GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2023-24 Performance 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 Christina Henderson, Chairperson

Thursday, February 8, 2024

The John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Introduction

Good morning, Chairperson Henderson, Councilmember Gray, and members of the Committee on Health and the Committee on Hospital & Health Equity. My name is Wayne Turnage and I serve as the Deputy Mayor for Health and Human Services and the Director of the Department of Health Care Finance (DHCF). I am joined in this hearing by my stellar executive management team at DHCF, as well as my wonderful staff in the Office of the Deputy Mayor for Health and Human Services. At DHCF, our collective job, of course, is to work closely with the Office of the City Administrator and the Executive Office of the Mayor (EOM) to steer the Medicaid, Alliance, and Immigrant Children's (ICP) programs in a manner that promotes equitable access to quality health care across all neighborhoods of the District of Columbia. As a management team, these individuals boast significant experience in health care policy development, program management, and financial analysis, making them well-equipped to confront the frequent and significant challenges that accompany our efforts to manage a budget of over $4 billion.

As noted, we work closely with EOM to aggressively pursue the priorities and goals established for DHCF, based on proposals that have secured the Mayor's support. From the days of her first term, the Mayor pursued policies aimed at giving all District residents a "fair shot." For publicly funded health care this requires attention to the question of health care access involving a full range of primary and acute care services. Nothing more appropriately signifies the Mayor's laser focus on this issue than the new hospital under construction in the city's most underserved community. It is within the framework of ensuring health care access to all citizens – most especially those who live on the economic margins – that DHCF operates each year.

As we develop proposals and execute the day-to-day administration of the program, my team leans heavily on the use of complex data analytics – we are unquestionably a data driven

operation. With the sophistication of data analysis tools, the availability of extensive beneficiary and service utilization databases, and a team of skilled policy and data analysts, we efficiently and repeatedly evaluate Medicaid and Alliance program trends and outcomes, allowing us to speak to the efficacy of our efforts. I encourage my staff to embrace rigor in daily problem solving by treating easy solutions with relentless skepticism, in the process, rejecting viscerally derived positions that are bereft of clear thinking and hard evidence.

My testimony today is drawn from the work we have conducted for the period encompassing FY23 through January of 2024. It is structured to provide a high-level summary of the major issues and challenges that DHCF faced over this time as well as outline the progress we continue to see from a few initiatives that were put in place in the years preceding. Accordingly, I specifically discuss the following projects and topics for this performance hearing:

1. Current enrollment trends for Medicaid and Alliance, as well as the status of DHCF's efforts to successfully execute Medicaid unwinding as required by the Centers for Medicare and Medicaid (CMS).

2. The bifurcated structure of programming in Medicaid – Managed Care and Fee-For-Service – and the performance, challenges, and pending policy changes within these two structures.

3. Implementation of the behavioral health rate study.

4. Future Medicaid policy changes including maternal health programming and the 1115 Waiver Renewal.

5. The status of the Cedar Hill Regional Medical Center GW Health, focusing on the project completion timeline, and the steps that George Washington University Hospital must implement to be ready to deliver care when the hospital opens.

Program Enrollment Trends And Medicaid Unwinding

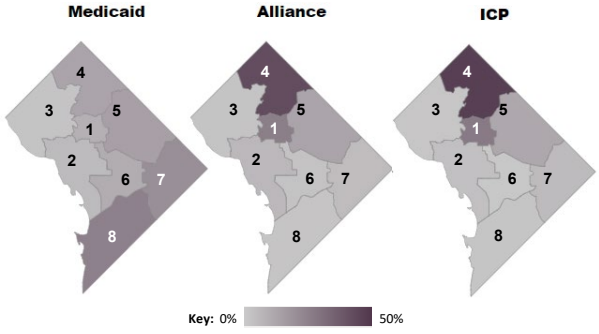
An unquestioned impact of the pandemic on the Medicaid, Alliance, and ICP was the accelerated growth in enrollment, reaching levels for Medicaid that had never been witnessed in the District of Columbia. In March of 2020, as states were required by the federal government to

implement continuous enrollment during the Public Health Emergency (PHE), only those persons who self-reported a disqualifying change were removed from the program. Similar pauses in eligibility terminations were put in place in Alliance and ICP, which also increased program enrollments. Consequently, for Medicaid, program enrollment reached a historical high of over 300,000 beneficiaries in 2023.

While enrollment increased the penetration of the program in the District, the distribution of beneficiaries across the city's eight Wards was largely unchanged. As shown below, most Medicaid beneficiaries continue to reside in Wards 7 and 8 while most Alliance and ICP beneficiaries reside in Wards 1 and 4.

Most Medicaid Beneficiaries Live in Wards 7 and 8, While Most Alliance and ICP Beneficiaries Live in Wards 1 and 4

Ward Distribution by Program Type, FY 2023



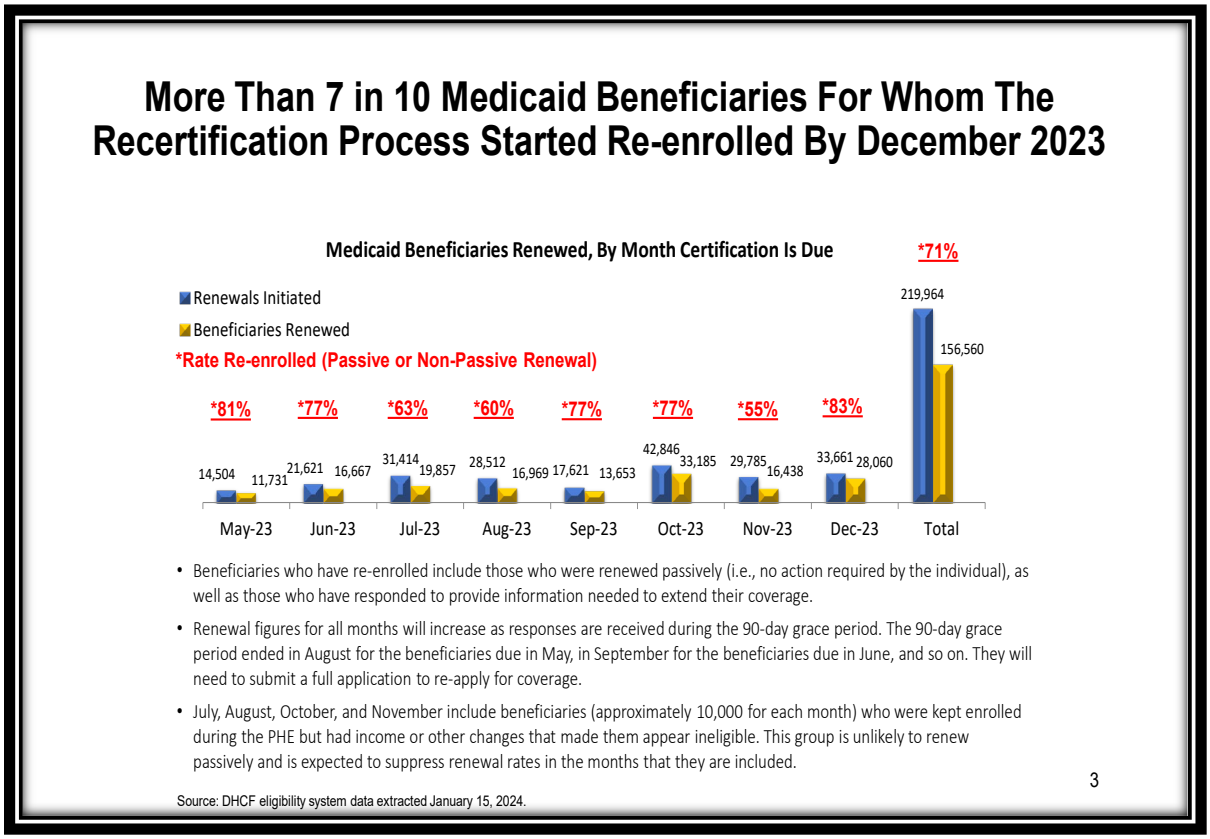
Ward	Medicaid	Alliance	ICP
Ward 1	26,006 (8%)	4,303 (24%)	947 (23%)
Ward 2	11,933 (4%)	1,017 (6%)	124 (3%)
Ward 3	7,994 (3%)	554 (3%)	87 (2%)
Ward 4	37,295 (12%)	6,354 (35%)	1,397 (34%)
Ward 5	42,210 (14%)	3,114 (17%)	937 (23%)
Ward 6	29,043 (9%)	628 (3%)	105 (3%)
Ward 7	59,047 (19%)	938 (5%)	197 (5%)
Ward 8	70,496 (23%)	449 (2%)	102 (2%)
Other*	23,795 (8%)	916 (5%)	216 (5%)
Total	**307,819 (100%)**	**18,273 (100%)**	**4,112 (100%)**

