DC CHILDREN'S LAW CENTER
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250 Massachusetts Ave. NW, Suite 350
Washington, DC 20001
T 202.467.4900 · F 202.467.4949
www.childrenslawcenter.org

Testimony Before the District of Columbia Council
Committee on Health
January 27, 2026

Public Oversight Hearing:
Performance Oversight
Department of Health Care Finance

Chris Gamble
Behavioral Health Policy Analyst
Children's Law Center

Introduction

Good morning, Chairperson Henderson, and members of the Committee on Health. My name is Chris Gamble, and I am a Behavioral Health Policy Analyst at Children's Law Center. Children's Law Center believes every child should grow up with a strong foundation of family, health, and education and live in a world free from poverty, trauma, racism, and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for citywide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify today about the Department of Health Care Finance's (DHCF) performance over the past year. The health sector overall faced a challenging year, but the Medicaid program in particular was impacted by local and federal pressures that resulted in major changes.[1] Medicaid is critical to the District's health system, with over 40% of residents covered by the program.[2] Last year's changes to Medicaid eligibility criteria, limits in services covered under the Healthy DC Plan, and the long-term gutting of the Alliance program mean that DC's Medicaid enrollees are maneuvering through a dramatically different health-care landscape.[3] And more change is to come as federal policies are enacted over the next few years that will lead to even more people losing health coverage.[4]

In our testimony at the Medicaid and Alliance program roundtable, we acknowledged that DHCF had to respond to the real financial pressures affecting Medicaid, but that the agency could have done more to minimize the harm on enrollees.[5] Further, the process through which

the public was informed about the changes to Medicaid demonstrates a need to improve community engagement when decisions with major impacts on people's lives are made. DHCF sent out mailed and digital communications and held several forums for the public to learn about changes to Medicaid.[6] While informative, it was clear that residents would need continued guidance to make the best healthcare decisions for themselves and their families. We hope to see DHCF engage the community and use feedback to inform future adjustments that restore crucial elements of their health coverage.

Beyond operating Medicaid, DHCF holds many other roles that impact the accessibility and quality of the health care that District residents receive. My testimony today provides several recommendations to improve both access to and quality of health care for District residents. Specifically, my testimony will focus on:

1) The benefits of carving-in behavioral health services into managed care
2) The need to enhance behavioral health performance standards for managed care organizations
3) Progress on establishing Certified Community Behavioral Health Clinics
4) Success and continued opportunities in maternal health
5) Ensuring the 1115 Waiver can be used to support health outcomes through promoting housing stability

The health of residents must be prioritized as DC continues to experience shifts across the health system.

The Managed Care Carve-in of Behavioral Health Services Remains Necessary to Improve Provider Accountability and Care Quality

We have consistently testified about the District's need to integrate all behavioral health services into the managed care plans through a process referred to as a "carve-in."[7] The District's current Medicaid financing system siloes out Mental Health Rehabilitative Services (MHRS) and Substance Use Disorder (SUD) services, paying for them through a fee-for-service structure where DBH allocates money to DHCF who then pays providers for billed services. Other health services are financed through capitated rate payments from DHCF to the managed care organizations (MCOs), a much more streamlined process. This separation of MHRS and SUD services from the rest of the system creates data gaps, complicates referral processes, and leaves MCOs without the ability to "see" all the care that their beneficiaries receive. DHCF and DBH identified the carve-in as a solution to these issues, a way to work toward improved cost efficiency and provider quality. The agencies initially planned for the carve-in to be implemented in October 2022 but have delayed it year after year to the point that there is now no start date indicated or a plan for how to move forward.

