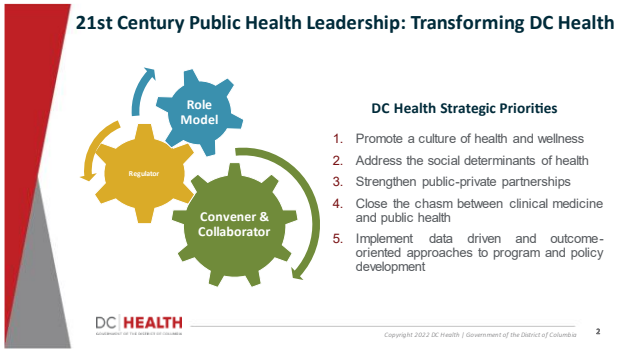
Before the
Committee on Health
Council of the District of Columbia
Vincent Gray, Chairperson

April 4, 2022
10:00 AM
Virtual Meeting Platform
The John A. Wilson Building
1350 Pennsylvania Avenue NW
Washington, DC 20004

Good morning, Chairman Gray and members of the Committee on Health. My name is Dr. LaQuandra Nesbitt, Director of the District of Columbia Department of Health, or DC Health. I am pleased to offer testimony before you today on Mayor Bowser's Fiscal Year 2023 (FY23) Proposed Budget and Financial Plan, entitled "A Fair Shot."

The District's economy is strong, and revenue has returned to pre-pandemic levels. This allows Mayor Bowser to continue supporting District residents and businesses' recovery from the pandemic while also making new investments in the future. This budget reflects the needs of District residents and aims to give more Washingtonians a fair shot by investing in a safer, stronger, healthier, and more equitable DC.

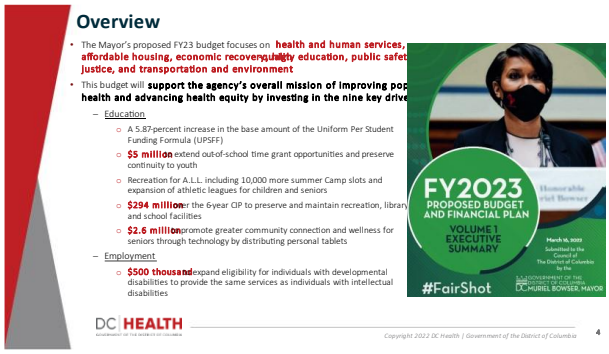




DC Health continues its focus on the District's post-pandemic landscape and strategic alignment to address the drivers of population health through an equity lens. As the Chief Health Strategist for the District, DC Health works in tandem with sister agencies, community partners, and the overall health system. Public Health 3.0, the model under which DC Health operates, leverages this Chief Health Strategist role to address the social, economic, and environmental factors that impact population health.

DC Health's administrations collaborate internally and externally to leverage our understanding of the drivers of health outcomes to promote a culture of health and wellness, address the social determinants of health, strengthen public-private partnerships, and close the

chasm between clinical medicine and public health. Additionally, to ensure success in these areas, we implement data-driven and outcome-oriented approaches to program and policy development.



Mayor Bowser's proposed Fair Shot Budget for FY23 continues significant investments in what we call the "nine key drivers of health": education, employment, income, housing, transportation, food environment, medical care, outdoor environment, and community safety. Since these areas have a larger impact on health outcomes than clinical care, this budget makes strong investments in some of the most important foundations of a healthy District of Columbia. The $19.5 billion District of Columbia proposed FY23 Fair Shot budget is also the most equitable and largest, with a 1.33% increase over the FY22 approved budget, making sizeable investments outside of DC Health to improve population health. Highlights of the Mayor's proposed investments across the District include:

- Education: A 5.87% increase in the base amount of the Uniform Per Student Funding Formula; $5 million to extend out-of-school time grant opportunities and preserve continuity to youth; Recreation for A.L.L.—including 10,000 more summer camp slots and expansion of athletic leagues for children and seniors; and $294 million over the six-year Capital Improvement Plan (CIP) to preserve and maintain recreation, library, and school facilities.

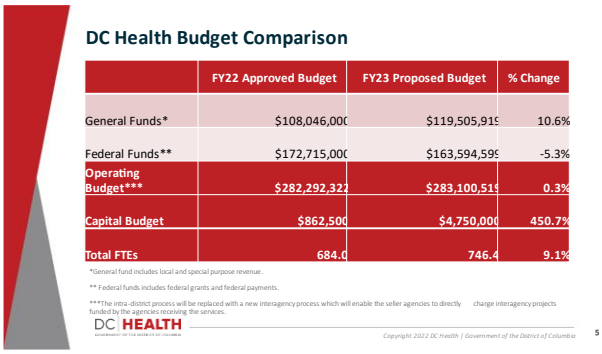
- Employment: $21 million to raise participant wages in training programs in all Department of Employment Services (DOES) programs – including the Mayor Marion S. Barry Summer Youth Employment Program (MBSYEP).
- Housing: A historic $500 million contribution to Housing Production Trust Fund and $41 million for project-sponsor vouchers to make housing deeply affordable to low-income residents; $120 million in rent and utility assistance across two years, plus $12 million for a new Housing Provider fund; and $26 million to help low-income first-time homebuyers with down payments and closing costs.
- Transportation: $200 million over six years for longer-term streetscape projects to redesign our most dangerous roads and intersections.
- Food Environment: $22 million to add fresh food access points East of the River.
- Community Safety: $1.7 million to provide 23 personnel to support high-quality care coordination, including life coaches, to provide critical violence intervention services for at-risk individuals.

As part of a commitment to continue equitably improving population health, Mayor Bowser has proposed an FY23 budget of $5.7 billion for the Health and Human Services cluster which represents an increase of 3.65% as compared to the FY22 approved budget. While 5% of cluster funding goes to DC Health, the other 95% is also geared towards improving health outcomes as follows:

- Education: $2.6 million to DACL to promote greater community connection and wellness for seniors through technology by distributing personal tablets.

- Employment: $500,000 to DDS to expand eligibility for individuals with developmental disabilities to provide the same services as individuals with intellectual disabilities.
- Income: $11.5 million to DHCF to retain direct support professionals – who care for our most vulnerable residents – by raising wages over a three-year period.
- Housing: $114.6 million to DHS across two years for modernizations and renovations of permanent and temporary support housing and shelter services; $2.8 million to enhance programs and services at the new 801 East Men's Shelter; and $31 million to invest in Homeward DC that will add permanent supportive housing vouchers for 500 more individuals, 260 more families, and 10 more youth as well as other critical outreach and prevention services so that the District can end chronic homelessness.
- Transportation: $1 million to DACL to expand city-wide mobility for seniors through increasing the Connector Card program.
- Food Environment: $750,000 to DACL for increased nutrition support through grocery card distribution for eligible seniors.
- Medical Care: $3.8 million to DBH for school mental health services and $4.2 million to DHCF to extend Alliance enrollment to 12 months and end the required in-person 6-month re-certification for District residents, and $500,000for free dental services for District seniors.
- Outdoor Environment: $750,000 to DCRA to enforce a new ban on flavored tobacco sales.

- Community Safety: $321,000 to DHS to expand capacity at Virginia Williams Family Resource Center with additional Domestic Violence specialists.



DC Health Budget Comparison

	FY22 Approved Budget	FY23 Proposed Budget	% Change
General Funds*	$108,046,000	$119,505,919	10.6%
Federal Funds**	$172,715,000	$163,594,599	-5.3%
Operating Budget***	$282,292,322	$283,100,519	0.3%
Capital Budget	$862,500	$4,750,000	450.7%
Total FTEs	684.0	746.4	9.1%

*General fund includes local and special purpose revenue.

** Federal funds includes federal grants and federal payments.

***The intra-district process will be replaced with a new interagency process which will enable the seller agencies to directly charge interagency projects funded by the agencies receiving the services.

DC HEALTH

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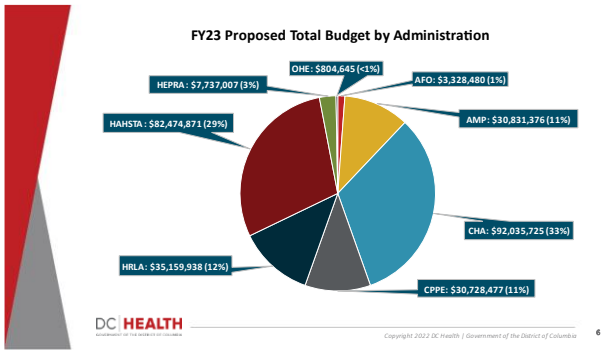
5

The proposed DC Health FY23 operating budget of $283.1 million represents a slight increase of 0.3% over the FY22 approved budget of approximately $282.3 million. More importantly, the District continues to make significant investments in public health using local dollars, with a 10.6% increase in general funds to support DC Health's activities. Additionally, DC Health's capacity is strengthened through an increase of 9.1% in FTEs. Key investments by the Mayor's proposed budget include:

- $250,000 to create a new public awareness campaign about the new services available for brain health and Dementia prevention.
- $500,000 to provide free covered dental health care services to seniors 65+ who have incomes at or below $139,900 through grants to private practice providers.
- $4.5 million to hire additional school nurses.
- $354,000 to maintain the Medical Orders for Scope of Treatment (MOST) program and move the form to an electronic system.
- $200,000 to maintain an upgraded online registry and repository solution for Emergency Medical Services (EMS) and Trauma data from healthcare providers within the District.

