GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Testimony of
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Before the
Committee on Health
Council of the District of Columbia
The Honorable Christina Henderson, Chairperson

John A. Wilson Building
Room ___
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Good morning, Chairperson Henderson and members of the Committee on Health. I am Wayne Turnage, Deputy Mayor for Health and Human Services (DMHHS) and Director of the Department of Health Care Finance (DHCF). It is my pleasure today to provide introductory remarks regarding the subject for this roundtable – behavioral health services in the District of Columbia. I am joined by Dr. Barbara Bazron, director of the Department of Behavioral Health (DBH) and Dr. Ayanna Bennett, director of the DC Health Department (DC Health).

As requested by email from your staff, our collective testimony will focus on the role of DBH and DC Health in monitoring in-patient mental health facilities, assessing the effectiveness of their statutory and regulatory frameworks, and identifying any gaps in oversight that may impact the quality of care. Further, we are also prepared to discuss the Department of Health Care Finance's role in rate-setting for these services. To the extent that this roundtable raises questions around provider certification and other service delivery issues, we are prepared to address those as well.

The first section of this testimony provides background information on behavioral health system as it exists today in the District of Columbia. This discussion is followed by testimony on the operating structure of the current system – namely the continuum of care, the underpinning regulatory framework, and the Medicaid funding of, and rate-setting process for behavioral health services. The testimony concludes with a discussion of challenges faced by the current system and the opportunities for service and regulatory improvements.

Improving Mental Health Services Through Legislation

Through visionary leadership and multi-year investments, DBH has the elements in place for a mature public behavioral health system and to begin to adopt a population-based approach to support the wellness of all District residents. To put this historic opportunity in perspective,

federal court direction and oversight of the District's public mental health system ended 12 years ago, after 37 years. Further, the Federal government relinquished control of the District's state mental health hospital in 1987. Over the past decades, successive Mayors and Councilmembers have prioritized behavioral health. As a result, today, the behavioral health transformation and the integration is currently underway to provide whole person care in a holistic and equitable way, which promises healthier residents who live longer, more fulfilling lives. But there are remaining challenges which we will discuss later in our testimony.

A Look Back at the Past. Prior to 1964, treatment for persons suffering with mental illness was delivered in an environment once aptly described as a "subculture of misery". Nationwide, the mental health system, as it were, was defined by frequent use of involuntary confinement, poorly staffed and depressingly benighted state mental health hospitals with high death rates, patients who often and against their will, were largely controlled using psychotropic medications, and a near complete absence of structured outpatient services. This systematic depersonalization and cruel neglect of persons suffering with mental illness was widespread. In the District of Columbia, the federal government opened the DC or state mental health hospital in 1855 under the name Government Hospital for the Insane – the first federally operated psychiatric hospital in the United States. Congress changed the name in 1916 to Saint Elizabeths Hospital but maintained federal control.

Passage of the Ervin Act. In keeping with the national movement to provide more local outpatient facilities and drug therapy as a more humane and effective means of allowing persons with mental illnesses to maintain family and social supports living in the community system, Senator Sam Ervin, Chairman of the Subcommittee on Constitutional Rights of the Judiciary Committee, spearheaded major reform of the mental health laws in the city with the 1964

passage of the Ervin Act. His work defined the District's civil commitment process and codified the civil rights for persons in the system with mental illnesses. While also focusing on treatment in the least restrictive environment, the law established a three-stage process for involuntary commitment of persons suffering with mental illness. The first focused on the emergency involuntary detention of persons but required an explicit demonstration that the persons to be committed posed a danger to themselves or others. The second outlined the process for the filing of a petition to govern a longer-term commitment and a hearing before the then Commission on Mental Health. The third delineated the parameters for a trial if a request was made to contest the Commission's recommendation of long-term commitment, while also developing guidelines for all post-commitment proceedings.

A major shortcoming of the Ervin Act, however, was that it did not require systematic court reviews of a person's involuntary commitment. This oversight ultimately created civil liberty issues in the District's mental health system for persons in restricted settings because once committed, patients often spent decades in the District's state hospital and other restricted settings, notwithstanding their ability to maintain treatment and recovery safely in the community.

In 1974, a group of individuals in care at Saint Elizabeths, filed a lawsuit against the federal and District governments for violating the Ervin Act by unnecessarily hospitalizing patients in the Hospital when they could be treated in less restrictive environments. The class included former, current, and future patients. Because the lead plaintiff was William Dixon, the case is referred to as the "Dixon case."