The carve-in will give MCOs the ability and incentive to coordinate their beneficiaries' care such that they get the right care at the right time and ultimately reduce time-consuming and costly interventions like hospitalization. Shifting behavioral health into managed care will also strengthen the impact of MCO network adequacy and timeliness standards as MCOs will have a direct relationship with providers through which accountability mechanisms can be established. The direct contracting between providers and MCOs will also enable MCOs to de-panel a provider when quality of care or billing fraud concerns are confirmed, protecting consumers from receiving poor services. These benefits to our health system and consumer

experience have been delayed by financial constraints that the District has not been able to resolve since pausing work on the carve-in back in February 2024.[8]

In recent meetings with Budget Director Jenny Reed and Deputy Mayor Wayne Turnage, we have received encouraging feedback that there are viable steps DHCF and other executive agencies can take to move the District forward in making the carve-in a reality. We appreciate their transparency and commitment to explore avenues for moving forward with this important change. We ask that the Committee talk with both officials before FY27 budget hearings to understand what steps can be taken this year to begin implementation of the carve-in.

DHCF Must Hold MCOs to High Performance Standards to Improve the Quality of and Access to Behavioral Health Services

As of December 2025, there are almost 240,000 District residents who are enrolled in an MCO: Wellpoint DC, Amerihealth Caritas DC, MedStar Family Choice DC, Health Services for Children with Special Needs, or United Healthcare (Dual Choice program).[9] The Committee's September 2025 roundtable was a welcome example of the engagement that must continue with MCOs to keep track of their performance and spur further improvements. Consistent oversight will also benefit the eventual carve-in of behavioral health services to managed care.

MCO Behavioral Health Performance Standards Should Be Expanded

For Children's Law Center clients, access to behavioral health services is a critical need.[10] For years, challenges with accessing and receiving consistent, quality services have hindered the opportunities our clients have to address the trauma and other behavioral health ramifications of abuse, neglect, and removal from their homes.[11] In FY25, out of the children in foster care represented by our guardians ad litem, over 40% had either a diagnosed behavioral health

condition or suspected behavioral health needs.[12] After they were assessed for their needs and recommended behavioral health services, only half actually received the recommended services. Even when a child does access care, patterns of delays in starting services and clinician turnover disrupt treatment. One of our clients had three therapists this past year due to the widespread issue of staffing instability within the District's behavioral health provider network.[13] That means that with each therapist, the child had to share their experiences and traumas all over again in hopes of forming a trusting, effective therapeutic relationship.

The network adequacy standards that MCOs currently follow need to be strengthened in order to address the kinds of challenges our clients and other DC residents face in accessing care. Although the annual reports that purportedly assess whether DC's MCOs are meeting network adequacy standards seem to conclude MCO performance is satisfactory,[14] our clients' experiences call this conclusion--and the performance standards on which it is based--into question. Currently, DC's MCOs must meet network adequacy standards around time and distance, specifically at least one behavioral health provider type within five miles or thirty minutes travel time.[15] While geographic accessibility is important, it does not capture all aspects of accessibility. Bundles of measures that assess for the types of services offered, scope of practice, cultural demographics, and the availability of telehealth services in the network account for unique features of behavioral health services that matter for outcomes.[16]

Timeliness of care has also been an issue. A 2024 Performance Improvement Project required MCOs to improve across several metrics related to timeliness, including timeliness of follow-ups after emergency department visits or hospitalization for mental illness.[17] While care continuity post-discharge is important, additional standards can deepen understanding of how

enrollees access care. For example, the *A Path Forward* report recommends the creation of standards regarding the wait time between appointments, such as time from initial appointment to second appointment.[18] CLC clients sometimes have an intake appointment with a provider and then experience a significant gap before the first appointment where treatment is provided. If not tracked separately, the occurrence of the intake appointment can make it look like treatment is being accessed sooner than is actually the case. We ask the Committee to work with DHCF on implementing more precise behavioral health metrics for MCOs.