Source: DHCF Medicaid Management Information System data extracted in January 2024.
Note: Based on average monthly enrollment. May 2023 represents the peak of Medicaid enrollment prior to a restart of redeterminations after the federal public health emergency ended; Alliance and the Immigrant Children's Program (ICP) peaked in August 2022 prior to a restart of their redeterminations. The population size in later months is lower as some individuals are no longer eligible or have not responded to a redetermination notice. Sum of components may not equal total due to rounding.
*Other includes cases where a mapping is not readily available (e.g., due to a non-standard address format).

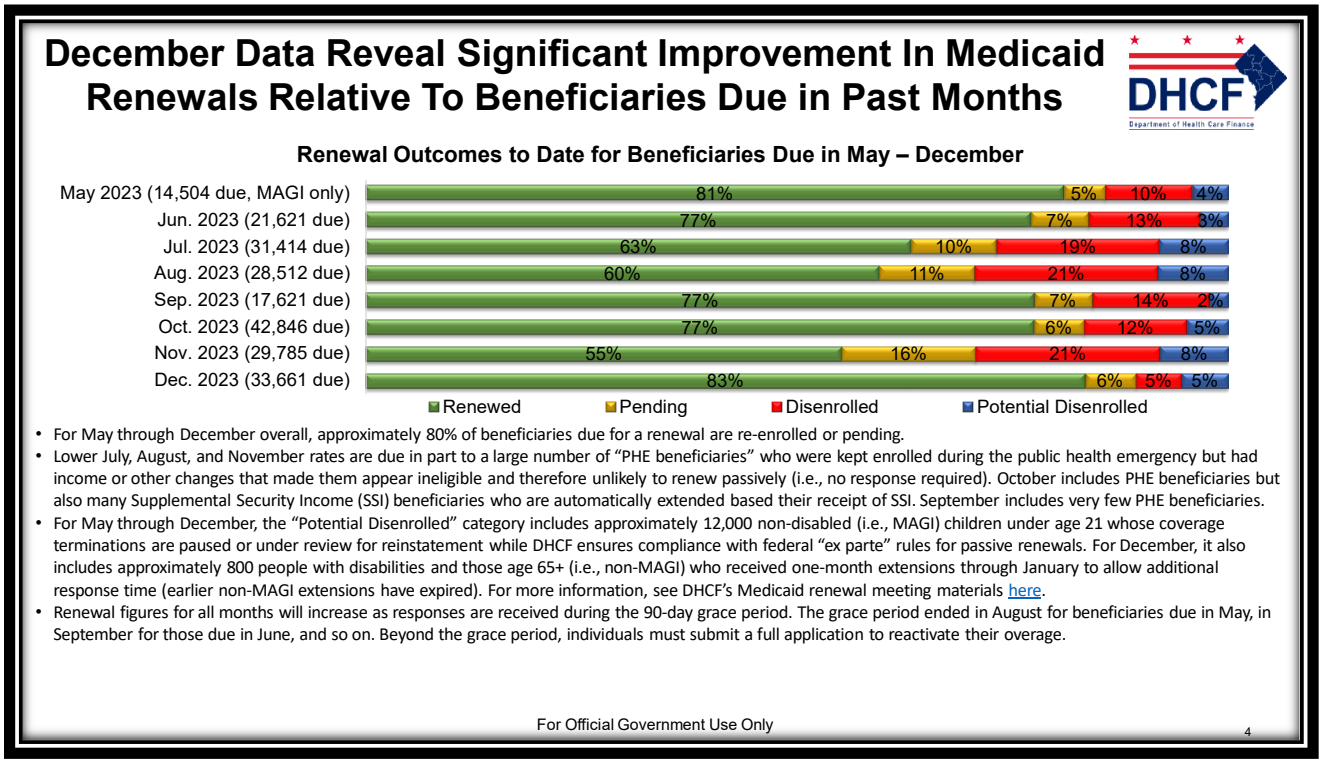
Medicaid Unwinding. The federal termination of PHE and the cessation of Medicaid continuous enrollment on March 31, 2023, created the demanding requirement that states begin the heavy lift of restarting the annual eligibility process. Since March 2020 – the last month before the pause in disenrollments – the District's Medicaid program grew by 50,000 beneficiaries, most of

whom renewed their eligibility and accessed their benefits through a new access point called District Direct. Additionally, a sub-group of beneficiaries called non-MAGI – those 65 and over, or persons who are either blind or have a disability – were later required to renew eligibility through the portal and DHCF subsequently integrated these beneficiaries into the District of Columbia Access System (DCAS).

In recognition of this challenge, DHCF launched its most intensive outreach program, and, with the diligence of our residents and the support of certain stakeholder groups, DC is now in the top ten in renewal rates across state Medicaid programs. Notably, since the recertification process was initiated in May 2023 through December 2023, over 70 percent of 220,000 Medicaid beneficiaries for whom renewal dates arrived, successfully reenrolled as of December 2023 (see below). While we clearly have more work to do, these numbers demonstrate why the District is among the top 10 states in unwinding from pandemic rules and recertifying Medicaid beneficiaries.