At that time, the Hospital housed more than 3,600 patients and there were few community-based alternatives for individuals with mental illnesses who could have been treated

in less restrictive environments. It was on this ground that the Court held, in 1975, that the federal and District governments had violated the Ervin Act and subsequently appointed a receiver to oversee the public system. In response, the federal government, in 1987, transferred operational and financial responsibility for Saint Elizabeths to the District of Columbia, 13 years into a class action lawsuit, leaving the city as the only defendant.

In 2001, the Court ordered that the city's mental health system be reshaped according to 13 exit criteria and performance targets overseen by a court monitor. In that same year, the Court approved a plan for the development of a new Department of Mental Health and established the framework for what would be the Mental Health Establishment Act of 2001. A key feature of the Act passed by both the Council and Congress, updated the civil commitment procedures that now provide for regular reviews of persons who are civilly committed.

Through focused leadership and significant multi-year investments, District political leaders along with a pioneering group of committed clinicians, primarily from Saint Elizabeths – some of whom are still practicing today – made significant progress in building a robust, community based mental health system of care that resulted in the dismissal of the Dixon lawsuit in 2010 during the term of former Mayor Gray.

Three years later, Mayor Gray established the Department of Behavioral Health to bring together treatment and services for District residents with mental health and substance use disorders to promote better health, prevent behavioral problems and build stronger communities. DBH achieved reforms that ended federal oversight of its operation resulting in a smaller hospital with half of its population through civic commitment. Today, 74 providers are certified to provide outpatient services for adults, children and youth, serving more than 42,000 residents.

While there are multiple opportunities for community-based treatment for youth in their home, school or community with 18 certified youth providers and all managed care plans providing in office services, there are challenges with inpatient care rooted in the development of the District's public health system. Saint Elizabeths Hospital today only treats adults considering that best practices recognize that the treatment of children and youth require different modalities and an environment of care. At one time, about 50 youth under 18 lived at Saint Elizabeths, a fraction of the population. Living and receiving care in an institution designed for adults, these young patients did not fully benefit from the available programs.

In 2001, a special program opened at Saint Elizabeths to provide care of young adults, adolescents, and children, was closed due to a significant diseconomy of scale and the challenge of maintaining such a program in an adult facility. Subsequently, with the closure of Riverside Hospital in 2002, today only PIW and Children's National Hospital provide inpatient treatment of young people with psychiatric illnesses. These challenges are discussed in some detail in a later section of this testimony.

Madam Chair, the next section of our testimony focuses on the continuum of care in the current system, the existing regulatory framework, and the rate setting process for behavioral health services.

The Current System of Behavioral Health Care.

The DC Department of Behavioral Health (DBH) supports healthier and stronger communities through the provision of a high-quality system of care for individuals suffering from mental illness and substance use disorders. In FY24, 42,613 people received mental health (MH) services and 4,063 received substance use disorder (SUD) services from DBH certified providers. A total of 2,932 people served received both MH and SUD services.

DBH provides a range of community-based prevention, treatment and recovery services and supports for residents of all ages through a network of 74 certified behavioral health providers with 124 locations across all eight wards. This continuum of care includes prevention, intervention, treatment and recovery support services for children, youth, and adults experiencing behavioral health challenges. A robust crisis support system is also available for individuals with immediate and acute behavioral health care needs. DBH is also responsible for the management of Saint Elizabeths, the District's 292 bed psychiatric inpatient hospital.

Prevention and Early Intervention Services. Prevention and early intervention services are designed to build resilience and self-care skills, promote health decision-making and prosocial behavioral and improve well-being. DBH funds four DC Preventions Centers (DCPC) which cover all eight wards. In FY23 & FY24, the DCPCs conducted 32 community conversations designed to assess current knowledge about behavioral health and provide education and information to residents. Each Center has a Youth Prevention Leadership Corp which is a youth-led, adult supported group equipped to provide prevention education to their peers and member of their communities. A total of 4,377 residents participated in DCPC activities in FY23 and FY24.

DBH also funds prevention and early intervention services for children and youth through the School Based Behavioral Health Program Healthy Futures and the Primary Project. School Based Behavioral Health clinicians provide evidence-based prevention curricula and observe youth in their classrooms to determine if early intervention support is required for those evidencing early signs of behavioral issues. Infant and Early Childhood Mental Health Consultants conduct observations to identify young children and families in need of behavioral

health support in 116 Early Childhood Development Centers. They also provide information to staff to help them recognize and provide appropriate support to the District's youngest learners.

Outpatient Treatment Services. The Department of Behavioral Health offers a robust array of treatment services for residents. Several pathways have been created to provide easy access for residents who require behavioral health care. This includes the 24/7 Access Helpline (AHL) and the ability to enroll at any of DBH's 74 certified provider sites.