Communication Gaps Between Social Security And HSCSN Create Challenges With Maintaining Coverage

During the fall MCO roundtable, we testified about an issue where some of our clients covered by HSCSN have been improperly dropped from Medicaid coverage completely when their parent's income increases above the threshold for SSI, despite the child's qualifying disability.[19] This seems to be primarily an issue with the Department of Human Services' (DHS) District of Columbia Access System (DCAS),[20] but we urge DHCF to pursue answers and address the underlying issue to ensure that no more children improperly lose health coverage.

DHCF Should Show Progress on Establishing Certified Community Behavioral Health Clinics, Critical Additions to Our Continuum of Care

The continuum of care for children's behavioral health services in the District continues to deteriorate with longstanding gaps in acute care staying stagnant while community-based programs like CBI, MST, and FFT shrink in availability year after year and intentional cuts are made to youth mobile crisis services.[21] The District has an opportunity, by establishing Certified Community Behavioral Health Clinics (CCBHC), to institute a more stable model of providing comprehensive community-based care supported by an enhanced financing model.

CCBHCs provide services to people of all ages, across all mental health and substance use diagnostic categories, regardless of their ability to pay. Their structure removes many of the barriers people experience when seeking care. CCBHCs may provide services directly or through partnerships with existing providers in a given locale. The model provides a federally determined set of nine required core services.[22] They also have federally determined care quality standards. Additionally, CCBHCs rely on a Prospective Payment System (PPS), an enhanced Medicaid reimbursement rate that covers the expected cost of delivering the required services.[23] This funding model sustainably supports service provision instead of relying on billing volume.

In 2025, DC was awarded a $1 million, one-year CCBHC Medicaid Demonstration Program planning grant.[24] The planning grant allowed DHCF and DBH to develop a CCBHC certification process, establish its PPS, and prepare to apply for a four-year CCBHC demonstration grant in 2026. To date, there have not been clear public updates on the agencies' planning progress. Requests for application have been posted for organizations that want to become CCBHCs, but no information is available on how many have applied. The care and quality standards for CCBHCs are high,[25] and establishing a PPS is complex, so transparency is needed to ensure progress is being made on bringing this vital resource to the District. We ask this Committee to ask DHCF about progress in establishing CCBHCs in the District.

The Department of Health Care Finance Continues to be a Leader in the District for Maternal Health Initiatives, But Continued Opportunities for Growth

The First Year of the Transforming Maternal Health Model Has Moved Forward Conversations on Improving Implementation of the Doula Medicaid Benefit

The District's doula Medicaid benefit allows for all pregnant individuals covered by Medicaid to have access to a total of 12 doula visits across the prenatal, childbirth, and postpartum periods.[26] Covering doula services through Medicaid was an important step forward in addressing DC's poor maternal health outcomes.[27] While doulas are only one element for preventing maternal morbidity and death, ensuring Medicaid beneficiaries have access to doulas is critical to supporting those who often face worse outcomes in maternal health. Prior to the doula Medicaid benefit, doulas were almost unattainable to those who could not afford them – the average doula cost costing anywhere from $1000 to $4000.[28] Now those enrolled in Medicaid can access doulas at no cost them – and they have been. However, as this Committee heard during the September 2025 MCO Roundtable, access has been limited due to significant implementation concerns with the doula Medicaid benefit.[29]

The doula Medicaid benefit became effective/available on October 1, 2022 – thanks to the leadership of this Committee, the work of DHCF, and the Maternal Health Advisory Group. However, in the subsequent years we have continued to be concerned about how implementation of the benefit was going.[30] We, therefore, were excited when DC received the Transforming Maternal Health (TMaH) award from the Center for Medicare and Medicaid Services (CMS) in January 2025. Over the course of the next 10 years. DHCF will work to implement TMaH – CMS's new framework for supporting improved maternal healthcare delivery for Medicaid enrollees.[31]

In the first three years of TMaH, DHCF must focus on (1) access, infrastructure, and workforce – including expanding access to doula services; (2) quality improvement and safety – including implementation of AIM patient safety bundles; and (3) whole person care delivery –

including increased risk assessment screenings and home monitoring efforts.[32] We were excited to see the focus on doulas as a part of TMaH. In general, DHCF has been a partner in the work of the doula Medicaid benefit implementation – the agency has been both responsive and collaborative in trying to help doulas navigate the complexities of the Medicaid system. DHCF has made significant investments in staff time, energy, and expertise.