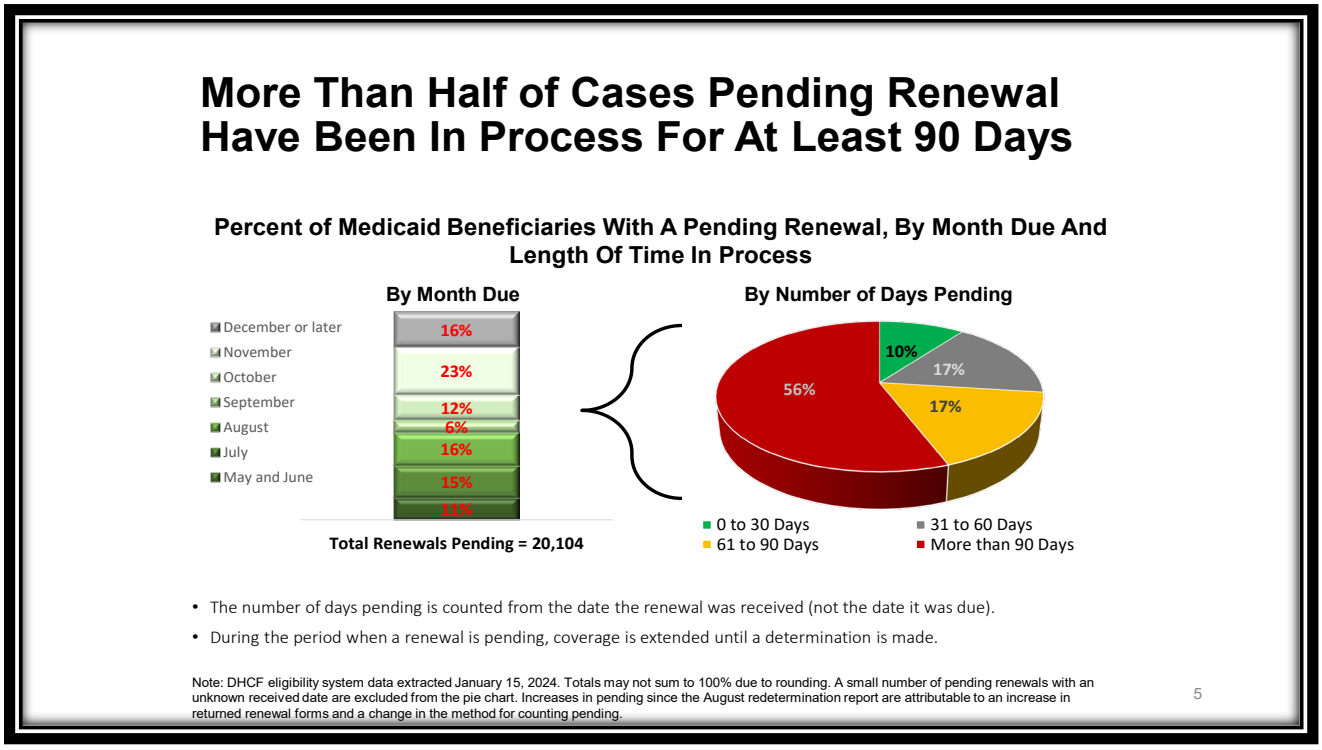
The data presented below further indicates the progress made in the process for the persons whose renewals were due in December 2023, compared to those in other months. As indicated, we witnessed a sharp increase in completed renewals for December and a precipitous decrease in pending, disenrolled, and potential disenrolled cases. Specifically, 83 percent of those with recertifications due in December are now renewed. Further, only 6 percent of December cases are pending, while 5 percent were disenrolled. These numbers are significant improvements from previous months. The question, of course, is whether they will be sustained.



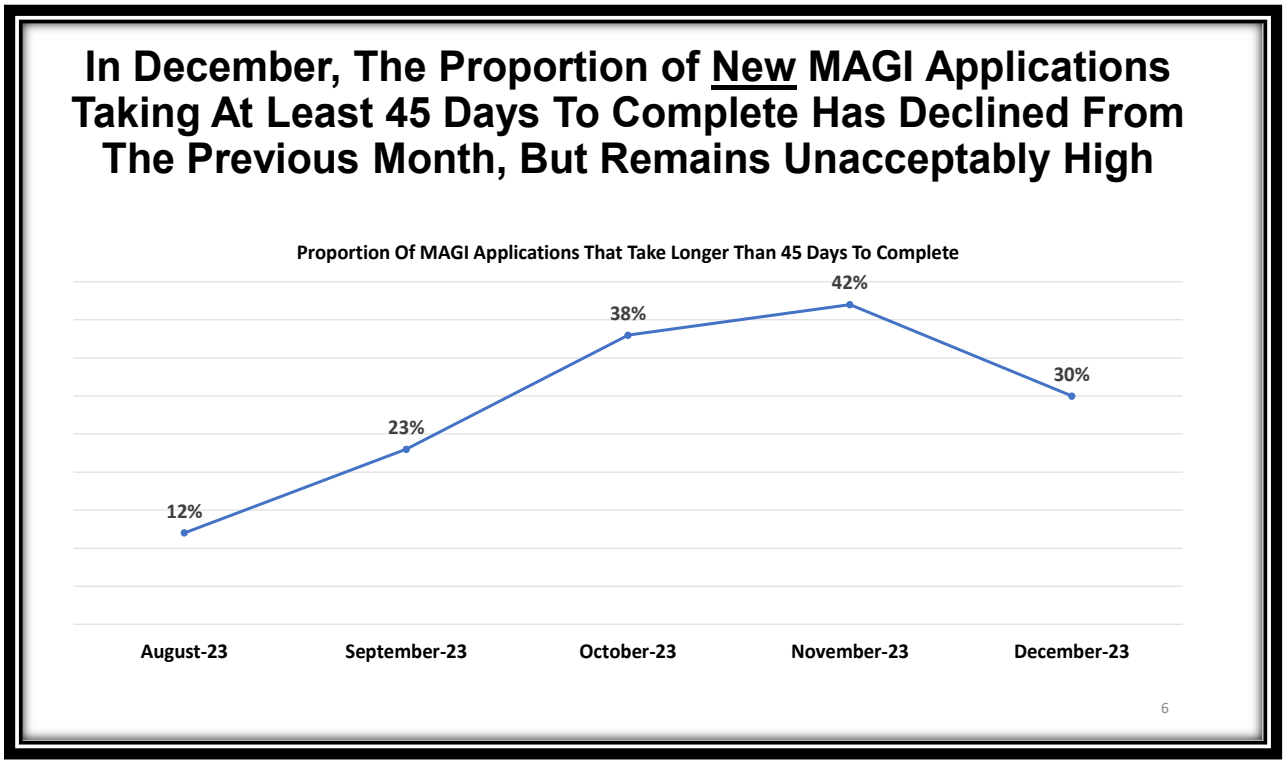
Remaining Challenges with Case Processing. Clearly, we are making progress but reaching this point has not been without challenges. Federal guidance and requirements have evolved during this period in ways that intensified the challenges states faced with Medicaid unwinding. For example, in August 2023, DHCF and several other states discovered they were out of compliance with federal *ex parte* renewal requirements for passive renewals that resulted in procedural terminations of some children who did not submit renewal forms. DHCF immediately

reinstated 13,000 affected children and paused future terminations of those who had not yet renewed. Once we adjusted system rules and came into compliance, approximately 17% of the 13,000 were determined eligible and remained enrolled. The remainder could not be determined eligible and were required to submit a renewal form. This and other adjustments required in-process changes to DCAS as we worked to familiarize beneficiaries and stakeholders with District Direct, the new eligibility portal.