Residents can get connected to care offered by DBH and its certified provider network by calling Access Helpline at 1(888)7WE-HELP or 1-888-793-4357 or the recently activated "988" line. This 24-hour, seven-day-a-week telephone line is staffed by behavioral health professionals who refer a caller to immediate help, ongoing care, or provide support through chat or text. The helpline can mobilize crisis teams to respond to adults and children who are experiencing a psychiatric or emotional crisis and are unable or unwilling to travel to receive behavioral health services.

Residents seeking care may also walk in any of DBH's 74 certified providers to enroll in services. Providers certified to deliver mental health and substance use disorder services are available in all eight Wards. An Individualized Plan of Care (IPC) is developed and implemented for every individual in care. Services include diagnostic assessment, medication, counseling, and community support, all supported by a wide array of program models.

Care Coordination. Care Coordination is provided to ensure that behavioral health care delivered by different agencies or entities are connected and aligned. All certified providers are required to develop and manage each consumer's person-centered Individual Plan of Care across providers and service systems to ensure that services are integrated and coordinated. Care

coordination services are delivered to keep people in care and re-engage those who leave care prematurely.

DBH staff provide intensive care coordination services for those with complex behavioral health care and physical health care needs that require cross systems-level support. In FY24, 1,643 individuals received intensive care coordination. Care coordination is also provided by this team for individuals being re-integrated into the community for a psychiatric hospital stay.

Crisis Services and Supports. Crisis services are provided to residents who require immediate and acute mental health intervention and support by DBH's Community Response Team (CRT). The CRT is a 24/7 multidisciplinary team comprised of licensed and trained clinicians and peers in recovery who conduct on the spot assessments and referrals to behavioral health care for individuals experiencing a mental health crisis. CRT staff make every attempt to de-escalate or diffuse crisis behavior before it becomes violent or aggressive and results in an injury to the individual or others. CRT members are certified to have an individual taken into custody and transported to the Crisis Psychiatric Emergency Program (CPEP) or a hospital for emergency observation and diagnosis if there is a reasonable belief that the person is mentally ill and likely to injure self. A total of 2,901 involuntary commitments were made in FY24.

The Department of Behavioral Health contracts with two acute care hospitals, Washington Hospital Center (30 operational beds), United Medical Center (34 operational beds) and the Psychiatric Institute of Washington (PIW), the District's only Institute for Mental Disease other than Saint Elizabeths Hospital - 45 adult psychiatric beds and 42 beds for adolescents.

It is important to note, however, that all acute care hospitals must accept both involuntary and voluntary psychiatric admissions for assessment and stabilization in accordance with the

Emergency Medical Treatment and Labor Act (EMTALA). If persons seeking care is no longer deemed a danger to self or others, they can be discharged. However, if an individual requires long term inpatient treatment to address a serious and persistent mental illness, they are transferred to Saint Elizabeths Hospital. If screening and assessment indicates a less acute need, then behavioral health treatment is provided in an outpatient setting by DBH's network of certified behavioral health providers.

Additionally, DBH has strengthened crisis services through investments by Mayor Bowser, which include increasing the number of trained crisis counselors, expanding mobile crisis capacity, diverting behavioral health-related crisis calls from an automatic law enforcement response to 911, and opening the first DC Stabilization Center. DBH's People Assisting the Homeless (PATH) team, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) works with about 450 consumers a year in homeless shelters and encampments to connect unhoused persons to behavioral health services.

DBH continues to partner with certified behavioral health providers to ensure the incorporation of crisis planning in treatment plans to help residents avoid psychiatric crisis episodes and to reduce their severity and duration. Inadequate crisis care can lead to missed opportunities for self-management, treatment and recovery, avoidable emergency department visits and longer hospital stays. A comprehensive, integrated crisis network can offer hope and support sustained recovery.

Recovery Services and Supports. Behavioral health can be a chronic and relapsing condition. As such, recovery supports are an integral component of the continuum of care. DBH offers recovery supports through certified peers, certified providers, family run organizations,

and family strengthening collaboratives. Over 188 certified peers with lived experience provide recovery support services in our system of care.

Existing Regulatory Framework

In the District, inpatient psychiatric facilities are overseen by DC Health while outpatient care is regulated by the Department of Behavioral Health (DBH). DC Health and DBH have a primary focus on patient safety and physical infrastructure and can act when a deficiency is identified through a routine survey or a complaint.

For inpatient settings such as hospitals with psychiatric services, the relevant facility must first attain a Certificate of Need (CON) from the State Health Planning and Development Agency (SHPDA). SHPDA is charged with determining whether there is a public need for a new health care facility or an expansion to an existing facility. The Health Systems Plan is critical to determining whether such a facility is needed and while the current plan is undergoing final review, the 2017 plan discusses the need for behavioral health services and how new services can best fill gaps and coordinate with other systems of care, including physical health services.