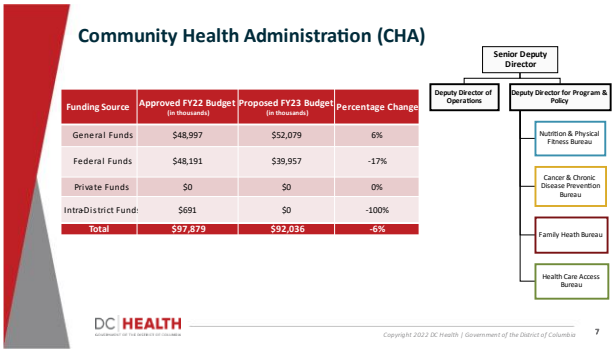
- $2.4 million to fund a new animal shelter that will support the best practices for animal care and control in the animal sheltering environment and will provide District residents with improved access to the animal shelter facility and enhanced interaction with the animals residing in the shelter.
- $183,000 to improve environmental health capacity by reducing the incidence of community hygiene related illnesses, increased public safety, and to enhance public health reporting, inspection capability, data management, and improve community hygiene-related communication and outreach in the District.



The work conducted by DC Health is aligned with our mission, vision, and values, and aims to improve population health equitably. We also look beyond financial investments to leverage policy to support programmatic interventions and drive improvements throughout the healthcare system. Some highlights of this for the proposed FY23 budget include:

- Continuing to leverage CDC immunization grant funding to support the infrastructure for routine COVID-19 vaccination by enrolling healthcare providers and promoting health literacy as a means of promoting COVID-19 immunization;
- Investing $1.5 million into the Health Professional Loan Repayment Program (HPLRP);

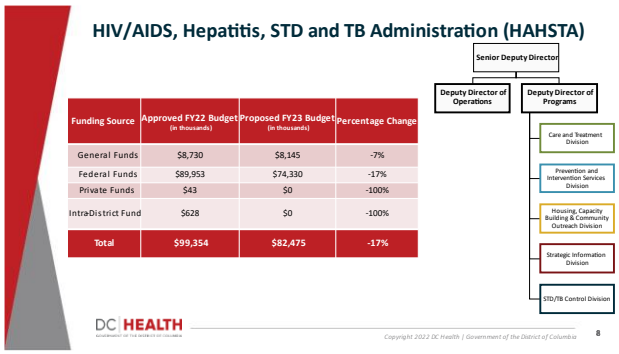
- Collaborating on reimagining the healthcare workforce;
- Updating the Pregnancy Risk Assessment Monitoring System (PRAMS) data collection efforts, including adding a COVID-19 vaccine supplement to inform DC Health's strategic planning and needs assessment;
- Releasing the SHPDA Annual Implementation Plan (AIP) in April of 2022 to guide for health system stakeholders as they implement initiatives in FY23;
- Launching a Health Literacy Strategy for the District; and
- A $2.3 million extension, in addition to the base level funding of $7.6 million, for the Overdose Data & Action (ODA) grant to support the Prescription Drug Monitoring Program, addiction consultation for providers, ongoing opioid surveillance and prevention, and a communication campaign with the Department of Behavioral Health.



Funding Source	Approved FY22 Budget (in thousands)	Proposed FY23 Budget (in thousands)	Percentage Change
General Funds	$48,997	$52,079	6%
Federal Funds	$48,191	$39,957	-17%
Private Funds	$0	$0	0%
Intra-District Funds	$691	$0	-100%
Total	$97,879	$92,036	-6%

In FY23, DC Health will begin using an updated framework to prevent the leading causes of death, protect and promote the health of mothers and children, and eliminate racial/ethnic health disparities. This work, led by CHA and in collaboration with the Office of Health Equity (OHE) and other administrations, includes highlights such as:

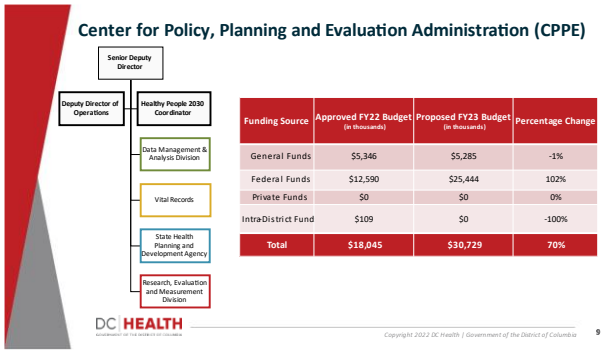
- Launching a pilot program that places community health workers at Federally Qualified Health Centers (FQHCs) to support primary care teams in treatment of high blood pressure;
- Improving community health to prevent the leading causes of death, protect and promote the health of mothers & children, and eliminate racial/ethnic health disparities;
- Updating WIC to make it an all-digital benefit system and create a single card for residents to access several healthy food supplement programs;
- Developing public facing dashboards that display city-wide progress towards preventing cancer and cardiovascular diseases using several data sources;
- Increasing funding to ensure 40 hours a week of nursing coverage (either RN or LPN) at all current school-based health suites in the District;
- Providing free dental services for seniors ages 65 and over who have incomes under $139,900;
- A campaign to spread awareness of new services available for brain health and dementia prevention; and
- Work with the Hospital Association and the PQC (Perinatal Quality Collaborative) to reduce the number of women developing severe complications during pregnancy.



Funding Source	Approved FY22 Budget (in thousands)	Proposed FY23 Budget (in thousands)	Percentage Change
General Funds	$8,730	$8,145	-7%
Federal Funds	$89,953	$74,330	-17%
Private Funds	$43	$0	-100%
Intra-District Fund	$628	$0	-100%
Total	$99,354	$82,475	-17%

The agency's FY23 HIV/AIDS elimination activities build upon the past successes of the Ryan White program. Highlights include:

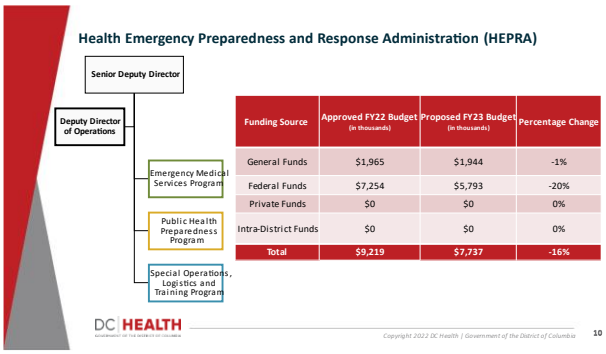
- Incentivizing positive health outcomes by linking provider performance to award size;
- Taking a "no wrong door" approach that allows community partners to provide wraparound supports to those living with HIV to get them virally suppressed and those at risk of HIV infection to keep them from acquiring HIV; and
- Leveraging community partnerships to expand a new housing initiative, PrEP Housing, which aims to improve health outcomes for men who have sex with men (MSM) of color ages 25-35 through support services and transitional housing.



Funding Source	Approved FY22 Budget (in thousands)	Proposed FY23 Budget (in thousands)	Percentage Change
General Funds	$5,346	$5,285	-1%
Federal Funds	$12,590	$25,444	102%
Private Funds	$0	$0	0%
Intra-District Fund	$109	$0	-100%
Total	$18,045	$30,729	70%

With a significant investment of federal funds, the data arm of DC Health will use $11.7 million to expand its Epidemiology and Laboratory Capacity (ELC) activities to:

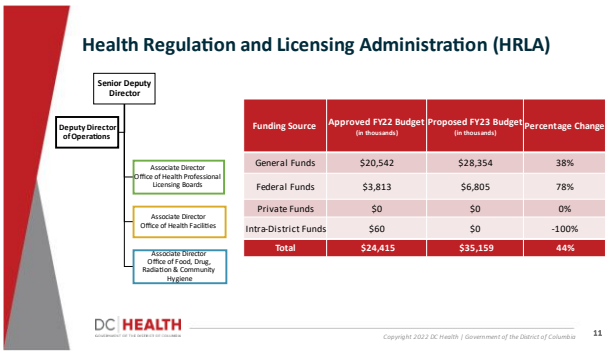
- Improve COVID-19 mitigation and detection in high-risk settings and support significant data modernization efforts throughout the agency;
- Expand wastewater surveillance to monitor COVID-19 levels and other infectious diseases;
- Modernize data systems to promote faster and more automated sharing of information;
- Enhance Project Firstline by expanding its training on infection control and prevention to additional academic institutions and healthcare settings and create a podcast for nurses and a monthly training facilitator meeting; and
- Add non-influenzas respiratory viruses to current flu surveillance data collection efforts.



Funding Source	Approved FY22 Budget (in thousands)	Proposed FY23 Budget (in thousands)	Percentage Change
General Funds	$1,965	$1,944	-1%
Federal Funds	$7,254	$5,793	-20%
Private Funds	$0	$0	0%
Intra-District Funds	$0	$0	0%
Total	$9,219	$7,737	-16%

The agency will engage in several efforts to prepare for future pandemics. This includes:

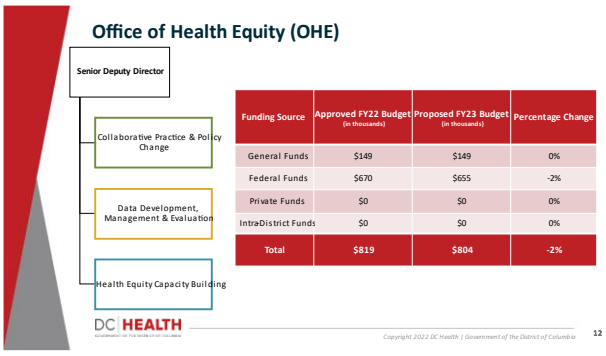
- Updating 2013 EMS regulations to modernize the profession and implement lessons learned from the COVID-19 pandemic;
- Investing $969,000 of workforce funding for personnel throughout DC Health to support emergency planning;
- Updating existing pandemic-related plans, policies, and procedures; and
- Reinvigorating and strengthening the Medical Reserve Corp Program.



Funding Source	Approved FY22 Budget (in thousands)	Proposed FY23 Budget (in thousands)	Percentage Change
General Funds	$20,542	$28,354	38%
Federal Funds	$3,813	$6,805	78%
Private Funds	$0	$0	0%
Intra-District Funds	$60	$0	-100%
Total	$24,415	$35,159	44%

DC Health's licensing and regulation body, HRLA, is undertaking expansive efforts to improve the District's healthcare workforce. This includes:

- Implementing regulations overseeing new professions;
- Updating and modernizing the licensure process itself to ensure a smooth transition from applicant to licensee for qualified individuals;
- Implementing licensure compacts;
- Overseeing the development of a brand-new animal shelter; and
- Expanding the scope of the community hygiene program.



