



District of Columbia
Primary Care Association

Action And Innovation For Health Equity.

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**B18-1101, THE "FISCAL YEAR 2011 REVISED
BUDGET REQUEST ACT OF 2010" AND
B18-1100, THE "FISCAL YEAR 2011
SUPPLEMENTAL BUDGET SUPPORT ACT OF 2010"**

Council of the District of Columbia

November 30, 2010

**Committee of the Whole
The Honorable Vincent C. Gray, Chairman**

By

**Sharon A. Baskerville
Chief Executive Officer
District of Columbia Primary Care Association**

Good morning, Chairman Gray and distinguished members of the committee. My name is Sharon Baskerville, chief executive officer of the DC Primary Care Association (DCPCA). DCPCA represents historic, safety net, community-based primary care providers and other key stakeholders who are committed to our mission of creating a health care system in the District of Columbia that allows for everyone to be covered and everyone to be cared for. I am here today to speak on behalf of DC's most vulnerable; and about how the Fiscal Year 2011 Revised Budget Request Act of 2010 and Fiscal Year 2011 Supplemental Budget Support Act of 2010 proposals may impact health equity in the District.

On Poverty

Mr. Chairman, we are aware that tough decisions must be made. We are not here to debate that. However, as a voice for the voiceless and an advocate for the District's most vulnerable populations, we want to make sure their voices are heard – loud and clear, of how the proposed cuts will play out and negatively impact their quality and wellness of life. **Poverty itself is not a force of nature; it is a construct of man.**

And the District has experienced perpetual poverty in a way unlike any other jurisdiction in the country. A study released in March 2010 by the DC Fiscal Policy Institute shares that:

- The poverty rate in the District is estimated to have increased from 16.9 percent in 2008 to 18.9 percent in 2009. This means an estimated additional 11,000 residents fell into poverty in 2009, bringing the number of poor DC residents to 106,500. (The federal poverty line in 2009 was \$21,800 for a family of four.)
- The projected growth in DC's poverty rate in 2009 is the largest year-to-year increase since 1995.

According to Defeat Poverty DC and a report by the DC Fiscal Policy Institute released in September 2010, based on new data from the US Census Bureau:

- Nearly 1 in 5 DC residents live in poverty.
- Nearly 1 in 3 children in DC live in poverty.
- 1 in 5 workers in DC has a job that won't lift a family out of poverty.
- 1 in 3 residents east of the Anacostia River lives in poverty. The poverty rate for residents living in Wards 7 and 8 grew from 27 percent in 2007 to 34 percent in 2009.
- 1 in 4 residents with a high school diploma lives in poverty. Among residents with a high school diploma or GED, poverty increased from 20 percent in 2007 to 25 percent in 2009.

There is also a direct correlation between certain diseases and poverty, such as diabetes. In fact, just 3.5 percent of those with incomes of at least \$75,000 have been diagnosed with diabetes, whereas 14.1 percent of those with incomes less than \$15,000 have been diagnosed.

IMPLICATIONS OF BUDGET CUTS ON VULNERABLE POPULATIONS

We all recognize the need to close a \$188 million budget gap for the current fiscal year, with deficits climbing into \$400 million through 2013. There are two ways to reduce a deficit and close a budget gap: eliminate spending and/or increase taxes. In the proposed budget, the largest share of budget cuts, 39 percent, would fall on services for low-income residents, even though these programs represent just 26 percent of the locally funded budget and have already been cut substantially over the past three years. Mayor Adrian M. Fenty's new proposal to close the fiscal year 2011 budget gap would make further cuts in a wide array of services: adult job training, affordable housing, child care, and small business assistance, among others. This should be a

shared budget, with shared responsibility, and we cannot continue to only ask the poor, the disabled, and the vulnerable to pay up, without paying our own share.

Arguing for a “cuts only” approach ignores the real problem facing DC’s budget. DC cannot be “penny wise and pound foolish.” A balanced approach to closing the gap that includes sensible revenue increases can help DC protect many of the quality of life services our communities rely on and help address the biggest problem facing our budget – the drop in revenue.

On Health Equity

Health equity is achieving the highest level of health for all people – equality in health care so that every person is guaranteed the best care with the best health care outcomes. DCPCA has spent more than a decade improving the primary health care system in the District and promoting a system that guarantees access to good health care for all by eliminating disparities in health outcomes for the residents of the District of Columbia. As we move from disparity-thinking to equity-thinking, our focus will remain on the uninsured and underserved, so that everyone has the opportunity and resources to live healthier lives.

The budget proposal reflects \$32 million in reduced expenses for certain services, \$19 million in greater use of federal funds, and \$21 million from tapping unspent resources in special funds. Only \$2.5 million would come from new fees – an increase in DC’s hospital tax from \$1,500 per licensed bed to \$2,000, and an increase in parking rates at Washington Metropolitan Area Transit Authority (Metro) lots. This means that the proposal includes more than \$40 in spending cuts for every \$1 in revenue increases.