Additionally, if changes are made to a CON, SHPDA must also approve and issue a new certificate. The CON process maintains an equitable and integrated healthcare system and focuses on healthcare affordability and access for patients in all eight Wards. While this process applies to inpatient psychiatric facilities, it also applies to other provider types. Through this process, SHPDA can ensure that facilities are serving priority populations, including those in specific geographic areas or covered by different insurance types.

Once a hospital has its CON, the entity is eligible to receive a hospital license through the Health Systems and Preparedness Administration (HSPA) of DC Health. The Office of

Healthcare Facilities, a key component of HSPA, licenses and regulates hospitals to ensure compliance with infrastructure, safety, protocols, and planning requirements. In its role, OHF routinely surveys licensed hospitals to monitor for sustained compliance with licensure requirements and standards of practice and investigates reports of alleged or potential non-compliance. When non-compliance is substantiated, the Office uses available enforcement mechanisms, including imposed plans of correction, to ensure that identified issues are remedied. HSPA also, through its Office of Health Professional Licensure, licenses and regulates health professionals including many staff at hospitals. These staff include Psychiatrists and other physicians licensed through the Board of Medicine as well as other behavioral health professionals licensed through the Boards of Social Work, Psychology, and Professional Counseling.

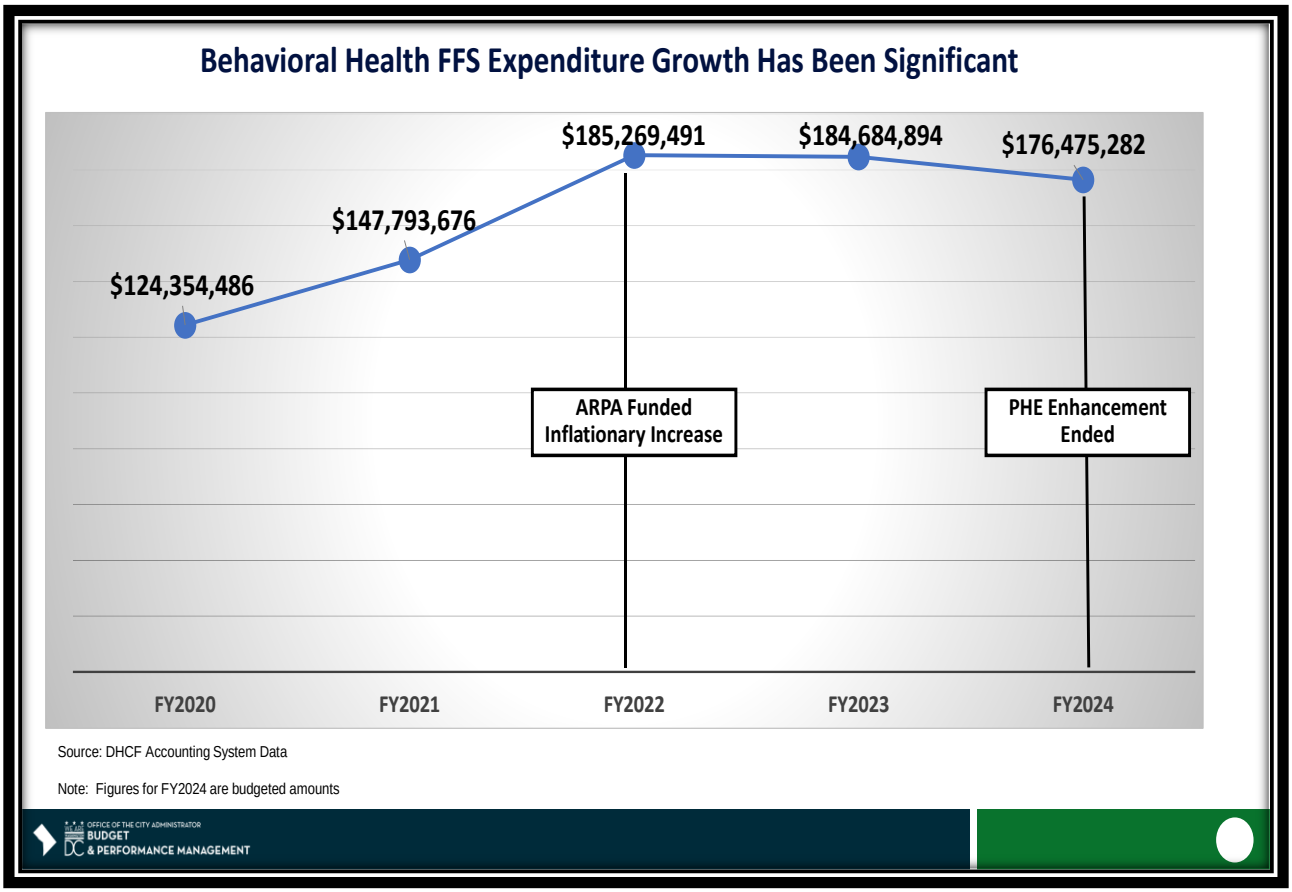
Finally, the process for outpatient psychiatric facilities requires entities to obtain certification from DBH. Additionally, both inpatient and outpatient psychiatric facilities must pursue Medicaid certification from DHCF, allowing them to treat patients with publicly funded insurance. In Fiscal Year 2024, providers certified through DBH saw 42,613 people received mental health services and 4,063 people received substance use (SUD) services. These providers are critical to ensuring that at-risk populations have access to quality behavioral health care.