Funding Source	Approved FY22 Budget (in thousands)	Proposed FY23 Budget (in thousands)	Percentage Change
General Funds	$149	$149	0%
Federal Funds	$670	$655	-2%
Private Funds	$0	$0	0%
IntraDistrict Funds	$0	$0	0%
Total	$819	$804	-2%

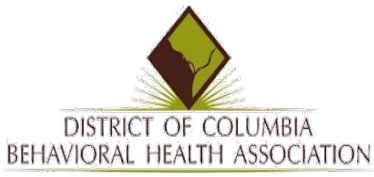
DC Health will continue its role as the District's thought leader on health equity through the development and implementation of a multi-sectoral health equity agenda in collaboration with District agencies and partners. To that end, OHE will:

- Develop and implement a Health Opportunity Index, and
- Work with our sister agencies and community partners to implement a multi-sectoral health equity agenda.

Mayor Bowser's FY23 proposed Fair Shot Budget continues a strong commitment to investing in equitable health outcomes for District residents, visitors, and workers. It continues existing investments in critical areas such as maternal and child health and expands into newer areas such as building out a healthcare workforce designed for the post-pandemic future. I want to thank DC Health's team of dedicated public health professionals for developing and implementing strategies that work to improve population health, while still engaging in COVID-19 related activities that help the District recover from the pandemic. I would also like to honor those first responders and other public health professionals who have served the public and are no longer with us. On behalf of DC Health and the entire team, I send my thoughts and prayers to their loved ones.

DC Health continues to ensure that we are ready for the next pandemic by identifying lessons learned from COVID-19. Under the Mayor's FY23 proposed Fair Shot Budget, DC Health will be better prepared for future pandemics and will build a safer, stronger, healthier, and more equitable District. We look forward to continuing to work with you, Chairman Gray, members of the Committee on Health, and the Council, in addition to our clinical and community partners, to keep all District residents healthy and safe.

This concludes my testimony. I am available to respond to questions at this time.



April 15, 2022

The Honorable Vincent C. Gray
Chair, Committee on Health
Council of the District of Columbia
1350 Pennsylvania Avenue NW, Suite 406
Washington, DC 20004

Dear Chairman Gray,

We want to first thank you for your continued support of the health care industry throughout the pandemic, particularly when it came to licensure and the implementation of the legislative waiver. As DC Health and health providers transition back to regular order, it is critical that the Health Regulation and Licensing Administration has the resources needed to process license applications and provide additional support to licensees as well.

We ask that the Committee use certified fund balances across the various special purpose licensure funds to authorize the hiring of at least fifteen licensing support FTEs on a recurring basis to improve the customer experience. The FTEs are needed across many boards including the Board of Medicine, Board of Nursing, Board of Dentistry, Board of Long-Term Care Administration and the Behavioral Health and Allied Boards, to name only a few. Health Licensing Specialists are critical to the process and have to balance processing applications, taking calls, and providing in person assistance. We believe additional staff can improve the overall flow and process

Along with this letter, we have included average costs for additional Health Licensing Specialists, Supervisory Health Licensing Specialists and Licensing Assistants in order to aid in the formulation process and inform discussions with the agency and Council's Budget Office.

As health associations, we share DC Health's concerns regarding healthcare workforce challenges. We look forward to continued partnership with DC Health to ensure that their licensure staffing needs are met. We stand ready to assist and answer any questions you or your staff may have about this request. You can contact Justin Palmer directly at jpalmer@dcha.org for additional information.

Sincerely,

DC Coalition of Disability Service Providers
District of Columbia Behavioral Health Association
District of Columbia Dental Society
District of Columbia Health Care Association
District of Columbia Hospital Association
District of Columbia Primary Care Association
Medical Society of the District of Columbia

Agency Operating Budget by Program

Program	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
Department of Behavioral Health					
0000 - (no program selected)	$0	$0	$0	$0	$0
1000 - AGENCY MANAGEMENT	$24,042,213	$28,433,442	$26,859,759	$0	$26,859,759
100F - DBH FINANCIAL OPERATIONS	$1,996,650	$2,230,398	$2,477,958	$0	$2,477,958
1800 - BEHAVIORAL HEALTH AUTHORITY	$4,800,390	$5,816,784	$6,506,086	($125,076)	$6,381,010
3800 - ST. ELIZABETHS HOSPITAL	$109,605,106	$113,486,407	$104,389,969	($77,269)	$104,312,700
4800 - BEHAVIORAL HEALTH SERVICES AND SUPPORTS	($43)	$0	$0	$0	$0
4900 - ACCOUNTABILITY	$3,566,776	$3,626,509	$3,478,460	($128,782)	$3,349,678
5800 - CLINICAL SERVICES DIVISION	$39,119,829	$23,209,144	$14,198,202	($160,564)	$14,037,638
5900 - SYSTEM TRANSFORMATION	$5,970,198	$0	$0	$0	$0
6500 - ADULT/TRANSITIONAL YOUTH SERVICES	$0	$113,778,688	$138,979,928	($1,139,473)	$137,840,455
6600 - CHILD/ADOLESCENT/FAMILY SERVICES	$0	$59,830,654	$48,494,824	$2,463,107	$50,957,931
6700 - "POLICY, PLANNING, & EVALUATION ADMIN "	$0	$0	$0	$118,000	$118,000
6800 - ADDICTION PREVENTION AND RECOVERY ADMIN	$0	$0	$0	$0	$0
6900 - COMMUNITY SERVICES	$140,361,288	$0	$0	($108,556)	($108,556)
7000 - ACTIVE TREATMENT	$0	$0	$0	$0	$0
9220 - DEPARTMENT OF MENTAL HEALTH - P-CARD	$0	$0	$0	$0	$0
9960 - YR END CLOSE	($11,395)	$0	$0	$0	$0
9980 - PAYROLL DEFAULT PROGRAM	$0	$0	$0	$0	$0
DCRP - DISTRICT RECOVERY PLAN	$0	$0	$10,158,063	$0	$10,158,063
TOTAL GROSS FUNDS	**$329,451,014**	**$350,412,027**	**$355,543,250**	**$841,387**	**$356,384,637**
Department of Health					
0000 - (no program selected)	$0	$0	$0	$0	$0
1000 - AGENCY MANAGEMENT SUPPORT	$25,785,723	$29,305,082	$30,831,376	$0	$30,831,376
100F - AGENCY FINANCIAL OPERATIONS	$2,502,498	$3,256,271	$3,328,480	$0	$3,328,480
2000 - ADDICTION PREVENTION & RECOVERY ADMIN	$0	$0	$0	$0	$0
2500 - HLTH EMERG PREPAREDNESS AND RESP.ADMIN	$11,235,213	$9,219,112	$7,737,007	$0	$7,737,007
3000 - HIV/AIDS HEPATITIS STD AND TB ADMIN	$89,618,236	$99,354,397	$82,474,871	$700,000	$83,174,871
4500 - HEALTH REGULATION AND LICENSING ADMIN.	$0	$0	$0	($2,918,369)	($2,918,369)
4500 - HEALTH REGULATION AND LICENSING ADMIN.	$25,760,201	$24,414,487	$35,159,938	$1,048,351	$36,208,289
5000 - PRIMARY CARE AND PREVENTION ADMIN.	$607,969	$0	$0	$0	$0
7000 - OFFICE OF HEALTH EQUITY	$653,790	$818,952	$804,645	$0	$804,645
8500 - COMMUNITY HEALTH ADMINISTRATION	$85,382,272	$97,878,839	$92,035,725	$2,600,697	$94,636,422
9220 - DOH PCARD POOL	($452)	$0	$0	$0	$0
9960 - YR END CLOSE	($51,920)	$0	$0	$0	$0
9980 - PAYROLL DEFAULT PROGRAM	$0	$0	$0	$0	$0
TOTAL GROSS FUNDS	**$241,493,529**	**$264,247,141**	**$252,372,042**	**$1,430,679**	**$253,802,721**