Additionally, we appreciate DCHF's collaboration with the Doula Learning and Action Collaborative (DLAC). In partnership with A Queen Mama Doula Services, supported by an Institute of Medicaid Innovation grant, Children's Law Center convened stakeholders including doulas, DHCF, Department of Health, MCOs, community organizations, and other health care providers to work together on improving implementation of the doula Medicaid benefit.

DLAC has identified some key areas of improvement for smoother implementation of the benefit including the need to create a landscape of doulas and the current implementation of the doula Medicaid benefit in the District, guidance for doulas to support enrollment and billing a Medicaid provider, and to establish a place for centralized resource navigation for doulas trying to access the benefit like a website. DLAC, with support from other resources like National Health Law Program, has identified what many other jurisdictions have done to implement the doula benefit and are working on how we may translate those efforts in the District. We first want to address issues that doulas face when enrolling, credentialing, contracting, and billing MCOs for their services. After improving these barriers to entry, the work will shift to increasing the number of enrolled doulas and broadening awareness among Medicaid beneficiaries.

Most recently, DLAC announced that it would be running the State Doula Advisory Council – a requirement of TMaH. We appreciate DHCF's partnership in this work and trust in DLAC to play this important role. While there is significant more work to do realize the full potential of the doula Medicaid benefit – we appreciate the progress made over the past year and look forward to continuing this crucial work. We thank this Committee for collaborating with DLAC, holding the MCO roundtable, and continuing to partner to support implementation of the doula Medicaid benefit. Moving forward, we hope this Committee will continue to support transparency and consistent reporting on MCOs, the implementation of Medicaid services, and the TMaH work.

DHCF Continues to the Leave Home Visiting Funding on the Table by Not Implementing a State Plan Amendment for Medicaid Funding

Another component of DHCF's maternal health work is home visiting. Generally, home visiting is a voluntary, free support service where trained professionals visit expectant parents and families with young children at home to provide education, resources, and coaching on healthy pregnancy, child development, parenting skills, and connecting to community services, aiming to improve family well-being and child outcomes.[33] Currently, DHCF manages funding for one home visiting program – Nurse Family Partnership (NFP). NFP is free, evidence-based home-visiting program that pairs specially trained registered nurses with low-income, first-time expectant mothers, starting in pregnancy and continuing until the child's second birthday to improve maternal/child health, development, and family self-sufficiency.[34]

In the District, Mary's Center is implementing NFP. The programs helps ensure parents are engaging in postpartum visits, receiving of perinatal depression screening and substance use screening, and initiating breastfeeding as well as supports infants to ensure receipt of

recommend immunizations by 12 months age.[35] At a national level, NFP has been show to help parents have successful long-term outcomes.[36]

Based on the success of NFP in the District and its current reliance on grant and local funds – efforts were undertaken two years ago to leverage Medicaid dollars to create a more sustainable pathway for NFP funding and hopefully expand to other community-based organizations in the District.[37] Currently, the Home Visiting Services Reimbursement Act of 2023 requires DHCF to submit a State Plan Amendment (SPA) to include reimbursement for nurse-led home visiting services like NFP.[38] DHCF could choose to expand the scope of reimbursement to include more home visiting services – the Act currently limits the scope of the required SPA to nurse-led due to funding availability.[39] DHCF has refused to submit the SPA for two years now despite available funding.[40]