Notwithstanding important technical adjustments and the progress we made with December renewals, there are lingering issues from earlier months that we are working diligently to address. As we near the end of the formal unwinding period in April 2024, the sheer volume of renewals has created a backlog in processing for pending case renewals (see below). Though 34 percent of the cases have been pending for less than two months, 56 percent have been in process for at least three months. This challenge does not result in the loss of health care coverage, but it creates pressures in the case processing pipeline that must be cleared.



Moreover, we are aware of the delays in processing time for new applications. In December the proportion of new applications that required more than 45 days to complete grew from 12 percent in August 2023 to 30 percent – yet the 30 percent figure compares favorably to the performance just one month prior (see below). Our work on this issue continues.



Other technical issues have created problems and revealed case processing errors that, unaddressed, would result in the inappropriate disenrollment of significant numbers of beneficiaries. Most recently, an issue affecting children with special needs was identified. Our response was to reinstate coverage for the impacted children while we work to solve the root cause of the problem. It is imperative that we work through issues as they arise since Medicaid renewals do not end after the formal renewal period. Rather, without approval from CMS, DHCF must return to the regular cadence of annual certifications beginning in April 2024.

So, how are we fixing things? First, apart from continuing the most extensive outreach to both residents and stakeholders in the program's history, we have a DCAS system fix that will go

into production by March which will address a few issues. This includes automation of eligibility for children in the Supplemental Security Income program (SSI) and newborns. Second, we are bringing in temporary staff to take calls, and process data entry for pending applications. Our expectation is that these changes will lessen demands for both DHS and DHCF caseworkers, allowing them to focus on processing more cases. Third, we are also authorizing overtime for the DHCF caseworkers that handle applications and renewals for long term care services and supports, thereby expanding the number of case processing hours in the system for the most difficult and complex applications. We have established case processing targets of 145 cases per bi-weekly pay period for the DHCF caseworkers that will deplete their current backlog of 1,245 cases within approximately four months. DHCF will continue to monitor our progress and adjust as needed, including the possibility of requesting an extension of the unwinding period for those in-process cases which approach a new annual recertification requirement.

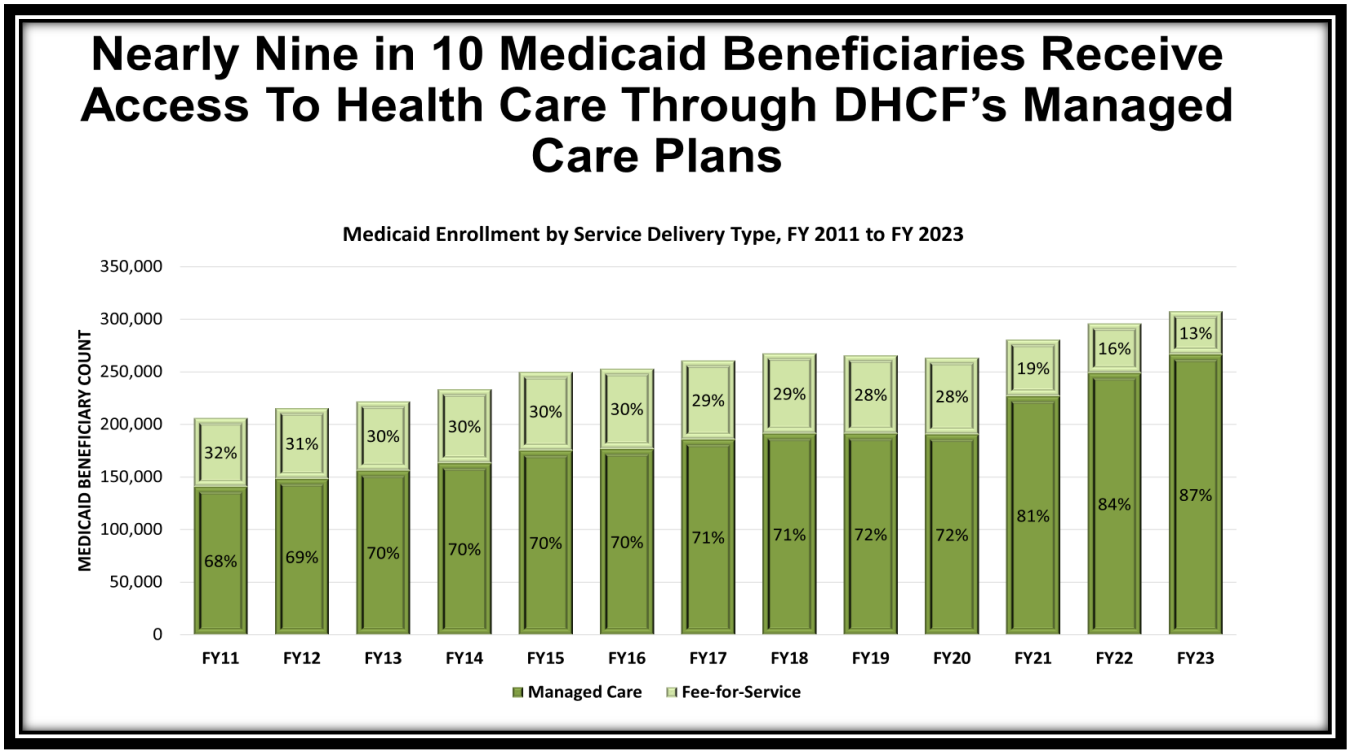
Finally, the agency is preparing for a new outreach campaign in 2024 for Medicaid Renewal. The message will shift from "Don't Wait to Update" toward "Act Now. Stay Covered!". Outreach materials and advertisements will inquire about whether beneficiaries have checked their mail lately, subsequently urging that they check their mail and renew. The change in the messaging is important because most beneficiaries who will see these materials have received a renewal notice. As we shift from the formal Medicaid renewal period to standard renewal operations, it will remain important to ensure residents are aware that renewal is an annual process requiring their attention.

Medicaid Program Structure And Service Trends

DHCF organizes the delivery of care to over 300,000 beneficiaries in two ways. First, like many state Medicaid programs, most of the beneficiaries who are enrolled in Medicaid, Alliance, and ICP participate through a managed care organization (MCO). Other members are enrolled in

the fee-for-service program where they lack a prescribed care network and are largely without access to care coordination services that DHCF mostly funds through the MCOs.

District Managed Care. As shown by the chart below, the proportion of beneficiaries who are enrolled in an MCO has grown by nearly 30 percent since FY2011. This has been an intentional and systematic shift by DHCF because of the reputed benefits of health plans in organizing the delivery of care while controlling unnecessary growth in health care costs. For some certainty around price, members in health plans gain access to a wide and diverse network of providers, an efficiently delivered pharmacy benefit, as well as the prospect for important care coordination services which can be especially valuable for plan members with complex health care needs. In exchange for the payment of federally certified, actuarially sound per-member, per-month rates, the MCOs that contract with the District agree to establish an adequate provider network, manage the care of its beneficiaries in their network, and timely pay the physicians, clinics, and hospitals that submit invoices for the services delivered to their members.