Agency Operating Budget by Program					
Program	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
Department of Health Care Finance					
1000 - AGENCY MANAGEMENT	$31,153,937	$38,707,784	$47,708,113	($100,000)	$47,608,113
100F - AGENCY FINANCIAL OPERATIONS	$5,175,513	$6,786,406	$6,136,935	$0	$6,136,935
2000 - HEALTHCARE DELIVERY MANAGEMENT	$22,780,810	$29,032,940	$27,674,432	$0	$27,674,432
200L - LONG TERM CARE PROGRAM	$20,009,751	$23,444,775	$27,791,330	$0	$27,791,330
3000 - HEALTHCARE POLICY AND PLANNING	$4,786,282	$6,196,055	$5,198,508	$0	$5,198,508
300A - DCAS PROGRAM MANAGEMENT ADMINISTRATION	$72,403,722	$82,925,589	$73,133,587	$0	$73,133,587
5000 - HEALTH CARE FINANCE	$3,541,139,694	$3,407,944,734	$3,449,704,808	$0	$3,449,704,808
6000 - HEALTH CARE OPERATIONS	$41,599,006	$54,248,979	$55,939,073	$0	$55,939,073
8000 - HEALTH CARE REFORM AND INNOVATION	$15,262,873	$7,743,284	$13,463,605	$0	$13,463,605
9960 - YR END CLOSE	$0	$0	$0	$0	$0
DCRP - DISTRICT RECOVERY PLAN	$0	$0	$2,480,000	$0	$2,480,000
TOTAL GROSS FUNDS	**$3,754,311,588**	**$3,657,030,545**	**$3,709,230,390**	**($100,000)**	**$3,709,130,390**
Health Benefit Exchange Authority					
1000 - AGENCY MANAGEMENT	$23,031,741	$5,810,791	$5,974,210	$0	$5,974,210
100F - AGENCY FINANCIAL OPERATIONS	$703,153	$772,838	$806,495	$0	$806,495
5000 - CONSUMER EDUCATION AND OUTREACH PROGRAM	$3,018,043	$2,995,799	$3,231,707	$0	$3,231,707
6000 - BUSINESS DEVELOPMENT PROGRAM	$0	$0	$0	$0	$0
7000 - MARKETPLACE INNOVATION POLICY AND OPS	$9,466,130	$11,728,422	$13,325,626	$0	$13,325,626
8000 - IT RELATED OPERATIONS	$13,020,454	$11,534,130	$12,346,018	$0	$12,346,018
TOTAL GROSS FUNDS	**$49,239,520**	**$32,841,979**	**$35,684,055**	**$0**	**$35,684,055**
Medicaid Reserve					
1000 - MEDICAID RESERVE	$0	$0	$0	$0	$0
TOTAL GROSS FUNDS	**$0**	**$0**	**$0**	**$0**	**$0**
Not-for-Profit Hospital Corporation					
1000 - NOT FOR PROFIT HOSPITAL CORPORATION	$0	$155,000,000	$155,000,000	$0	$155,000,000
TOTAL GROSS FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
Not-for-Profit Hospital Corporation Subsidy					
1000 - NOT FOR PROFIT HOSPITAL CORP. SUBSIDY	$40,000,000	$15,000,000	$15,000,000	$0	$15,000,000
TOTAL GROSS FUNDS	**$40,000,000**	**$15,000,000**	**$15,000,000**	**$0**	**$15,000,000**
Office of the Deputy Mayor for Health and Human Services					
1000 - AGENCY MANAGEMENT	$1,747,383	$2,343,728	$2,343,376	$0	$2,343,376
2000 - HUMAN SUPPORT SERVICES	$337,894	$162,120	$517,841	$0	$517,841
3000 - THRIVE BY FIVE COORDINATING COUNCIL	$634,137	$416,694	$0	$0	$0

Agency Operating Budget by Program					
Program	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
9220 - OFFICE OF THE DEPUTY MAYOR FOR HSS-PCARD	$6,781	$0	$0	$0	$0
9980 - PAYROLL DEFAULT PROGRAM	$0	$0	$0	$0	$0
TOTAL GROSS FUNDS	**$2,726,195**	**$2,922,542**	**$2,861,218**	**$0**	**$2,861,218**
GRAND TOTAL	**$4,417,221,846**	**$4,477,454,233**	**$4,525,690,955**	**$2,172,066**	**$4,527,863,021**

Operating Budget Summary						
Fund Type	Fund Detail	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
DC Health Benefit Exchange Subsidy						
LOCAL FUND	CONTINGENCY CASH RESERVE FUNDING COVID19	$0	$0	$0	$0	$0
TOTAL GROSS FUNDS		**$0**	**$0**	**$0**	**$0**	**$0**
Department of Behavioral Health						
DEDICATED TAXES	GAMBLING ADDICTION TREATMENT & RESEARCH	$0	$200,000	$200,000	$0	$200,000
FEDERAL GRANT FUND	FEDERAL GRANTS	$37,675,422	$38,852,910	$39,308,586	$0	$39,308,586
FEDERAL GRANT FUND	FEDERAL GRANTS - COVID19	$3,673,669	$0	$8,487,366	$0	$8,487,366
FEDERAL GRANT FUND	MEDICAID PUBLIC PROVIDER RECOVERY GRANT	$0	$0	$7,245,763	$0	$7,245,763
FEDERAL MEDICAID PAYMENTS	FEDERAL MEDICIAD PAYMENTS	$2,265,946	$2,857,676	$2,742,751	$0	$2,742,751
FEDERAL PAYMENTS	ARPA - COUNTY	$0	$3,828,001	$0	$0	$0
FEDERAL PAYMENTS	ARPA - MUNICIPAL	$0	$6,392,785	$7,995,785	$0	$7,995,785
FEDERAL PAYMENTS	ARPA - STATE	$3,093,001	$0	$2,162,278	$0	$2,162,278
LOCAL FUND	(no fund selected)	$0	$0	$0	($60,651)	($60,651)
LOCAL FUND	CONTINGENCY CASH RESERVE FUNDING COVID19	$0	$0	$0	$0	$0
LOCAL FUND	CONTINGENCY RESERVE	$0	$0	$0	$0	$0
LOCAL FUND	LOCAL - APPROPRIATED FUNDS	$261,161,101	$287,275,225	$298,081,971	$902,038	$298,984,009
LOCAL FUND	LOCAL FUNDING - COVID-19	$0	$0	$0	$0	$0
LOCAL FUND	MEDICAID STIMULUS GRANT - LOCAL MATCH	$0	$83,847	$0	$0	$0
LOCAL FUND	RESERVE FUNDS	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	ASSESSMENT & TREATMENT NEEDS FOR ADULTS	$67,703	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	CFSA CHOICE PROVIDERS	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	CFSA TRAIN FAMILY COACH & FAMILY SERVICE	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	CFSA WRAP AROUND SVCS	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	CO-LOCATED STAFF FOR THE NC INITIATIVE	$196,289	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	CRISIS COUNSELING IMMEDIATE SVCS PROGRAM	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DBH ASSESSMENT OF TANF CUSTOMERS AT DHS	$560,000	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DBH-OSSE PRE-K ENHANCEMENT AND EXPANSION	$630,128	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DISTRICT OF COLUMBIA PROJECT AWARE	$419,250	$514,978	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DMH APRA PREVENTION TREATMENT TO DC TANF	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	ELEMENTARY AND SECONDARY SCH RELIEF FUND	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	FEDERAL MEDICAID TRANSFER	$7,136,602	$8,390,236	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	FUNCTIONAL FAMILY THERAPY IMPLEMENTATION	$44,336	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	FUNCTIONAL FAMILY THERAPY TRAINING	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	GOVERNOR'S EMERGENCY EDUCATION RELIEF	$1,357,854	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	IN HOME STAFF COLLABORATIVE WITH CFSA	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	MHRS DAY TREATMENT - FEE FOR SERVICE	$4,300,000	$4,300,000	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	PUBLIC HEALTH CRISIS RESPONSE	$4,014,459	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	REIMBURSEMENT FROM EP0	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	TRANSITIONAL EMPLOYMENT PROGRAM DIVISION	$42,939	$104,883	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	UPGRADE TO DATA WITS SYSTEM FOR SUD	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	YOUTH MENTAL HEALTH SUICIDE PREV MODULES	$10,080	$0	$0	$0	$0
PRIVATE DONATIONS	PRIVATE DONATIONS	$7,571	$161,153	$36,000	$0	$36,000
PRIVATE GRANT FUND	COVID - 19 PRIVATE GRANTS	$56,977	$0	$0	$0	$0
PRIVATE GRANT FUND	PRIVATE GRANT FUND	$137,501	$486,290	$486,290	$0	$486,290
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	AGREEMENT WITH INDEPENDENT AGENCIES	$0	$17,000	$50,000	$0	$50,000
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	DMH ENTERPRISE FUND	$4,920	$25,000	$25,000	$0	$25,000
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	DMH FEDERAL BENEFICIARY REIMBURSEMENT	$2,125,320	$2,144,962	$2,098,080	$0	$2,098,080
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	DMH MEDICARE & 3RD PARTY REIMBURSEMENT	$469,947	$500,000	$500,000	$0	$500,000
TOTAL GROSS FUNDS		**$329,451,014**	**$356,134,948**	**$369,419,870**	**$841,387**	**$370,261,257**