There are additional mechanisms for oversight when entities contract directly with District agencies for services – one relevant example is the Psychiatric Institute of Washington (PIW), which contracts with DBH to provide involuntary admission beds (commonly called FD-12s). However, such oversight is limited only to the terms in the contract.

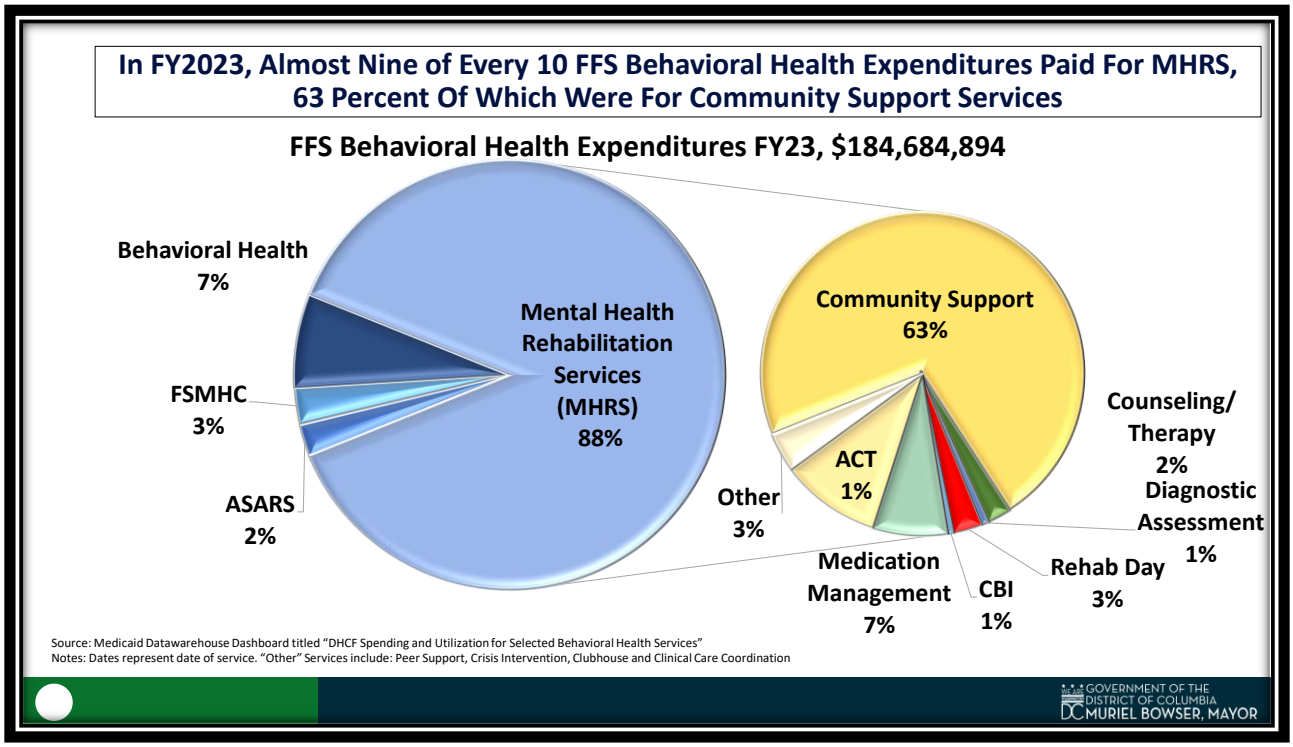
Medicaid Financing of Behavioral Health Services

As the primary funding source for public health insurance programs, DHCF, through Medicaid is the dominant payor for behavioral health services in the District, especially for both inpatient and outpatient psychiatric services. Data collected by the department show that 25 percent of the nonelderly adult Medicaid population in the District had a diagnosed mental health or substance use disorder (SUD) in FY2023. Among the youth population under age 21, the data show nearly one out of five (19 percent) of those on Medicaid have such a diagnosis.