We are grateful to this Committee and Councilmember Nadeau's investment in NFP funding – increasing local funding from $225,000 to $625,000 for Fiscal Year 2026 and beyond. The $625,000 existing in the budget could and should be leveraged for Medicaid reimbursement for NFP. Currently, the Center for Medicare and Medicaid Services (CMS) provides a 70 Federal Medical Assistance Percentage (FMAP) – meaning that if DC were to put all existing local NFP dollars into Medicaid, they could draw down an additional $1.4 million.[41] Making the total available funding for NFP over $2 million – significantly more money they what is needed to support the existing program meaning there could be opportunities for expansion to more families or to additional community based organizations.[42]

Moreover, after year three of TMaH implementation, home visiting is an optional component that DHCF can choose to include in this model transformation. The inclusion of

home visiting in TMaH as optional means that DHCF does not have to include it the modeling that is being done for transforming maternal health care in the District. This would, however, be a missed opportunity. Given the success that programs like NFP and others have had in improving maternal health outcomes, the inclusion of home visiting in year four of the TMaH work is necessary. As recognized in the Perinatal Mental Health Task Force Report, home visiting is a crucial element of the continuum of care for maternal health – home visiting programs enhance prenatal care access, reduce preterm births, and support mental health. We, therefore, highly encourage DHCF to include home visiting in this work – if not sooner per the Home Visiting Reimbursement Act.[43]

We, therefore, ask this Committee to work with DHCF to understand why they continue to leave Medicaid reimbursement funding for home visiting on the table especially given there is existing funding for the program. DHCF has made significant progress in the area of maternal health. To continue this forward momentum, we ask the committee to work with the agency to identify and eliminate barriers to pursuing Medicaid reimbursement for home visiting or at least make clear and transparent why the agency is not moving forward with this seemly common-sense path to increasing and stabilizing resources for HV.

To maximize impact and cost efficiency, Medicaid funding must be skillfully braided with other funding sources like Maternal, Infant, Early Childhood Home Visiting (MIECHV), Children's Bureau Child Abuse and Prevention, Title IV, and local dollars.[44] While there is a general need to better coordinate home visiting in the District, leveraging all available funding is a starting point. We appreciate this Committee's continue support for home visiting. We look

forward to working with relevant stakeholders – DHCF, CFSA, DC Health, and home visiting partners – to ensure successful implementation of home visiting for DC families.

Ensure 1115 Waiver Is Utilized to Support Health Outcomes by Promoting Housing Stability

In its implementation of Medicaid, DHCF may request that the U.S. Department of Health and Human Services (HHS) approve small program adjustments to evaluate approaches to better servicing the Medicaid populations.[45] These approved program adjustments are referred to as "1115 Waivers."[46]

Through a Section 1115 waiver, a state may, among other permissible purposes, allow Medicaid funding to be used for purposes not typically covered by the program.[47] HHS has found social determinants of health ("non-medical factors that affect health outcomes")[48] to be permissible uses of 1115 Waivers.[49] At least 32 different jurisdictions, including DC, have had HHS approve waivers proposing to provide housing and related services.[50]

DC identified housing support as one proposed purpose for Section 1115 waivers in its March 2022 Amendment to its plan.[51] Housing was further identified as a requested item in the District's June 2024 waiver renewal request,[52] following DHCF engagement with the community and a public comment period.[53]

Following an extension to December 31, 2026, the District's Section 1115 plan from 2022 continues to be in place as DHCF and HHS negotiate the terms of the June 2024 waiver renewal request.[54]

We urge the Council to monitor DHCF's development of the 1115 waiver plan and ensure that permissible uses include housing costs (e.g., rent, housing transitions, utility support, and tenancy stabilization). Housing stability is a critical social determinant of health

that directly affects health outcomes and Medicaid costs.[55] Experts and cross-sector leaders are increasingly recognizing the role of housing in health care delivery.[56] Moreover, including housing in the waiver aligns with both local stakeholder feedback and emerging national practice of integrating social determinants of health into Medicaid innovations.[57]

Accordingly, we suggest the Council consider formal reporting or check-ins with DHCF throughout the waiver negotiation process with HHS to ensure that housing services are not excluded from the waivers' scope.