Operating Budget Summary						
Fund Type	Fund Detail	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
Department of Health						
FEDERAL GRANT FUND	FEDERAL GRANT FUND	$0	$0	$0	$0	$0
FEDERAL GRANT FUND	FEDERAL GRANTS	$121,653,724	$147,530,264	$137,027,448	$0	$137,027,448
FEDERAL GRANT FUND	FEDERAL GRANTS - COVID19	$58,844,828	$7,122,508	$21,567,151	$0	$21,567,151
FEDERAL GRANT FUND	FEDERAL GRANTS STIMULUS OVER AND ABOVE	$0	$0	$0	$0	$0
FEDERAL GRANT FUND	PUBLIC HEALTH CRISIS RESPONSE	$2,469,220	$2,749,220	$0	$0	$0
FEDERAL PAYMENTS	ARPA - COUNTY	$0	$1,941,000	$0	$0	$0
FEDERAL PAYMENTS	ARPA - STATE	$378,038	$7,541,500	$0	$0	$0
FEDERAL PAYMENTS	ARPA FUNDS 2021	$0	$831,000	$0	$0	$0
FEDERAL PAYMENTS	CORONAVIRUS RELIEF FUND	$0	$0	$0	$0	$0
FEDERAL PAYMENTS	FEDERAL PAYMENTS - INTERNAL	$4,198,612	$5,000,000	$5,000,000	$0	$5,000,000
LOCAL FUND	ARPA - LOCAL REVENUE REPLACEMENT	$0	$50,000	$0	$0	$0
LOCAL FUND	CONTINGENCY CASH RESERVE FUNDING COVID19	$0	$0	$0	$0	$0
LOCAL FUND	HEALTH PROFESSIONAL RECRUITMENT FUND	$607,969	$0	$0	$0	$0
LOCAL FUND	LOCAL FUNDS	$86,104,049	$88,825,692	$94,695,913	$4,349,048	$99,044,961
OPERATING INTRA-DISTRICT FUNDS	CFSA - VITAL RECORDS	$0	$20,000	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	CSFA PAT PROGRAM BUDGET	$100,945	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DC BOARD OF ELECTIONS - VITAL RECORDS	$0	$5,000	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DC HEALTH BED BUG INSPECTION	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DC OPIOID RESPONSE	$7,002,846	$627,803	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DC PUBLIC LIBRARY - VITAL RECORDS	$0	$3,500	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DCRA HEALTH INSPECTIONS	$33,184	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DOH TEEN PREGNANCY	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DYRS BIRTH CERTIFICATES	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DYRS JUVENILE FACILITIES INSPECTION	$5,854	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	FEMA PUBLIC ASSISTANCE	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	HEALTH CARE FIANCE DC LINKAGE TRACK SYS	$227,628	$280,846	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	ID-ON SITE INSP. FOR SUMMER MEAL SERVICE	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	LICENSE CERTIFICATION EMERGENCY MEDICAL	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	MPD SUBLEASE	$57,900	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	NEW HOSPITAL AT SAINT ELIZABETH ACT	$300,000	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	OAG- CHILD SUPPORT	$73,271	$80,250	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	PUBLIC HEALTH CRISIS RESPONSE	$1,280,000	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	REIMBURSEMENT FROM EP0	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	RODENT ABATEMENT SERVICES DOH/DHS	$0	$60,000	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	SCHOOL HEALTH NURSING SUITE SUPPLIES	$158,680	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	SENIOR NUTRITION PROGRAM	$410,000	$410,000	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	SUPPORT SVC FOR CHILDREN FROM BIRTH TO 5	$0	$0	$0	$0	$0
PRIVATE GRANT FUND	PRIVATE GRANT FUND	$255,299	$42,988	$0	$0	$0
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	BOARD OF MEDICINE	$9,112,309	$9,921,560	$13,844,667	($2,918,369)	$10,926,298
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	CIVIC MONETARY PENALTIES	$0	$0	$0	$0	$0
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	COMMUNICABLE AND CHRONIC DISEASE	$2,389,472	$2,594,639	$3,103,246	$0	$3,103,246
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	EMS FEES	$10,065	$237,893	$181,200	$0	$181,200
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	ICF / MR FEES & FINES	$140,681	$264,074	$276,200	$0	$276,200
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	OTHER MEDICAL LICENSES AND FEES	$0	$0	$0	$0	$0
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	PHARMACY PROTECTION	$2,178,142	$1,728,781	$2,540,912	$0	$2,540,912
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	RADIATION PROTECTION	$171,433	$140,863	$257,833	$0	$257,833
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	SHPDA ADMISSION FEE	$293,844	$468,070	$375,956	$0	$375,956
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	SHPDA FEES	$275,812	$1,060,983	$1,708,743	$0	$1,708,743

Operating Budget Summary						
Fund Type	Fund Detail	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	VITAL RECORDS REVENUE	$2,343,183	$2,753,889	$2,521,248	$0	$2,521,248
TOTAL GROSS FUNDS		**$301,076,987**	**$282,292,322**	**$283,100,519**	**$1,430,679**	**$284,531,198**
Department of Health Care Finance						
DEDICATED TAXES	DC PROVIDER FEE	$4,770,931	$8,716,080	$5,544,178	$0	$5,544,178
DEDICATED TAXES	HEALTHY DC FUND	$58,057,172	$60,748,426	$66,927,696	$0	$66,927,696
DEDICATED TAXES	HOSPITAL ASSESSMENT TAX	$8,454,037	$8,454,037	$8,454,038	$0	$8,454,038
DEDICATED TAXES	NURSING HOMES QUALITY OF CARE FUND	$20,958,476	$17,215,325	$17,654,971	$0	$17,654,971
DEDICATED TAXES	STEVIE SELLOW'S	$4,911,714	$8,085,517	$6,524,194	$0	$6,524,194
FEDERAL GRANT FUND	FEDERAL GRANTS	$2,250,176	$3,206,819	$5,174,115	$0	$5,174,115
FEDERAL MEDICAID PAYMENTS	FEDERAL MEDICIAD PAYMENTS	$2,827,516,339	$2,553,572,305	$2,663,283,088	$0	$2,663,283,088
FEDERAL PAYMENTS	ARPA - COUNTY	$0	$500,000	$0	$0	$0
FEDERAL PAYMENTS	ARPA - MUNICIPAL	$0	$1,500,000	$2,000,000	$0	$2,000,000
LOCAL FUND	ARPA - LOCAL REVENUE REPLACEMENT	$0	$480,000	$480,000	$0	$480,000
LOCAL FUND	CONTINGENCY CASH RESERVE FUNDING COVID19	$9,900,000	$0	$0	$0	$0
LOCAL FUND	CONTINGENCY RESERVE	$0	$0	$0	$0	$0
LOCAL FUND	LOCAL FUNDS	$735,930,508	$846,748,958	$927,178,867	($100,000)	$927,078,867
OPERATING INTRA-DISTRICT FUNDS	BEHAVIORAL HEALTH TRANSFORMATION WAIVER	$1,219,955	$12,741,099	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DBH - ADULT SUBSTANCE ABUSE	$14,810	$369,320	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DBH-DHCF TELEHEALTH SERVICES	$523,757	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DHCF - HEALTH HOMES I	$171,999	$1,386,392	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DHS - DCAS LOCAL OPERATING	$5,677,576	$10,104,904	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	HCFA - DBH APRA ASTEP	$549	$2,149	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	HCFA IFS WAIVER	$214	$1,170,604	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	HCFA: DMH-REHAB OPTION PROGRAM	$17,903,494	$30,113,759	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	HCFA: MRDDA WAIVER	$54,078,856	$83,773,762	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	PERMANENT SUPPORTIVE HOUSING	$0	$1,706,852	$0	$0	$0
PRIVATE GRANT FUND	PRIVATE GRANT FUND	$0	$0	$365,701	$0	$365,701
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	ASSESSMENT FUND	$0	$46,688	$0	$0	$0
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	BILL OF RIGHTS-(GRIEVANCE & APPEALS)	$1,587,542	$2,524,463	$2,524,542	$0	$2,524,542
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	INDIVIDUAL INSUR MKT AFFORD & STABILITY	$0	$0	$600,000	$0	$600,000
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	MEDICAID COLLECTIONS-3RD PARTY LIABILITY	$383,483	$3,863,084	$2,519,000	$0	$2,519,000
TOTAL GROSS FUNDS		**$3,754,311,588**	**$3,657,030,545**	**$3,709,230,390**	**($100,000)**	**$3,709,130,390**
Health Benefit Exchange Authority						
ENTERPRISE AND OTHER FUNDS	HBX LEVEL 1 FUND - ACA GRANT	$445,451	$0	$0	$0	$0
ENTERPRISE AND OTHER FUNDS	HBX LEVEL 11 FUND	$0	$0	$0	$0	$0
ENTERPRISE AND OTHER FUNDS	HEALTH BENEFIT EXCHANGE AUTHORITY FUND	$31,691,407	$32,841,979	$35,684,055	$0	$35,684,055
ENTERPRISE AND OTHER FUNDS	MASSACHUSETTS HEALTH CONECTOR	$3,641,590	$0	$0	$0	$0
FEDERAL PAYMENTS	ARPA - MUNICIPAL	$13,461,073	$0	$0	$0	$0
PRIVATE DONATIONS	PRIVATE DONATIONS	$0	$0	$0	$0	$0
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	HEALTH BENEFIT EXCHANGE AUTHORITY FUND	$0	$0	$0	$0	$0
TOTAL GROSS FUNDS		**$49,239,520**	**$32,841,979**	**$35,684,055**	**$0**	**$35,684,055**
Medicaid Reserve						
FEDERAL MEDICAID PAYMENTS	FEDERAL MEDICIAD PAYMENTS	$0	$0	$0	$0	$0
LOCAL FUND	LOCAL	$0	$0	$0	$0	$0
TOTAL GROSS FUNDS		**$0**	**$0**	**$0**	**$0**	**$0**
Not-for-Profit Hospital Corporation						

Operating Budget Summary						
Fund Type	Fund Detail	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
ENTERPRISE AND OTHER FUNDS	ENTERPRISE AND OTHER FUNDS - HW0	$0	$155,000,000	$155,000,000	$0	$155,000,000
TOTAL GROSS FUNDS		**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
Not-for-Profit Hospital Corporation Subsidy						
LOCAL FUND	CONTINGENCY RESERVE	$25,000,000	$0	$0	$0	$0
LOCAL FUND	LOCAL FUNDS	$15,000,000	$15,000,000	$15,000,000	$0	$15,000,000
TOTAL GROSS FUNDS		**$40,000,000**	**$15,000,000**	**$15,000,000**	**$0**	**$15,000,000**
Office of the Deputy Mayor for Health and Human Services						
LOCAL FUND	LOCAL FUNDS	$1,969,078	$2,922,542	$2,861,218	$0	$2,861,218
OPERATING INTRA-DISTRICT FUNDS	DC SAFE SLEEP EDUCATION & OUTREACH PROJ	$75,000	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	DEPUTY MAYOR SUPPORT STAFF	$0	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	NATIONAL MATERNAL & INFANT HEALTH SUMMIT	$500,000	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	OUTREACH SERV. FOR HOMELESS DC RESIDENTS	$182,117	$0	$0	$0	$0
OPERATING INTRA-DISTRICT FUNDS	THRIVE BY FIVE DC WEBSITE ENHANCEMENT	$0	$0	$0	$0	$0
TOTAL GROSS FUNDS		**$2,726,195**	**$2,922,542**	**$2,861,218**	**$0**	**$2,861,218**
GRAND TOTAL		**$4,476,805,304**	**$4,501,222,335**	**$4,570,296,052**	**$2,172,066**	**$4,572,468,118**