As shown in the graph below, added by American Rescue and Protection Act dollars (ARPA), Medicaid spending for behavioral health services has increased significantly since FY2020, growing from $124.3 million to $176.4 million. The largest increase occurred from FY2021 to FY2022, due in part to rising demand for services and support from ARPA.

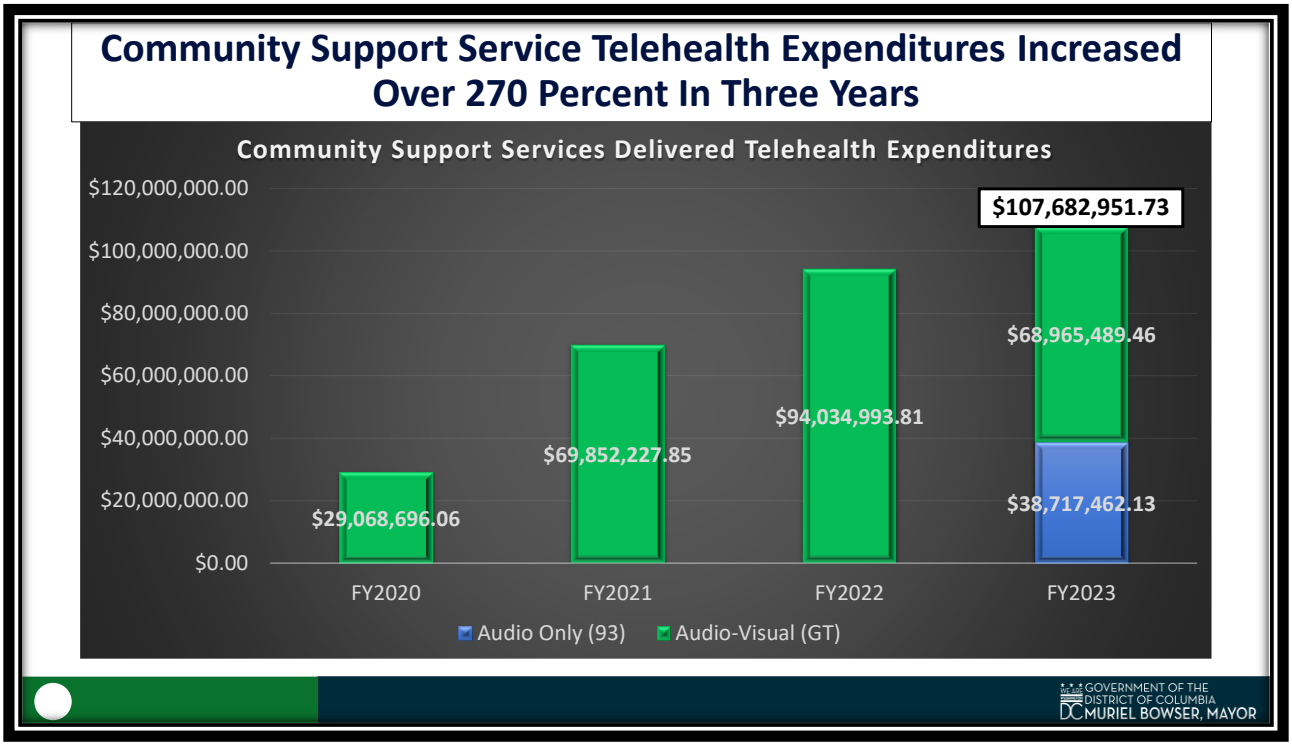


In terms of service type, the graph below indicates that nearly 90 percent – over $162 million – of the Medicaid funding for mental health services paid for treatment delivered by MHRS providers. These funds paid for services that run the gamut – prevention, crisis support, recovery, and care coordination. Further shown, most of the funding for Medicaid mental health services were allocated to programs delivered by community providers. This is clearly a reflection of the District's response to the Dixon Lawsuit that emphasized the importance of building the necessary community supports to allow persons to receive treatment in the least restrictive environment when possible.



Still, there are some concerns that will require greater oversight, monitoring, and fraud surveillance by both DBH and DHCF. During the public health emergency that was spawned by the pandemic, DBH worked with DHCF to expand the use of telehealth services for behavioral health. This expansion was intended to maintain access to services for people in need of

treatment, but who were unable to leave their home and safely secure services in the community for fear of contracting COVID. The data shown in the graph below reveals a major growth in telehealth by persons seeking mental health services. In a three-year period, spending on these services increased by 270 percent – this is a 90 percent annual growth rate. And while DBH is encouraged by the expansion on telehealth, greater scrutiny is required in the coming months to ensure that the integrity of the service is not undermined by poor quality or fraudulent practices.