The most recent shift in members to managed care occurred in FY23 when the Program for All-Inclusive Care (PACE) program was implemented. While the PACE program is not a traditional managed care plan, the core concept of paying a monthly rate to an entity that is responsible for the total cost of care for an individual is the same.

Managed Care Contracts: Performance and Change. Recently, the most significant change in the managed care program was the award and implementation of the new managed care contracts in FY23. Effective April 1, 2023, the Medicaid managed care program included the following MCOs: Amerigroup, AmeriHealthCaritas DC, MedStar Family Choice.

Each year, DHCF carefully evaluates the performance of the health plans across five major domains and reports the results through a comprehensive annual report. The goals of this assessment and report are to evaluate the financial stability of the health plans and gauge their success in ensuring members' access to an adequate network of providers, while managing the appropriate utilization of healthcare services. The latest report is available on DHCF's website and covers calendar year 2022. One of the health plans in the program at that time, CareFirst, was not awarded a contract and has been replaced by Amerigroup. However, due to the timing of the MCO report, data are reported for CareFirst in parts of this testimony.

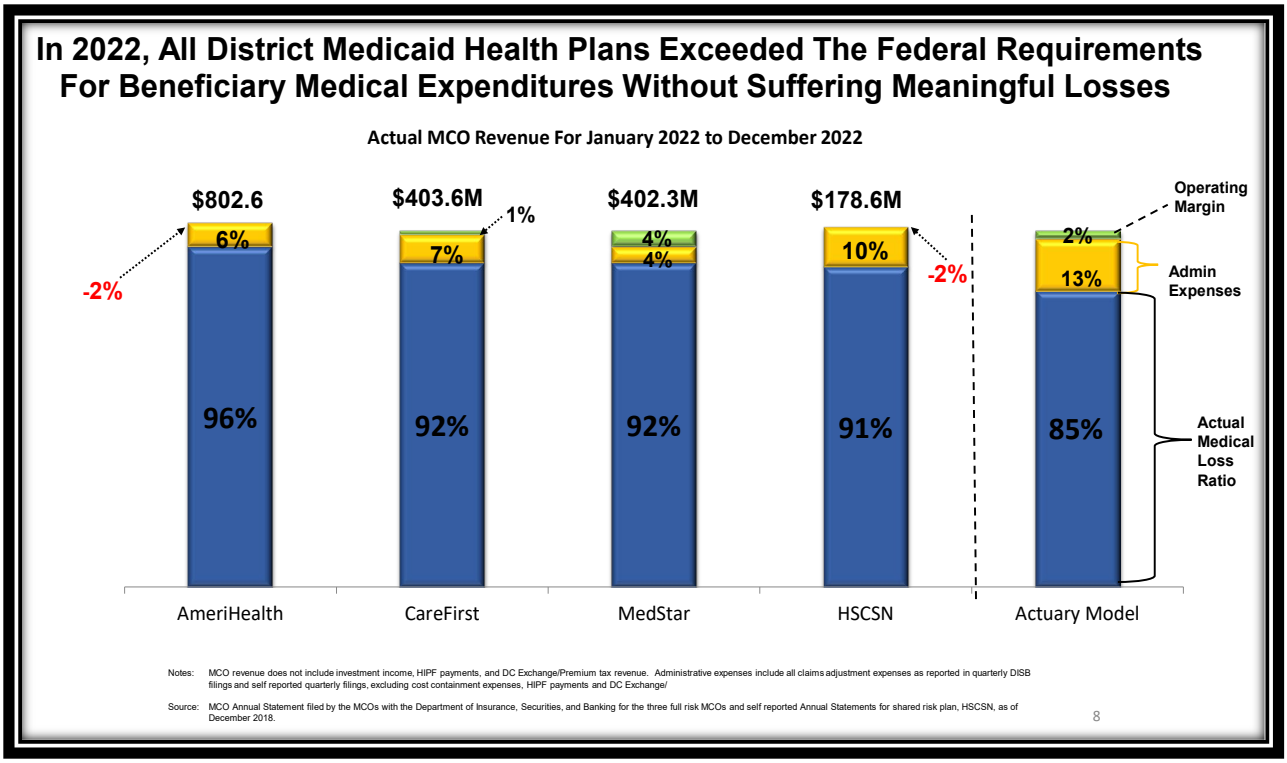
The current review highlights several key observations in the District's managed care program which were greatly influenced by the continued effects of the COVID-19 PHE on beneficiary enrollment, medical service utilization, and costs. First, we observed substantial enrollment increases in CY 2022 because of the federal maintenance of effort requirement that prevented any negative changes to Medicaid eligibility policy. This policy effectively increased the number of people in the Medicaid program. And, as service utilization was suppressed by the pandemic, the combination of more enrollees and less utilization lowered unit costs.

Second, due to several payment policies, DHCF has observed a better alignment of MCO

costs and associated payments across the Medicaid and Alliance programs. Notably, our continued application of risk adjustment – a policy that pays higher payments to those health plans with sicker patients in their membership panel – has been instrumental in defraying the higher cost experienced by health plans with disproportionately sicker patients. At the same time, DHCF added risk sharing arrangements for both Medicaid and the Alliance program in October 2021, to provide additional financial stability to both the MCOs and the District. These agreements require health plans to share a portion of any excessive profits with the District, while providing the MCOs with a financial backstop from DHCF in the event of excessive plan losses.

Due in part to the more widespread use of risk adjustment and a requirement the health plans contract with every acute care hospital and public clinic in the District, we believe the likelihood that that any of the MCOs will excessively profit from the program, or struggle through a financial death spiral – two historical problems for DC Medicaid – are greatly mitigated. I note that DHCF did not have to share in the losses for any MCO in FY22 but did receive $25.2 million in profit sharing payments from these health plans – roughly one percent of the total payments we made to the MCOs. This is prima facie evidence of DHCF's more syncretized alignment of payments and costs for the health plans. The graphic on the next page summarizes the financials reported by the relevant plans in calendar year 2022.

Third, as a part of our ongoing oversight of the health plans and Pay for Performance Plan development, DHCF's managed care quality team continues to monitor the degree to which the MCOs successfully reduced avoidable hospitalization admissions, readmissions, and inappropriate