Agency Full-Time Equivalent Summary					
Fund Type	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
DC Health Benefit Exchange Subsidy					
LOCAL FUND	0.00	0.00	0.00	0.00	0.00
TOTAL FTE	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Department of Behavioral Health					
LOCAL FUND	1,130.30	1,229.84	1,235.16	(9.10)	1,226.06
DEDICATED TAXES	0.00	0.00	0.00	0.00	0.00
FEDERAL PAYMENTS	0.00	55.00	55.00	0.00	55.00
FEDERAL GRANT FUND	94.01	88.55	147.53	0.00	147.53
FEDERAL MEDICAID PAYMENTS	5.09	4.00	3.50	0.00	3.50
PRIVATE GRANT FUND	0.80	0.00	0.00	0.00	0.00
PRIVATE DONATIONS	0.00	0.00	0.00	0.00	0.00
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	13.59	16.25	16.50	0.00	16.50
OPERATING INTRA-DISTRICT FUNDS	66.21	61.01	0.00	0.00	0.00
TOTAL FTE	**1,310.00**	**1,454.65**	**1,457.69**	**(9.10)**	**1,448.59**
Department of Health					
LOCAL FUND	139.80	157.72	177.10	11.00	188.10
FEDERAL PAYMENTS	0.00	0.00	0.00	0.00	0.00
FEDERAL GRANT FUND	420.35	378.46	425.20	0.00	425.20
PRIVATE GRANT FUND	1.25	0.30	0.00	0.00	0.00
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	113.79	141.86	144.11	0.00	144.11
OPERATING INTRA-DISTRICT FUNDS	4.11	5.68	0.00	0.00	0.00
TOTAL FTE	**679.30**	**684.02**	**746.41**	**11.00**	**757.41**
Department of Health Care Finance					
LOCAL FUND	117.15	142.89	168.23	0.00	168.23
DEDICATED TAXES	4.68	6.05	6.60	0.00	6.60
FEDERAL PAYMENTS	0.00	0.00	0.00	0.00	0.00
FEDERAL GRANT FUND	0.00	0.00	2.00	0.00	2.00
FEDERAL MEDICAID PAYMENTS	149.80	181.98	179.23	0.00	179.23
PRIVATE GRANT FUND	0.00	0.00	0.00	0.00	0.00
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	12.98	16.45	16.15	0.00	16.15
OPERATING INTRA-DISTRICT FUNDS	1.20	3.66	0.00	0.00	0.00
TOTAL FTE	**285.81**	**351.03**	**372.21**	**0.00**	**372.21**
Health Benefit Exchange Authority					
FEDERAL PAYMENTS	0.00	0.00	0.00	0.00	0.00
PRIVATE DONATIONS	0.00	0.00	0.00	0.00	0.00

Agency Full-Time Equivalent Summary					
Fund Type	FY 2021 Actuals	FY 2022 Approved	Mayor's FY 2023 Proposed	Committee Variance	Committee's FY 2023 Recommendation
SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	0.00	0.00	0.00	0.00	0.00
ENTERPRISE AND OTHER FUNDS	95.98	109.00	117.00	0.00	117.00
TOTAL FTE	**95.98**	**109.00**	**117.00**	**0.00**	**117.00**
Medicaid Reserve					
LOCAL FUND	0.00	0.00	0.00	0.00	0.00
FEDERAL MEDICAID PAYMENTS	0.00	0.00	0.00	0.00	0.00
TOTAL FTE	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Not-for-Profit Hospital Corporation					
ENTERPRISE AND OTHER FUNDS	0.00	0.00	0.00	0.00	0.00
TOTAL FTE	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Not-for-Profit Hospital Corporation Subsidy					
LOCAL FUND	0.00	0.00	0.00	0.00	0.00
TOTAL FTE	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Office of the Deputy Mayor for Health and Human Services					
LOCAL FUND	12.54	15.75	14.75	0.00	14.75
OPERATING INTRA-DISTRICT FUNDS	0.00	0.00	0.00	0.00	0.00
TOTAL FTE	**12.54**	**15.75**	**14.75**	**0.00**	**14.75**
GRAND TOTAL	**2,383.63**	**2,614.45**	**2,708.06**	**1.90**	**2,709.96**