Especially concerning is the fact that in FY2023, more than $38 million in Medicaid spending for telehealth was generated by "audio only" services. Though there were no such services in the year prior to FY2023, this approach to care suddenly grew to 36 percent of all spending on telehealth in just 12 months – more than $38 million. This gives pause as the use of telehealth expands in the coming years.

Medicaid Payment Structure For Inpatient Psychiatric Mental Health Services. The most expensive among all behavioral health services is inpatient psychiatric care. Currently,

based on the provider type, DHCF uses various approaches to reimburse the facilities that provide this level of care. These rate models, which are discussed on page 16, are intended to recognize and reimburse providers for their reasonable Medicaid allowed cost, while ensuring access to care. To wit:

1. Youth Psychiatric Residential Treatment Facilities (PRTF): Medicaid currently covers some inpatient psychiatric services to youth through PRTF's across the states. The rate methodology is based on one of the following criteria:

    - States Medicaid Rate;
    - State Commercial Rate (if the provider is not a Medicaid Provider); or
    - States Private Pay Rate (if provider does not accept Medicaid or Commercial Insurance)

2. PIW Rates: DHCF sets annual rates for PIW as a "Specialty Inpatient Hospital", covering (at a minimum) 100 percent of cost based on cost reports and/or cost. In FY2025, the PIW rates support 147 percent of total cost or $1,157.44 per day ($2,259 per day prior to case mix adjustment).

3. Inpatient Hospitals: Medicaid covers inpatient psychiatric visits for inpatient hospitals using the APR DRG rate methodology, which is based on severity of illness, reason for admission and conditions presented during the stay.

4. St. Elizabeth: Medicaid covers eligible inpatient psychiatric visits at Saint Elizabeth based on a cost reimbursable methodology. An interim per diem rate of $342.90 is paid during the year and reconciled after year's end based on a retrospective analysis of facility cost. A hospital cost report is submitted in the following year and audited to determine a cost settlement by comparing the interim rate to actual incurred cost.

To ensure payment adequacy, DHCF employs a team of six analysts and one actuary in the Office of Finance and Rate Reimbursements to regularly update the rates across provider types and ensure accuracy in that process. While we are constrained by the realities of the District's budget, DHCF carefully evaluates providers' cost and the corresponding rates that we pay to avoid problems of access due to insufficient payment.

However, access to inpatient care for youth is a problem both in the District and nationwide, especially in PRTFs. PRTF is an optional service under Medicaid, but if the

treatment is deemed medically necessary, the state must provide this service for children and youth under 21. This is a problem due to the absence of any such facilities in the District. The severe mental health problems for many youths needing this type of care, combined with an overarching policy goal to reduce the use of institutional care for children, chronic staffing shortages for a treatment models that require highly skilled staff, and public reimbursement rates that cannot easily meet the rapidly rising cost of these operations, have created a perfect storm that is not easily addressed.

Notably, because of the lack of any PRTFs in FY2023, 23 youths were subsequently placed in out-of-state facilities. Several agencies can be involved in the placement of youths in PRTFs – Department of Youth and Family Services, Child Family Services Agency, District of Columbia Public School System, Office of the State Superintendent for Education, and Medicaid Health Plans. However, DBH is responsible for certifying medical necessity for the PRTF level of care for placements to be funded by Fee-for-Service (FFS) Medicaid, regardless of the agency seeking the placement.

In FY2023, DHCF established a prior authorization requirement for all PRTF placements that are paid for by FFS Medicaid. The prior authorizations are approved by DHCF only if medical necessity has been confirmed by the DBH's PRTF Placement Review Committee. This committee also reviews and makes determinations about the need for continued stays in PRTFs. The table on page 18 identifies those states and the number of children who were placed respectively. The average length of stay for these youths was 9.3 months.

Medicaid Payment Structure for Community-Based Psychiatric Care. By comparison, there is no shortage of community based mental health services in the District. Together, DBH

The Number of District Youths Placed In PRFTs by State	
State	**Number of Youth Placements**
Arkansas	2
Florida	4
Georgia	1
Pennsylvania	1
Virginia	9
Maryland	5
Tennessee	1
Total	23

and DHCF collaborated to establish over 50 community based behavioral health services using methodologies that are based on a rate study that was completed in FY2024. These methodologies are basic fee schedule rates that are established based on the cost to meet required outcomes to support District residents. For services that can be provided across the various provider groups below, the methodologies are the same to ensure parity. The services are provided under 5 programs based on individual need:

1. Free Standing Mental Health Clinics (FSMHC): A formally organized psychiatric clinic that provides mental health services on an outpatient basis. An FSMHC is run under the direction of a physician.