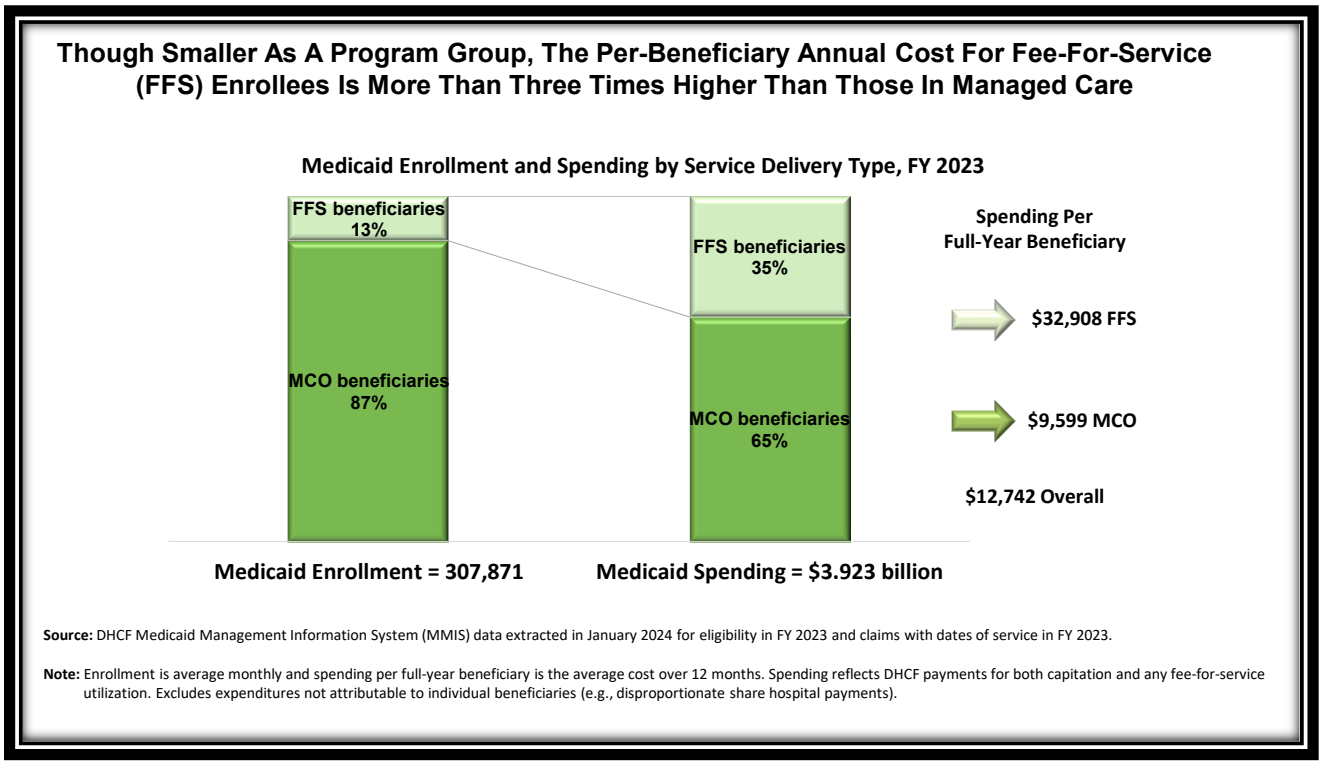
emergency department utilization. Though we observed mostly positive trends in reducing these unnecessary services and healthcare costs during the current reporting period, we found that the gains are small – clearly an area for improvement.

Finally, as stated earlier, the new contracts increase expectations for value-based purchasing (VBP). This is a strategy used by healthcare purchasers or health plans to increase quality and value for each health care dollar spent. This is accomplished by linking provider payments to improved performance by healthcare providers, holding them accountable for both the cost and quality of care they provide, and, rewarding those providers who most successfully reduce inappropriate service utilization for the patients they serve. Beginning this calendar year, MCOs must meet annual VBP targets as a percentage of their total medical expenditures. Those that fail will face compliance actions that could lead to sanctions.

Fee-For-Service Program. As noted earlier, Medicaid beneficiaries who are not enrolled in managed care receive their services through the District's fee-for-service Medicaid program. These

members include children who are in the custody and care of District government, persons who are at least 65 years of age, individuals with disabilities, and those who receive long-term care services to assist them with their basic activities of daily living. DHCF is evaluating whether additional groups of fee-for-service members will be moved into managed care in future years.

The motivation for further deliberations on this policy can be seen in the fee-for-service utilization and cost data. We know that this population has more complex and costly health needs relative to their peers in managed care (see graph below) but typically do not receive care coordination services. Through the My Health GPS program, DHCF has extended care management services to a small group of fee-for-service beneficiaries. The question that DHCF will explore in the coming months, however, is whether further expansion of this program is feasible.

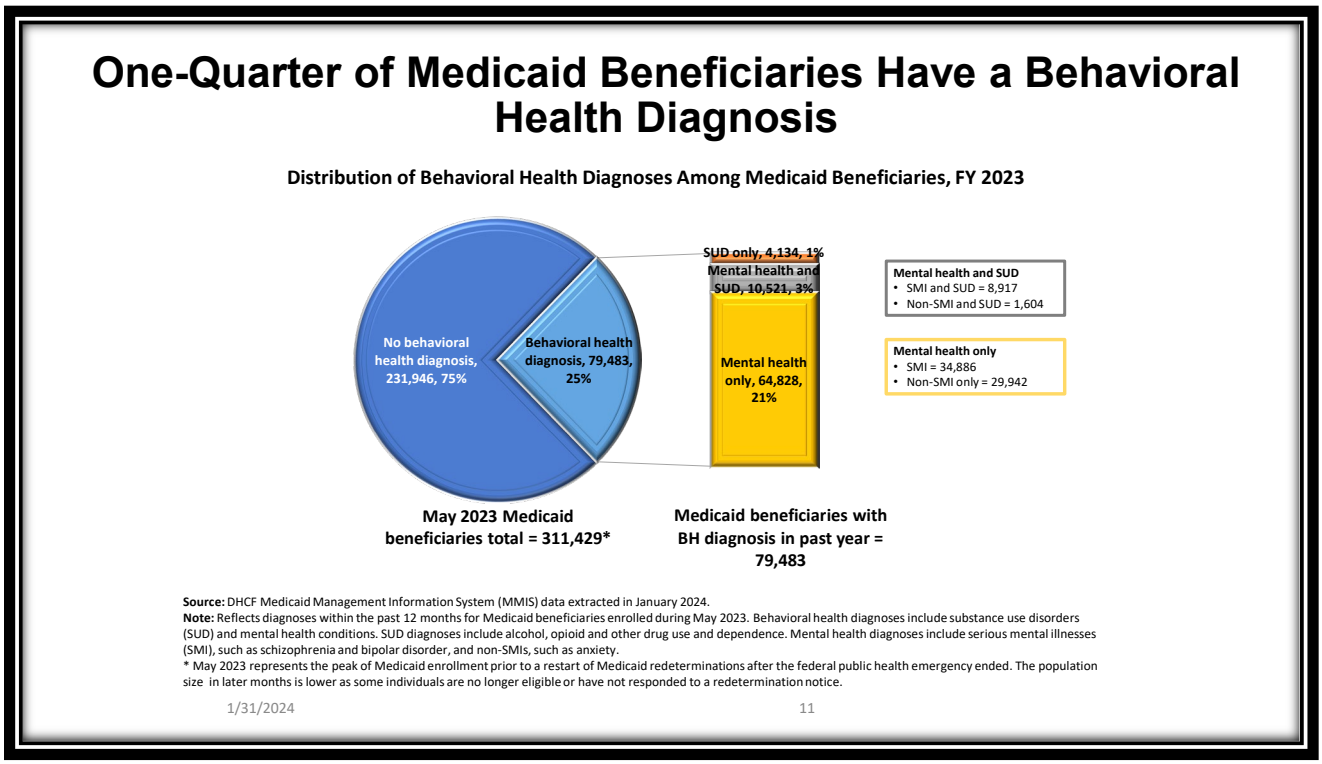


Implementation of the Behavioral Health Rate Study

According to the federal office of Health and Human Services, Medicaid is the largest payer for mental health services in the nation, accounting for nearly one quarter of US spending on these

services. Further, given the growing crisis with the misuse of opioids, states are expanding their programs to support community providers who serve persons in need of treatment for broader substance use disorders.