Agency	Scenario	Committee	Agency Code	Fund Type	Fund Detail	Program	Activity	Service	CSG	Project	Proposed Change in FTEs	Resources/ Budget	Adjustment	Recurring or One-Time Change	FY22	FY23	FY24	FY25	FY26	Comments	Legislation
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	1000 - AGENCY MANAGEMENT	1040 - INFORMATION TECHNOLOGY		0020 - SUPPLIES AND MATERIALS			Budget	Reduction	Recurring		($100,000)	($102,000)	($104,040)	($106,121)	Reduction to align budget with prior year expenditures.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0050 - SUBSIDIES AND TRANSFERS			Budget	Reduction	One Time		($150,000)				Reduction to align budget with prior year expenditures.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND								Resources	Shift Local Funds to Next FY	One Time		($150,000)	$150,000			Reduction to align budget with prior year expenditures.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6635 - EARLY CHILDHOOD SERVICES		0050 - SUBSIDIES AND TRANSFERS			Budget	Reduction	Recurring		($325,669)	($332,182)	($338,826)	($345,603)	Reduction to align budget with pojected spending on the budgeted program.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6500 - ADULT/TRANSITIONAL YOUTH SERVICES	6513 - SUBSTANCE USE DISORDER TREATMENT SVCS		0050 - SUBSIDIES AND TRANSFERS			Budget	Reduction	Recurring		($1,389,473)	($1,417,262)	($1,445,608)	($1,474,520)	Reduction to align budget with pojected spending on the budgeted program.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0011 - REGULAR PAY - CONT FULL TIME		(0.50)	Budget	Reduction	Recurring		($75,506)	($76,827)	($78,172)	($79,540)	Reduction to eliminate vacant position (No. 508 - Social Worker)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($20,689)	($21,181)	($21,686)	($22,202)	Reduction of associated fringe to eliminate vacant position (No. 508 - Social Worker)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0011 - REGULAR PAY - CONT FULL TIME		(0.80)	Budget	Reduction	Recurring		($85,209)	($86,700)	($88,217)	($89,761)	Reduction to eliminate vacant position (No. 1000 - Social Worker)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($23,347)	($23,903)	($24,472)	($25,054)	Reduction of associated fringe to eliminate vacant position (No. 1000 - Social Worker)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	5800 - CLINICAL SERVICES DIVISION	5880 - FORENSICS		0011 - REGULAR PAY - CONT FULL TIME		(1.00)	Budget	Reduction	Recurring		($57,162)	($58,162)	($59,180)	($60,216)	Reduction to eliminate vacant position (No. 16241 - Forensic Mental Health Counsel)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	5800 - CLINICAL SERVICES DIVISION	5880 - FORENSICS		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($15,662)	($16,035)	($16,416)	($16,807)	Reduction of associated fringe to eliminate vacant position (No. 16241 - Forensic Mental Health Counsel)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	1800 - BEHAVIORAL HEALTH AUTHORITY	1820 - CONSUMER AND FAMILY AFFAIRS		0011 - REGULAR PAY - CONT FULL TIME		(1.00)	Budget	Reduction	Recurring		($98,176)	($99,894)	($101,642)	($103,421)	Reduction to eliminate vacant position (No. 20046 - Resiliency Specialist)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	1800 - BEHAVIORAL HEALTH AUTHORITY	1820 - CONSUMER AND FAMILY AFFAIRS		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($26,900)	($27,371)	($27,850)	($28,337)	Reduction of associated fringe to eliminate vacant position (No. 20046 - Resiliency Specialist)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	3800 - ST. ELIZABETHS HOSPITAL	3815 - ENGINEERING AND MAINTENANCE - SEH		0011 - REGULAR PAY - CONT FULL TIME		(1.00)	Budget	Reduction	Recurring		($60,651)	($61,712)	($62,792)	($63,891)	Reduction to eliminate vacant position (No. 24852 - Climate Control Maint Mechanic)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	3800 - ST. ELIZABETHS HOSPITAL	3815 - ENGINEERING AND MAINTENANCE - SEH		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($16,618)	($17,014)	($17,418)	($17,833)	Reduction of associated fringe to eliminate vacant position (No. 24852 - Climate Control Maint Mechanic)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0011 - REGULAR PAY - CONT FULL TIME		(0.80)	Budget	Reduction	Recurring		($70,142)	($71,369)	($72,618)	($73,889)	Reduction to eliminate vacant position (No. 39199 - Social Worker)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($19,219)	($19,676)	($20,145)	($20,624)	Reduction of associated fringe to eliminate vacant position (No. 39199 - Social Worker)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0011 - REGULAR PAY - CONT FULL TIME		(1.00)	Budget	Reduction	Recurring		($85,209)	($86,700)	($88,217)	($89,761)	Reduction to eliminate vacant position (No. 39203 - Social Worker)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($23,347)	($23,903)	($24,472)	($25,054)	Reduction of associated fringe to eliminate vacant position (No. 39203 - Social Worker)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	4900 - ACCOUNTABILITY	4905 - OFFICE OF ACCOUNTABILITY		0011 - REGULAR PAY - CONT FULL TIME		(1.00)	Budget	Reduction	Recurring		($101,085)	($102,854)	($104,654)	($106,485)	Reduction to eliminate vacant position (No. 43286 - Program Analyst)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	4900 - ACCOUNTABILITY	4905 - OFFICE OF ACCOUNTABILITY		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($27,697)	($28,356)	($29,031)	($29,722)	Reduction of associated fringe to eliminate vacant position (No. 43286 - Program Analyst)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	5800 - CLINICAL SERVICES DIVISION	5810 - OFFICE OF THE CHIEF CLINICAL OFFICER		0011 - REGULAR PAY - CONT FULL TIME		(1.00)	Budget	Reduction	Recurring		($68,870)	($70,075)	($71,302)	($72,549)	Reduction to eliminate vacant position (No. 99443 - Comm Behavioral Hlth Spec)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	5800 - CLINICAL SERVICES DIVISION	5810 - OFFICE OF THE CHIEF CLINICAL OFFICER		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($18,870)	($19,319)	($19,779)	($20,250)	Reduction of associated fringe to eliminate vacant position (No. 99443 - Comm Behavioral Hlth Spec)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0011 - REGULAR PAY - CONT FULL TIME		(1.00)	Budget	Reduction	Recurring		($85,209)	($86,700)	($88,217)	($89,761)	Reduction to eliminate vacant position (No. 99567 - School Behav Hlth Clin Spec)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($23,347)	($23,903)	($24,472)	($25,054)	Reduction of associated fringe to eliminate vacant position (No. 99567 - School Behav Hlth Clin Spec)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6900 - COMMUNITY SERVICES	6912 - PREVENTION/EARLY INTERVEN-SCH MENT HLTH		11 - REGULAR PAY - CONT FULL TIME		(1.00)	Budget	Reduction	Recurring		($85,209)	($86,700)	($88,217)	($89,761)	Reduction to eliminate vacant position (No.99869 - Social Worker)	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6900 - COMMUNITY SERVICES	6912 - PREVENTION/EARLY INTERVEN-SCH MENT HLTH		14 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($23,347)	($23,756)	($24,171)	($24,594)	Reduction of associated fringe to eliminate vacant position (No.99869 - Social Worker)	
Department of Health	Committee Recommendation	Committee on Health	HC0	0600 - SPECIAL PURPOSE REVENUE FUNDS (O'TYPE)	0643 - BOARD OF MEDICINE	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Reduction	Recurring		($608,702)	($619,354)	($630,193)	($641,221)	Reduction to eliminate proposed IT contracts	
	Committee Recommendation	Committee on Health		0600 - SPECIAL PURPOSE REVENUE FUNDS (O'TYPE)	0643 - BOARD OF MEDICINE							Resources	Other	Recurring		($608,702)	($619,354)	($630,193)	($641,221)	Reduction to fund 643 - Board of Medicine to eliminate proposed IT contracts	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Other	Recurring		$608,702	$619,354	$630,193	$641,221	Converted SPR from fund 643 - Board of Medicine	
Department of Health	Committee Recommendation	Committee on Health	HC0	0600 - SPECIAL PURPOSE REVENUE FUNDS (O'TYPE)	0643 - BOARD OF MEDICINE	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Reduction	Recurring		($650,000)	($661,375)	($672,949)	($684,726)	Reduction to eliminate proposed SalesForce contracts	
	Committee Recommendation	Committee on Health		0600 - SPECIAL PURPOSE REVENUE FUNDS (O'TYPE)	0643 - BOARD OF MEDICINE							Resources	Other	Recurring		($650,000)	($661,375)	($672,949)	($684,726)	Reduction to fund 643 - Board of Medicine to eliminate proposed SalesForce contracts	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Other	Recurring		$650,000	$661,375	$672,949	$684,726	Converted SPR from fund 643 - Board of Medicine	
Department of Health	Committee Recommendation	Committee on Health	HC0	0600 - SPECIAL PURPOSE REVENUE FUNDS (O'TYPE)	0643 - BOARD OF MEDICINE	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Reduction	Recurring		($1,659,667)	($1,688,711)	($1,718,264)	($1,748,333)	Reduction to eliminate proposed contracts for deliverables supporting the Board of Medicine	
	Committee Recommendation	Committee on Health		0600 - SPECIAL PURPOSE REVENUE FUNDS (O'TYPE)	0643 - BOARD OF MEDICINE							Resources	Other	Recurring		($1,659,667)	($1,688,711)	($1,718,264)	($1,748,333)	Reduction to fund 643 - Board of Medicine to eliminate proposed contracts for deliverables supporting the Board of Medicine	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Other	Recurring		$1,659,667	$1,688,711	$1,718,264	$1,748,333	Converted SPR from fund 643 - Board of Medicine	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6635 - EARLY CHILDHOOD SERVICES		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$700,000	$714,000	$728,280	$742,846	Enhancement to support the Healthy Futures program	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$2,400,000	$2,448,000	$2,496,960	$2,546,899	Enhancement to support salary increase for SBMH clinicians	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8506 - FAMILY HEALTH BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$300,000	$306,000	$312,120	$318,362	Enhancement to support the Healthy Steps Pediatric Primary Care Demonstration program	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8506 - FAMILY HEALTH BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$1,396,631	$1,424,564	$1,453,055	$1,482,116	Enhancement to support increase to grant funding for school nurse	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0011 - REGULAR PAY - CONT FULL TIME		8.00	Budget	Enhance	Recurring		$621,776	$632,657	$643,729	$654,994	Enhancement to support salary for 8 License Specialists (Salary per FTE: $77,722) to handle licensure for DC Hospital Association health professionals	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Enhance	Recurring		$125,599	$128,588	$131,649	$134,782	Enhancement to support fringe for 8 License Specialists (Fringe per FTE: $15,699.84) to handle licensure for DC Hospital Association health professionals	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0011 - REGULAR PAY - CONT FULL TIME		1.00	Budget	Enhance	Recurring		$99,810	$101,557	$103,334	$105,142	Enhancement to support salary for a Licensing Supervisor to handle licensure for DC Hospital Association health professionals	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Enhance	Recurring		$20,162	$20,642	$21,133	$21,636	Enhancement to support fringe for a Licensing Supervisor to handle licensure for DC Hospital Association health professionals	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0011 - REGULAR PAY - CONT FULL TIME		1.00	Budget	Enhance	Recurring		$53,897	$54,840	$55,800	$56,776	Enhancement to support salary for a Licensing Assistant to handle licensure for DC Hospital Association health professionals	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Enhance	Recurring		$10,887	$11,146	$11,411	$11,683	Enhancement to support fringe for a Licensing Assistant to handle licensure for DC Hospital Association health professionals	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4530 - HEALTH CARE FACILITIES REGULATION		0011 - REGULAR PAY - CONT FULL TIME		1.00	Budget	Enhance	Recurring		$96,689	$98,381	$100,103	$101,855	Enhancement to support salary for a Nurse Specialist I to handle compliance at health care facilities	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4530 - HEALTH CARE FACILITIES REGULATION		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Enhance	Recurring		$19,531	$19,996	$20,472	$20,959	Enhancement to support fringe for a Nurse Specialist I to handle compliance at health care facilities	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8506 - FAMILY HEALTH BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$100,000	$102,000	$104,040	$106,121	Transfer In from the Committee on Transportation & the Environment to increase funding for Healthy Corners	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8506 - FAMILY HEALTH BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	One Time		$150,000				Transfer In from the Committee on Government Operations & Facilities to increase funding for Healthy Corners	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8506 - FAMILY HEALTH BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$129,066	$131,647	$134,280	$136,966	Transfer In from the Committee on Transportation & the Environment to increase funding for Produce Plus	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8506 - FAMILY HEALTH BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$200,000	$204,000	$208,080	$212,242	Transfer In from the Committee on Transportation & the Environment to increase funding for Food & Friends	

Agency	Scenario	Committee	Agency Code	Fund Type	Fund Detail	Program	Activity	Service	CSG	Project	Proposed Change in FTEs	Resources/ Budget	Adjustment	Recurring or One-Time Change	FY22	FY23	FY24	FY25	FY26	Comments	Legislation
Department of Health	Committee Recommendation	Committee on Health	HCD	0100 - LOCAL FUND	0100 - LOCAL FUNDS	3000 - HIV/AIDS HEPATITIS STD AND TB ADMIN	3040 - PREVENTION AND INTERVENTION SERVICES		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	One Time			$700,000			Transfer in from the Committee on Government Operations & Facilities to restore HAHSTA grants for community organizations for HIV/AIDS prevention	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6700 - "POLICY, PLANNING, & EVALUATION ADMIN "	6702 - STRATEGIC PLANNING & POLICY		0011 - REGULAR PAY - CONT FULL TIME		1.00	Budget	Enhance	One Time			$93,000			Transfer in from the Committee on the Judiciary & Public Safety to fund salary of 1 FTE to support the creation of a Maternal Mental Health Task Force (L22-139)	L22-139
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6700 - "POLICY, PLANNING, & EVALUATION ADMIN "	6702 - STRATEGIC PLANNING & POLICY		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Enhance	One Time			$25,000			Transfer in from the Committee on the Judiciary & Public Safety to fund fringe for 1 FTE to support the creation of a Maternal Mental Health Task Force (L22-139)	L22-139
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6500 - ADULT/TRANSITIONAL YOUTH SERVICES	6509 - STATE OPIOID RESPONSE PROGRAM		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	One Time			$250,000			Transfer in from the Committee on Government Operations & Facilities to insure continuity of services to reduce opioid overdoes	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6625 - CRISIS SERVICES		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Enhance	One Time			$200,000			Transfer in from the Committee on the Judiciary & Public Safety to support the creation of a pilot program in DBH's Crisis Services Team for surivivors of disasters for mental health resources	
Department of Health	Committee Recommendation	Committee on Health	HCD	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8510 - SUPPORT SERVICES		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring			$75,000	$76,500	$78,030	$79,591	Transfer in from the Committee on Transportation & the Environment to fund mental health services grant with Crittention Services of Greater Washington
Department of Health	Committee Recommendation	Committee on Health	HCD	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8506 - FAMILY HEALTH BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring			$100,000	$102,000	$104,040	$106,121	Transfer in from the Committee on Transportation & the Environment to support a pilot program for a Diaper Bank Fund
Department of Health	Committee Recommendation Committee Recommendation	Committee on Health Committee on Health	HCD	0100 - LOCAL FUND 0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8506 - FAMILY HEALTH BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget Resources	Enhance Transfer in	One Time Recurring			$150,000			To support a home visiting program for first-time mothers who are eligible for Medicaid (BSA Subtitle X First -Time Mothers Home Visiting Program)	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Transfer in	Recurring			$100,000	$102,000	$104,040	$106,121	Transfer in from the Committee on Transportation & the Environment to increase funding for Healthy Corners
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Transfer in	One Time			$150,000				Transfer in from the Committee on Government Operations & Facilities to increase funding for Healthy Corners
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Transfer in	Recurring			$129,066	$131,647	$134,280	$136,966	Transfer in from the Committee on Transportation & the Environment to increase funding for Produce Plus
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Transfer in	Recurring			$200,000	$204,000	$208,080	$212,242	Transfer in from the Committee on Transportation & the Environment to increase funding for Food & Friends
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Transfer in	One Time			$700,000				Transfer in from the Committee on Government Operations & Facilities to restore HAHSTA grants for community organizations for HIV/AIDS prevention
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Transfer in	One Time			$118,000				Transfer in from the Committee on the Judiciary & Public Safety to fund a subtitle to create a Maternal Mental Health Task Force
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Transfer in	One Time			$250,000				Transfer in from the Committee on Government Operations & Facilities to insure continuity of services to reduce opioid overdoes
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Transfer in	One Time			$200,000				Transfer in from the Committee on the Judiciary & Public Safety to support the creation of a pilot program in DBH's Crisis Services Team for surivivors of disasters for mental health resources
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Transfer in	Recurring			$75,000	$76,313	$77,648	$79,007	Transfer in from the Committee on Transportation & the Environment to fund mental health services grant with Crittenton Services of Greater Washington
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS							Resources	Transfer in	Recurring			$100,000	$102,000	$104,040	$106,121	Transfer in from the Committee on Transportation & the Environment to support a pilot program for a Diaper Bank Fund