Conclusion

With more hurdles ahead for the health sector, the well-being of District residents must remain a priority for DHCF. Thank you for the opportunity to testify, and I welcome any questions you may have.

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[1] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (December 3, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/12/C.-Gamble_Changes-to-the-Districts-Medicaid-and-Alliance-Programs_Written-Testimony_12.3.25-1.pdf.

[2] Monthly Medicaid and Alliance Enrollment Reports, (December 2025), *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCAC%20Enrollment%20Report%20-%20December%202025.pdf.

[3] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (December 3, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/12/C.-Gamble_Changes-to-the-Districts-Medicaid-and-Alliance-Programs_Written-Testimony_12.3.25-1.pdf.

[4] Health Provisions in the 2025 Federal Budget Reconciliation Bill, KFF, (July 8, 2025), *available at*: https://www.kff.org/medicaid/tracking-the-medicaid-provisions-in-the-2025-budget-bill/.

[5] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (December 3, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/12/C.-Gamble_Changes-to-the-Districts-Medicaid-and-Alliance-Programs_Written-Testimony_12.3.25-1.pdf.

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content/uploads/2025/02/DHCF-Performance-Oversight-2025-Childrens-Law-Center-Written-Testimony-2.12.25.pdf.

[8] DHCF Behavioral Health Integration, *available at*: https://dhcf.dc.gov/page/behavioral-health-integration.

[9] Monthly Medicaid and Alliance Enrollment Reports, (December 2025), *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCAC%20Enrollment%20Report%20-%20December%202025.pdf.

[10] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 3, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/02/DBH-Performance-Oversight-2025-Childrens-Law-Center-Written-Testimony-2.3.25.pdf.

[11] *Id.*

[12] Internal Children's Law Center Data Collection, "GAL Deep Dive," October 1, 2024 through September 30, 2025.

[13] Leah Castelaz, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 24, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/02/Leah-Castelaz___Testimony-before-DC-Council-Committee-on-Health___DC-Health-Performance-Oversight__2.24.25.pdf.

[14] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (September 30, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/09/C.Gamble-Managed-Care-Organizations-in-the-Districts-Medicaid-Program-Written-Testimony-9.30.25-3.pdf.

[15] Qlarant, District of Columbia Managed Care Programs 2024 Annual Technical Report, available at: https://dhcf.dc.gov/page/mco-external-quality-review-annual-technical-reports.

[16] National Committee for Quality Assurance, Improving Accountability for Behavioral Health Care Access: Evaluating the Current Evidence for Behavioral Health Network Adequacy Standards (2024), available at: https://wpcdn.ncqa.org/www-prod/NCQA-Improving-Accountability-for-Behavioral-Health-AccessWhitepaper.pdf.

[17] Qlarant, District of Columbia Managed Care Programs 2024 Annual Technical Report, available at: https://dhcf.dc.gov/page/mco-external-quality-review-annual-technical-reports.

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[19] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (September 30, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/09/C.Gamble-Managed-Care-Organizations-in-the-Districts-Medicaid-Program-Written-Testimony-9.30.25-3.pdf.

[20] DCAS is accessed through the District Direct website or app. *See*: https://districtdirect.dc.gov/ua/.

[21] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 3, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/02/DBH-Performance-Oversight-2025-Childrens-Law-Center-Written-Testimony-2.3.25.pdf.