Through our close collaboration with the Department of Behavioral Health (DBH), DHCF's focus and efforts in mental health mirrors the observed national trends. DHCF's data show that as Medicaid enrollments reached an apex in FY23, with more than 311,000 enrollees, fully one-quarter of these beneficiaries had a mental health diagnosis, with 15 percent suffering from severe mental illness (see below). Beneficiaries with substance use disorders alone – a small but growing and dangerous problem – were present in four percent of these members.



Objectives of Behavioral Health Rate Study. The other major activity specific to behavioral health was the rate study – the first since 2016. The study represents a cooperative effort between DHCF, DBH, the District's behavioral health providers, provider advocacy groups and the Medicaid managed care plans. The objectives of the rate study were as follows:

- Ensure the rates used to reimburse for Medicaid behavioral health services in the District adequately reflect the cost to providers of delivering the service.

- Build into the rate model, flexible options for adjusting the rates at regular intervals.

- Ensure the reimbursement methodology is appropriately designed to reimburse similar services at comparable levels, regardless of the provider type delivering the service.

The rate study was developed using provider surveys and focus groups. In total, 53 services were reviewed, falling into three categories: (1) rate adjustments to existing services; (2) payment methodology changes to existing services; and (3) new Medicaid services. These categories are explained in more detail in the table below.

Three Categories Of Service Type Were The Focus Of The Behavioral Health Rate Study

Service Type	Description	Examples
Rate Adjustments to Existing Services	Service definitions and procedure codes stay the same for these existing services, but rates are adjusted based on what it costs to provide the service to fidelity and according to DBH regulations.	• Rate model assumptions include BLS regional salary data and adjustments for high turnover and recruitment costs.
Payment Methodology Changes to Existing Services	Changes in service definitions or service definitions stay the same, but the unit and/or frequency of reimbursement changes.	• Shifting from 15-minute increment billing to hourly or monthly billing. • Using Evaluation and Mangement CPT codes vs HCPCS codes. • Expanding allowable qualified practitioner types to align reimbursement of similar services for MHRS, ASARS and FSMHC provider types.
New Medicaid Services	Services brand new to the District or services currently reimbursed with local or grant dollars.	• Saving local dollars by seeking Medicaid FMAP for currently local-only services. • Expanding the menu of services to fill in gaps in the behavioral health system.

Additionally, a host of key variables important to understanding provider service cost were collected through the engagement process, and both DHCF and DBH provided historic claims data and other utilization data to the contractor to inform the rate-setting process. Using these and other

data, the contractor provided draft rates for each of the identified services which were central to development of new rates for the behavioral health provider community.

The rate study was completed in October 2023. Extensive work was conducted to understand the impact of increasing rates based on the study. After this analysis, DHCF worked with DBH to implement rates in FY24, while including estimates for paying these higher in FY25 budget formulation. This will be the first full year of the new rates for behavioral health providers.

Maternal Health Programming and the Renewal of the 1115 Waiver

As we testified in December's Roundtable on Maternal Health, DHCF pays for almost half (48 percent) of all births in the district, mirroring national trends and we offer a full range of Medicaid services to improve maternal outcomes. Some of the services include:

- Doctor visits, hospitalization, medically necessary transportation, dental services and related treatment, laboratory services, behavioral health, and reproductive health;
- Pregnancy, labor, and delivery and services to ameliorate any complications that may occur during pregnancy, as well as postnatal care; and
- Specific maternal health services, including midwifery, doula, and lactation consultation.

Also, postpartum coverage was extended to 12 months of eligibility, and we are now working with our home-visiting grantee to support first-time mothers. In FY23, we led the Perinatal Mental Health Task Force that thoughtfully crafted 21 recommendations which provide a roadmap towards a future where perinatal mental health services are not only accessible but are compassionate, comprehensive, and community driven.

Finally, we also reconvened the Maternal Health Advisory Group (Advisory Group) with a focus on learning from Virginia Medicaid on their provider recruitment and retention strategies. In February/March 2024, we will reconvene the Advisory Group with new objectives and a regular meeting cadence. The purpose of the Advisory Group is to provide expert advice and

recommendations to the Medicaid agency on matters related to maternal health, with a focus on both physical and mental well-being. The group aims to contribute insights, expertise, and evidence-based recommendations to enhance the quality and effectiveness of Medicaid services for pregnant individuals. The first agenda items will explore opportunities to increase doula provider recruitment and develop an implementation plan for the Task Force recommendations that are under the purview of the agency.

Updating the 1115 Waiver. Currently, DHCF operates an 1115 demonstration waiver that must be renewed by December 2024. The current waiver is intended to provide a broader continuum of behavioral health services and supports for individuals with SMI, SED, SUD, and/or other behavioral health needs. The waiver renewal will maintain institution for mental disease (IMD) services, allowing for the continued coverage of needed behavioral health services delivered in inpatient and residential facilities with more than 16 beds.

We are exploring new flexibilities including adding health-related social need (HRSN) services and an additional focus on our most vulnerable populations (i.e., individuals who are justice-involved, at-risk for, or experiencing homelessness, or who have complex care needs).