Committee	Committee on Health
Absolute Value Available & Proposed	(Multiple Items)

Row Labels	Sum of Available Allotment as of 16 Mar 2022 (includes Pre-Encumbrances)	Sum of FY 2023 Planned Allotment	Sum of FY 2024 Planned Allotment	Sum of FY 2025 Planned Allotment	Sum of FY 2026 Planned Allotment	Sum of FY 2027 Planned Allotment	Sum of FY 2028 Planned Allotment	Sum of FY 2023-FY 2028 Total Planned Allotment
DEPARTMENT OF BEHAVIORAL HEALTH								
VEHICLE ACQUISITION-DBH								
Existing Balances	30,161	0	0	0	0	0	0	0
VEHICLE ACQUISITION-DBH Total	**30,161**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
DATA WAREHOUSE SAN, SERVER REPLACEMENT,								
Mayor's Proposed FY23 Change	0	1,000,000	0	0	0	0	0	1,000,000
DATA WAREHOUSE SAN, SERVER REPLACEMENT, Total	**0**	**1,000,000**	**0**	**0**	**0**	**0**	**0**	**1,000,000**
DBH FACILITIES SMALL CAPITAL IMPROVEMENT								
Existing Balances	703,029	0	0	0	0	0	0	0
DBH FACILITIES SMALL CAPITAL IMPROVEMENT Total	**703,029**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ELECTRONIC HEALTH RECORD SYSTEMS REPLACE								
Mayor's Proposed FY23 Change	0	4,800,000	0	0	0	0	0	4,800,000
Existing Balances	500,000	0	0	0	0	0	0	0
ELECTRONIC HEALTH RECORD SYSTEMS REPLACE Total	**500,000**	**4,800,000**	**0**	**0**	**0**	**0**	**0**	**4,800,000**
FACILITY UPGRADES								
Approved FY22 CIP for FY23-27	0	1,150,000	0	0	0	0	0	1,150,000
Mayor's Proposed FY23 Change	0	5,750,000	2,600,000	0	0	0	0	8,350,000
Existing Balances	7,595,401	0	0	0	0	0	0	0
FACILITY UPGRADES Total	**7,595,401**	**6,900,000**	**2,600,000**	**0**	**0**	**0**	**0**	**9,500,000**
HVAC MODERNIZATION AT SAINT ELIZABETHS H								
Existing Balances	1,333,199	0	0	0	0	0	0	0
HVAC MODERNIZATION AT SAINT ELIZABETHS H Total	**1,333,199**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
INTERCOM SYSTEM								
Existing Balances	655,000	0	0	0	0	0	0	0
INTERCOM SYSTEM Total	**655,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
PHARMACY MEDICINE DISPENSING UPGRADE (PY								
Existing Balances	974,240	0	0	0	0	0	0	0
PHARMACY MEDICINE DISPENSING UPGRADE (PY Total	**974,240**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ST. ELIZABETHS HOSPITAL EHR CAP IMPROVME								
Existing Balances	1,007,284	0	0	0	0	0	0	0
ST. ELIZABETHS HOSPITAL EHR CAP IMPROVME Total	**1,007,284**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
THERMAL DOCKING STATION SYSTEM								
Existing Balances	1,755,000	0	0	0	0	0	0	0
THERMAL DOCKING STATION SYSTEM Total	**1,755,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
DEPARTMENT OF BEHAVIORAL HEALTH Total	**14,553,314**	**12,700,000**	**2,600,000**	**0**	**0**	**0**	**0**	**15,300,000**
DEPARTMENT OF HEALTH								
COMPREHENSIVE HEALTH ASSESSMENTS								
Existing Balances	0	0	0	0	0	0	0	0
COMPREHENSIVE HEALTH ASSESSMENTS Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
DC ANIMAL SHELTER RENOVATION & EXPANSIO								
Existing Balances	4,162,500	0	0	0	0	0	0	0
DC ANIMAL SHELTER RENOVATION & EXPANSIO Total	**4,162,500**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
EMERGENCY CARE CAPITAL ENHANCEMENT								
Existing Balances	0	0	0	0	0	0	0	0
EMERGENCY CARE CAPITAL ENHANCEMENT Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FOOD SAFETY AND HYGIENE INSPECTION SERVI								
Approved FY22 CIP for FY23-27	0	250,000	0	0	0	0	0	250,000
FOOD SAFETY AND HYGIENE INSPECTION SERVI Total	**0**	**250,000**	**0**	**0**	**0**	**0**	**0**	**250,000**
FUTURE DC HEALTH ANIMAL SHELTER								
Mayor's Proposed FY23 Change	0	4,500,000	4,000,000	0	0	0	0	8,500,000
FUTURE DC HEALTH ANIMAL SHELTER Total	**0**	**4,500,000**	**4,000,000**	**0**	**0**	**0**	**0**	**8,500,000**
DEPARTMENT OF HEALTH Total	**4,162,500**	**4,750,000**	**4,000,000**	**0**	**0**	**0**	**0**	**8,750,000**
DEPARTMENT OF HEALTH CARE FINANCE								

Committee	Committee on Health
Absolute Value Available & Proposed	(Multiple Items)

Row Labels	Sum of Available Allotment as of 16 Mar 2022 (includes Pre-Encumbrances)	Sum of FY 2023 Planned Allotment	Sum of FY 2024 Planned Allotment	Sum of FY 2025 Planned Allotment	Sum of FY 2026 Planned Allotment	Sum of FY 2027 Planned Allotment	Sum of FY 2028 Planned Allotment	Sum of FY 2023-FY 2028 Total Planned Allotment
CLINICAL CASE MANAGEMENT SYSTEM REFRESH								
Mayor's Proposed FY23 Change	0	200,000	200,000	0	0	0	0	400,000
CLINICAL CASE MANAGEMENT SYSTEM REFRESH Total	**0**	**200,000**	**200,000**	**0**	**0**	**0**	**0**	**400,000**
DCAS RELEASE 3								
Existing Balances	32,630,016	0	0	0	0	0	0	0
DCAS RELEASE 3 Total	**32,630,016**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ENTERPRISE DATA INTEGRATION SYSTEM/MEDIC								
Approved FY22 CIP for FY23-27	0	1,475,000	1,475,000	0	0	0	0	2,950,000
Existing Balances	724,346	0	0	0	0	0	0	0
ENTERPRISE DATA INTEGRATION SYSTEM/MEDIC Total	**724,346**	**1,475,000**	**1,475,000**	**0**	**0**	**0**	**0**	**2,950,000**
MEDICAID DATA WAREHOUSE- GO BOND								
Existing Balances	2,562,268	0	0	0	0	0	0	0
MEDICAID DATA WAREHOUSE- GO BOND Total	**2,562,268**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
MES - FEDERAL MATCH								
Existing Balances	24,558,241	0	0	0	0	0	0	0
MES - FEDERAL MATCH Total	**24,558,241**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
MMIS UPGRADED SYSTEM								
Existing Balances	81,122,323	0	0	0	0	0	0	0
MMIS UPGRADED SYSTEM Total	**81,122,323**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
PHARMACY BENEFIT MANAGER SYSTEM REFRESH								
Existing Balances	360,000	0	0	0	0	0	0	0
PHARMACY BENEFIT MANAGER SYSTEM REFRESH Total	**360,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
PROVIDER DATA MANAGEMENT SYSTEM REFRESH								
Existing Balances	400,000	0	0	0	0	0	0	0
PROVIDER DATA MANAGEMENT SYSTEM REFRESH Total	**400,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
REPLACE CASE MANAGEMENT SYSTEM								
Existing Balances	1,113,405	0	0	0	0	0	0	0
REPLACE CASE MANAGEMENT SYSTEM Total	**1,113,405**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
SAINT ELIZABETHS MEDICAL CENTER								
Approved FY22 CIP for FY23-27	0	126,000,000	87,900,000	0	0	0	0	213,900,000
Mayor's Proposed FY23 Change	0	0	5,000,000	10,000,000	0	0	0	15,000,000
Existing Balances	126,558,290	0	0	0	0	0	0	0
SAINT ELIZABETHS MEDICAL CENTER Total	**126,558,290**	**126,000,000**	**92,900,000**	**10,000,000**	**0**	**0**	**0**	**228,900,000**
UNITED MEDICAL CENTER IMPROVEMENTS								
Existing Balances	3,048,313	0	0	0	0	0	0	0
UNITED MEDICAL CENTER IMPROVEMENTS Total	**3,048,313**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
DEPARTMENT OF HEALTH CARE FINANCE Total	**273,077,204**	**127,675,000**	**94,575,000**	**10,000,000**	**0**	**0**	**0**	**232,250,000**
Grand Total	**291,793,018**	**145,125,000**	**101,175,000**	**10,000,000**	**0**	**0**	**0**	**256,300,000**