[22] The nine services are: (1) outpatient mental health and substance use services, (2) person and family centered treatment planning, (3) care for veterans, (4) peer support services, (5) targeted case management, (6) outpatient primary care screening and monitoring, (7)psychiatric rehabilitation, (8) screening diagnosis and risk assessment, and (9) crisis services. *See*: CCBHC Certification Criteria, (March 2023), *available at*: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf.
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[25] SAMSHA set of certification criteria: (1) staffing requirements, (2) availability and accessibility of services, (3) care coordination, (4) scope of services, (5) quality and other reporting, and (6) organizational authority, governance, and accreditation.
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[26] Department of Health Care Finance, Doula Services Benefit Design and Reimbursement methodology, *available* at: https://dhcf.dc.gov/doula-services-spa.
[27] Doulas help support attendance of postpartum visits, doulas lower the risk of pre-term birth, and doulas are associated with a reduction in cesarean delivery risks. *See* April M. Falconi, Leah Ramirez, Rebecca Cobb, Carrie Levin, Michelle Nguyen, and Tiffany Inglis:
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[29] Committee on Health, Managed Care Organizations (MCOs) in the District's Medicaid Program, September 30, 2025, *available at*: https://lims.dccouncil.gov/Hearings/hearings/939.
[30] *Id.*
[31] Center for Medicare and Medicaid Services, TMaH (Transforming Maternal Health) Model, *available* at: https://www.cms.gov/priorities/innovation/innovation-models/tmah#:~:text=The%20Transforming%20Maternal%20Health%20(TMaH,%2C%20childbirth%2C%20and%20postpartum%20care.
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[33] National Home Visiting Resource Center, What is Home Visiting, *available at*: https://nhvrc.org/what-is-home-visiting/.
[34] Changent, Nurse-Family Partnership, *available at*: https://changent.org/what-we-do/nurse-family-partnership/.

[35] FY24 Department of Healthcare Finance Performance Oversight Responses, response to Q76, *available at*: https://dccouncil.gov/wp-content/uploads/2025/02/DHCF-FY24-25-Performance-Oversight-Responses.pdf.
[36] For example, a recent 2024 study, found that nurse home visits to mothers facing social and economic challenges can significantly reduce hypertension in mothers of females and obesity in their daughters. *See* Changent, *RESEARCH FOLLOW-UP HIGHLIGHTS NURSE-FAMILY PARTNERSHIP'S SUBSTANTIAL IMPACT ON LOWERING HYPERTENSION RATES IN MOTHERS AND REDUCING OBESITY AMONG THEIR DAUGHTERS,* January 25, 2024, *available at*: https://changent.org/news/research-follow-up-highlights-nurse-family-partnerships-substantial-impact-on-lowering-hypertension-rates-in-mothers-and-reducing-obesity-among-their-daughters-2/; All research available at NFP International, *available at*: https://nfpinternational.org/research/.
[37] If the home visiting reimbursement act had passed – Martha's Table was committed to standing up a NFP program. *See* Committee on Health, Hearing on B25-0321 Home Visiting Services Reimbursement Act of 2023, *available at*: https://lims.dccouncil.gov/Hearings/hearings/87.
[38] DC Act 25-390, Home Visiting Services Reimbursement Amendment Act of 2024.
[39] DC Act 25-550, Fiscal Year 2025 Budget Support Act of 2024.
[40] FY2024 Performance Oversight Department of Health Care Finance Hearing, *available at*: https://lims.dccouncil.gov/Hearings/hearings/639.
[41] Current funding is $625,000 and with the current FMAP, CMS would give an additional $1.4M (2.33 times $625,000). *See* Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, *available at*: https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[42] $1.4M + $625,000 is $2.025M. The current investment is $625,000. *See* Report and Recommendations of the Committee on Health on the Fiscal Year 2026 Budget for Agencies Under Its Purview, (June 23, 2025), *available at*: https://static1.squarespace.com/static/5bbd09f3d74562c7f0e4bb10/t/6858519ed3c7487ab15a385e/1750618528038/Health_FY26+Budget+Recommendations+and+Report+%28Revised+Draft+1%29.pdf.
[43] Department of Health Care Finance, Perinatal Mental Health Task Force Report and Recommendations, (January 17, 2024), *available at*: https://dhcf.dc.gov/publication/perinatal-mental-health-task-force.
[44] Healthy Families America, Supporting Home Visiting: A Guide to State and Federal Funding, *available at*: https://preventchildabuse.org/wp-content/uploads/2020/06/State-and-Federal-Funding-Streams.pdf.
[45] Social Security Act § 1115 (codified at 42 U.S.C. § 1315). DHHS will review proposals for consistency with Medicaid program goals, and for budget neutrality. About Section 1115 Demonstrations, Centers for Medicare & Medicaid Services, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html. If approved, the program adjustment will be in place for an initial five-year period, extendable upon request for a term of three or five more years. *Id.*
[46] David A. Super, *A Hiatus in Soft-Power Administrative Law: The Case of Medicaid Eligibility Waivers*, 65 UCLA L. REV. 1590, 1594 (2018).
[47] 42 U.S.C. § 1315(a); Janet Viveiros, *Affordable Housing's Place in Health Care*, Center for Housing Policy (June 2015), *available at*: https://www.nhc.org/publication/affordable-housings-place-in-health-care-opportunities-created-by-the-affordable-care-act-and-medicaid-reform/.