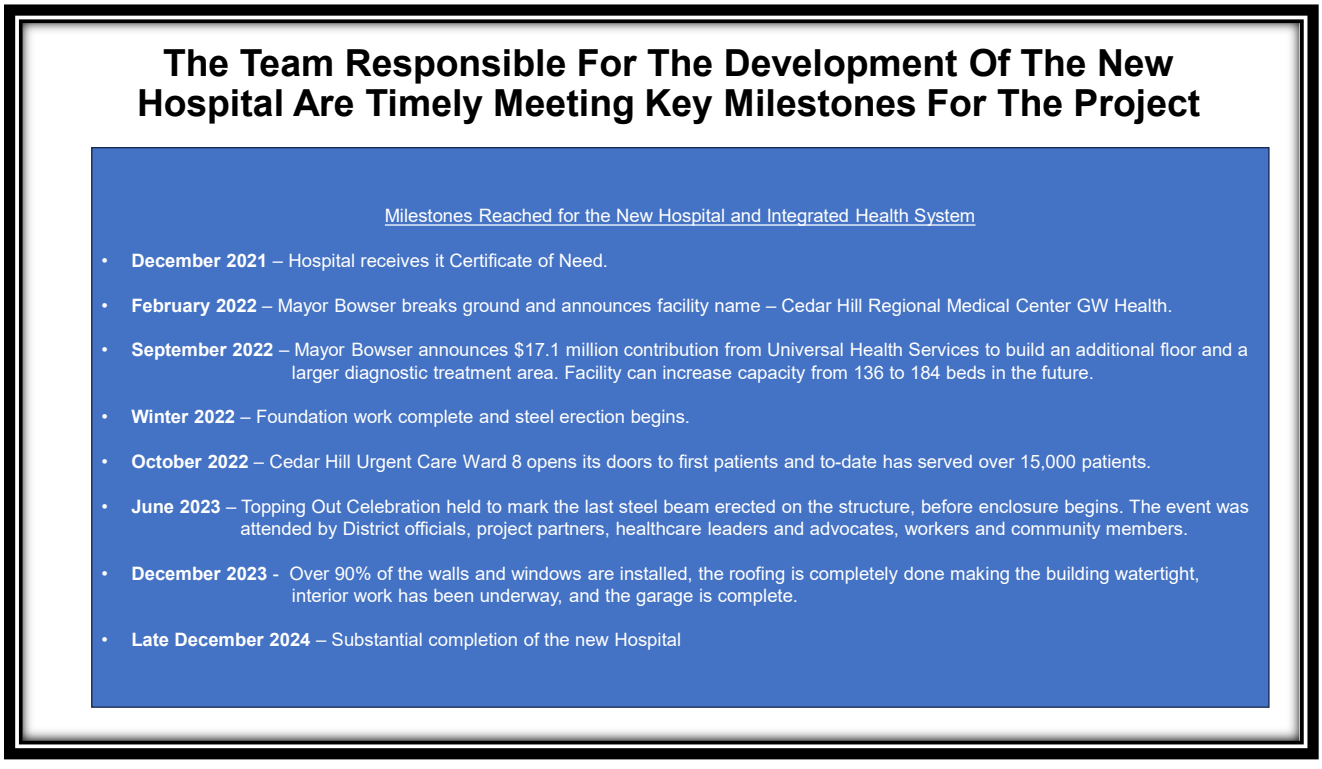
Finally, in partnership with other District agencies, DHCF is planning to submit a Medicaid State Plan Amendment to use Medicaid funds to pay for community-based programs intended to prevent gun violence in the District. Medicaid program options include allowing both hospitals and community partners to be reimbursed in their community violence prevention programs. Services include supporting victims' physical and mental health recovery and connecting them to social services.

I close the Medicaid-focused portion of this testimony by raising one very important caveat. In cases where we propose services that create local savings by substituting a Medicaid-subsidized service for one that is now fully supported with local funds, there are no budget pressures created

for EOM review. However, as we seek to expand programming that creates additional local costs, we cannot move forward without the concurrence of EOM and, most especially, the Mayor. Further, we are legally prohibited from submitting State Plan Amendments that expand care without the Mayor's approval.

Status of the New Hospital

Madam Chairwoman, the last topic for my testimony is the construction of the new Cedar Hill Regional Medical Center GW Health. First, and as always, let me say at the outset, that we are on schedule, within budget, and remain slated to open to patients in early 2025. The future hospital is over 65 percent complete, and we anticipate that the building will be substantially constructed by the end of 2024. Since the topping celebration last June, contractors have installed over 90 percent of the walls and windows. Additionally, we have permanent heat and power, the interior drywall work is underway, and the garage is complete (see milestone chart below).



The challenges created by the project have been numerous, but to date, there have been no problems that United Health Services (UHS) and its hired contractors have been unable to resolve. Some of the key issues that have been successfully managed are tackling inflation in the construction industry so that those pressures would not decimate the hospital project budget, meeting Certified Business Enterprise and project First Source requirements, implementing a voluntary training program for UMC employees, and building out the first urgent care facilities as a part of the GW hospital network.

Project Budget and Managing Inflationary Pressures. Nationally over the last four years, the cost of new facility construction has increased nearly 25 percent due to the impacts of COVID-19, global inflation, and labor and material shortages. Despite these challenges, to date, we have been able to hold inflation in the Cedar Hill project to less than nine (9) percent. UHS has done this by signing contracts early, which holds contractors' prices fixed, purchasing equipment and materials early, and constantly reviewing the hospital's design. With these steps, the development team has and continues to work diligently to mitigate inflation on the project.

On Track with Certified Business Enterprise (CBE), Local Hiring and Project Labor. We are proud of the progress made towards achieving the Mayor's and this Council's CBE goals. As of January 31, 2024, we have contracted $116.4M with CBEs on the project, approximately 37% of the current contract value. In terms of the location of the CBEs, there are 37 CBE vendors contracted across the District, with seven located in Ward 8, three in Ward 7, and five in Ward 5. In terms of contract value to date, of the $116.4M in total CBE contracts, $27.2M was awarded to CBEs in Ward 5, $1.6M in Ward 7, and $9.3M in Ward 8 - for a total of $38.1M.

In addition to meeting CBE goals, UHS has hired 174 new District residents just for this project, while also successfully implementing a Project Labor Agreement. We have also provided

47,000 hours for DC resident apprentices on the project, greatly exceeding our initial estimate of 15,000.

Creation of a Comprehensive and Integrated Health Delivery System. As you know, the hospital was only part of the District's agreement with UHS. In October 2022, the Mayor joined UHS to open the new Cedar Hill Urgent Care, located on MLK Avenue in Ward 8. The facility has been a huge success, offering convenient access to basic, non-emergency medical services, radiology, standard lab testing (blood work and urinalysis), and prenatal education. UHS initially expected the facility would see approximately 800 patients each month, however, after a full year of service, they are seeing closer to 1,200 patients monthly. This illustrates the need and interest for an accessible, high quality, community health care asset.

The future Ward 7 facility, which UHS expects to be larger, is now slated to open in late 2025. This delay reflects the challenge of finding an appropriate location and available real estate in the community. DHCF and DMPED continue to support UHS in this effort.

Voluntary Training Opportunity for United Medical Center Staff. As required by the District's Agreement with UHS, last fall, DHCF in partnership with GW Hospital and United Medical Center, launched a voluntary training program for full-time UMC employees. Employees who complete the training can leverage it in their application for a new position at Cedar Hill or any health care facility in the region. Completion of this training per se does not guarantee employment at Cedar Hill Regional Medical Center GW Health. But UMC employees will benefit from a hiring preference if they meet the minimum quality and hiring standards established by the new hospital. To inform staff, three in-person and virtual information sessions were held at UMC, which were attended by nearly one-third of the current workforce. Thirty-six employees have completed the first module and with rolling admissions we expect this number to increase.

Managing the Regulatory Requirements for Opening a New Hospital. The time between completion of the building and the first patient day is set aside for a comprehensive state and federal regulatory process that is required before any healthcare facility can begin treating patients. Our experts at UHS are steeped in experience with this process. To that end, UHS has, in partnership with DHCF, begun convening interagency meetings to review the complex hospital certification and activation process. While the eventual closure of UMC is a separate regulatory process being led by the UMC Board to ensure patients that meet medical standards for inpatient care are safely and appropriately transferred to other facilities, DHCF is in early communication with UHS and UMC leadership on the timing and coordination of any such transfers to Cedar Hill.

Lastly, this past December, UHS announced the hiring of Cedar Hill's inaugural CEO, Mr. Anthony Coleman, and their COO, Mr. Vaughn Williams. Both come with significant hospital and health system management experience. I have had the pleasure of meeting them both and I would be happy to facilitate an introduction.

Conclusion

Thank you for this opportunity to testify and we are ready to receive questions from the Committee.