2. Mental Health Rehabilitation Services (MHRS): A complement of individualized services and supports provided in a community- based setting. Services include diagnostic/assessment services, counseling, medication, intensive day treatment and crisis/emergency services. The services are rendered by Community Support Agencies who are certified by DBH

3. Adult Substance Use Rehabilitation Services (ASURS): A network of community-based providers to that deliver substance use disorder (SUD) services including detoxification, residential and outpatient services based on individual need

4. Adolescent Substance Abuse Treatment Expansion Program (ASTEP): Programs that provide expanded access to treatment and recovery support services from community-based substance abuse treatment providers. Services are available to adolescents under 21 years of age who have an Axis I diagnosis of substance use disorder

5. Behavioral Health Transformation Waiver: provide services to address gaps in the behavioral health delivery system for serious mental illness (SMI)/serious emotional disturbances (SED) and substance use disorder (SUD).

Challenges and Opportunities

Significant advancements have been made because of District leadership and investments in behavioral health since the conclusion of Federal oversight of the public mental health system in 2013. Under the terms of the Dixon settlement agreement, affordable housing units were added to the Department's portfolio, job-readiness was expanded and treatment services for children and youth were expanded. Although the system of care has been further developed, there are identified gaps in the service delivery system. This includes the need for additional inpatient psychiatric capacity for children, youth and adults, partial hospital and intensive outpatient programs that provide an outpatient therapeutic milieu that can stabilize behavioral health conditions and prevent hospitalization and out-of-home placements.

Inpatient Psychiatric Capacity. According to national data, current capacity does not meet the estimated bed need in the District of Columbia (Int J Environ Res Public Health.2021 Nov; 18 (22): 12205). This is a result of the following:

- The closure of Providence Hospital which eliminated critical capacity.
- A pending reduction in bed capacity at Washington Hospital Center in 2026.
- A unilateral decision by PIW to limit admissions for only certain types of patients.
- The elimination of alcohol/chemical dependency units in all facilities except PIW.
- The limited number of hospitals (two) that are licensed to provide inpatient psychiatric care to pediatric patients (children and youth up to 17 years of age) – PIW and Children's National.

- A growing reluctance among hospitals to accept youth in need of inpatient assessment and psychiatric care who are in the care and custody of DYRS.

Clearly these challenges will emerge as a crisis if the growing demand for psychiatric beds continues unabated in the District. Accordingly, DBH, DC Health, and the DC Hospital Association have recently agreed to work together to develop a surge plan proposal that will be designed to increase the existing psychiatric bed capacity for children, adolescents and adults requiring inpatient care. Preliminary discussions are currently underway to develop a strategy for addressing this issue, but the issue of cost – especially in the District's difficult budget environment – stands as a significant obstacle to progress on this front.

There is also a letter agreement with PIW that states that DYRS will refer, and PIW will consider court-involved youth for inpatient hospitalization who meet PIW's admission criteria. This assessment must be processed within eight (8) hours of the request for emergency psychiatric hospitalization services by DYRS. Both DBH and DC Health will work with PIW to strengthen this agreement to make inpatient hospitalization available to this population.

Partial Hospital (PHP) and Intensive Outpatient Programs (IOP). There are currently no Partial Hospital Programs (PHP) or Intensive Outpatient Programs (IOP) within the public behavioral healthcare system. However, Georgetown has an IOP program for youth. PIW and MedStar Georgetown operate programs for individuals 18 years of age or older. This program provides intensive psychiatric care for patients requiring a structured day program. MedStar and PIW offer IOP programs for individual in the District with mental illness. VIVE Treatment Center, a private, Commission on Accreditation of Rehabilitation Facilities accredited addiction agency offers IOP services for adults 18 years of age or older. DMHHS will explore the impact and financial feasibility of developing IOP and PHP services within the public behavioral health system.

Regulatory Gaps. DC Health has identified several opportunities to improve its oversight of inpatient psychiatric facilities. DC Health will update its schedule of fines for notices of infractions for hospitals to ensure that adverse action results in the appropriate disciplinary consequence. The agency will also enhance reporting requirements for hospitals, including explicitly including digital records such as video recording in materials that must be retained and provided to DC Health for investigations. This will provide a more comprehensive oversight process so that the District can clearly substantiate any allegations of abuse if they have occurred. Finally, DC Health will add behavioral health subject matter experts to their inspection team as CMS does not allow other agencies to be involved in investigations due to privacy and legal concerns. This will promote more specialized oversight of the District's overall behavioral health system. DC Health plans to explore this plan with the City Administrator and the Mayor's budget team for FY26.

Madam Chair, this concludes out testimony and we are available to answer any questions from you or other members of the Committee. Thank you.