[48] Social Determinants of Health, Center for Disease Control, (May 15, 2024), *available at* https://www.cdc.gov/public-health-gateway/php/about/social-determinants-of-health.html ("They include the conditions in which people are born, grow, work, live, and age. SDOH also include the broader forces and systems that shape everyday life conditions.").

[49] *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, Henry J. Kaiser Family Foundation, *available at*: https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/.
[50] Joshua Haas, Note, *Why Medicaid is Addressing Homelessness with Section 1115 Waivers: A Critical Examination of the United States' Federalist Mental Health System,* 100 WASH. L. REV. 511, 515 (2025).

[51] District of Columbia State Plan Amendment 21-0015, Mar. 25, 2022), *available at*: https://www.medicaid.gov/medicaid/spa/downloads/DC-21-0015.pdf.
[52] Department of Health Care Finance, District of Columbia Section 1115 Medicaid Demonstration Renewal Request, 19, (June 6, 2024), *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DC%201115%20Renewal%20Application_20240606.pdf.

[53] Department of Health Care Finance, Section 1115 Demonstration, *available at*: https://dhcf.dc.gov/1115-waiver-initiative ("The Health System Redesign (HSR) Subcommittee of the MCAC serves as the forum for focused community engagement on the 1115 waiver renewal. The HSR Subcommittee meets monthly, typically on the second Thursday of the month from 2-4pm. The HSR Subcommittee meetings are an open group and anyone is invited to attend.").

[54] Letter to Director Melisa Byrd, (Nov. 17, 2025), *available at* https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/dc-behavioral-health-transformation-temp-ext-appvl-11172025.pdf.
[55] EDGE PD & R, *Leveraging Healthcare Organization Assets for Affordable and Supportive Housing*, (July 30, 2024) *available at*: https://www.huduser.gov/archives/portal/pdredge/pdr-edge-featd-article-073024.html.

[56] *See e.g.*, Federal Reserve Bank of New York, *Fostering Neighborhoods: Hospitals and the Development of Affordable Housing*, (Mar. 7, 2024), *available at*: https://www.newyorkfed.org/newsevents/events/regional_outreach/2024/0307-2024 (a recorded event held by the Federal Reserve Bank of New York, in partnership with the NYU Furman Center, encouraging cross-sector collaboration to build more affordable housing in New York City and noted the role hospital systems are playing nationally in building affordable housing and their positive effect on health outcomes. One speaker identified that the effort and expense of treating unhoused individuals often is negated when discharged patients do not obtain access to safe or supportive housing).

[57] *See* Department of Health Care Finance, District of Columbia Section 1115 Medicaid Demonstration Renewal Request, 19, (June 6, 2024), *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DC%201115%20Renewal%20Application_20240606.pdf (describing the District past use of waivers for housing and collaboration with others).