We cannot keep “robbing Peter to pay Paul,” so to speak. We need to build a practical, complete system, (1) with sufficient education: to empower residents to make healthier choices; (2) sufficient job opportunities: to provide access to a path out of poverty and more affordable health coverage; and (3) a health care system that guarantees access to quality, affordable care.

Example: Temporary Assistance for Needy Families

The Temporary Assistance for Needy Families (TANF) program was created out of the need to provide assistance to needy families with children so that they can live in their own home or the homes of relatives. This program is critical to empowering many low-income adults in the District as it provides job search and job readiness activities. A few weeks ago, the Committee on Human Services held a hearing on Bill 18-1061, the DC Public Assistance Amendment Act of 2010. It was said that DC’s current TANF Employment Program can accommodate only 65 percent of active TANF cases. This means that 35 percent of eligible TANF families are not able to access the program’s integral services – including job readiness, education, and others. Members of the DC Council used the bill to open broader dialogue about lifting people out of poverty and empowering them to not be so dependent upon welfare programs. Using TANF as an example, we can see that we must find other opportunities for reducing the deficit, ones which do not include cutting spending alone. A similar issue arose with enrollment forecasts for Medicaid and the DC HealthCare Alliance. We need to be realistic about enrollment rates, as these are entitlement programs, and if people are eligible, as they should be, they should also be able to understand the services available to them and

access those services. If entitlement programs such as TANF and Medicaid are a strain on our budget, we need to ensure they are funded adequately, while also ensuring programs exist and revenue increasing efforts exist that help improve both the system and the well-being of its residents, making them less dependent on entitlements. Bill 18-1061 brings us to some of your own recommendations for reducing the District budget beyond cutting spending alone:

- Councilmembers Marion Barry and Yvette Alexander, who co-authored B18-1061, would like to see residents less dependent upon welfare.
- Councilmember Tommy Wells has vowed no additional cuts to the social services cluster without tax increases.
- Councilmembers Barry, Wells, Michael A. Brown, and Jim Graham have all considered raising income taxes. Graham recommended last summer that we raise the tax rate 0.4 percent on residents making an annual income of more than \$500,000 – which would generate a total of \$16 million to \$18 million.

These are all interesting ideas, and should help us focus a dialogue around equitable spending cuts and tax increases, as opposed to cutting spending from programs that are already operating on bare-bones budgets.

DCPCA RECOMMENDATIONS

Budget problems do not affect the District alone. Two weeks ago, *The New York Times* asked its readers how they would reduce the federal deficit. Since the puzzle went online, there have been more than one million page views, and more than 11,000 posted Twitter messages about the puzzle, most including their own solutions. The Times analyzed those solutions, each of which cut at least \$1.345 trillion from the 2030 deficit, to get a sense of readers' choices. Taxes are always the most controversial recommendation, whereas the first option is often to trim spending wherever possible. The Debt Reduction Task Force of the Bi-Partisan Policy Center, co-chaired by DC's own

Dr. Alice M. Rivlin, made several recommendations to the federal government, which includes reviving the economy through jobs creation, creating a simple, pro-growth tax system that broadens the base, reduces rates, makes the US more competitive, and raises revenue to reduce the debt. Ladies and gentlemen, my point is that the system needs to make sense, and both Council and Dr. Rivlin's recommendations have been useful, though their recommendations have not been fully represented in the budget we are discussing today. We cannot continue to make spending cuts, which keep people poor and sick, which results in **increased** spending. Our budgets have been cut too much and we continue on a downward spiral. No solution to this problem is going to be politically popular, but we need greater accountability, greater transparency, and more courage to make tough decisions. We need to focus on revenue building, because much revenue has been lost due to the recession. DCPCA makes the following recommendations to the Committee of the Whole:

- **Further increase the fee on hospital beds.** DCPCA understands that local hospitals provide a level of uncompensated care and such a fee may impact the bottom line of some hospitals more than others. DCPCA also partners with many of the hospitals through various efforts, including eHealthDC and the DC Regional Health Information Organization (DC RHIO). The current recommendation has been to increase the \$1,500 fee per licensed hospital bed (which would result in \$6.3 million revenue) to \$2,000 (which would result in closer to \$8.4 million revenue). However, the initial recommendation was a one percent charge on net patient revenue and penalties for not paying the fee on time, which could have raised \$25 million for the District. DCPCA's recommendation would be to increase the fee to \$3,000 per licensed hospital bed, yielding \$12.6 million in revenue, *which is still only half of the originally proposed assessment.*
- **Increase the tax rate** 0.4 percent on residents making an annual income of more than \$500,000 – which would generate a total of \$16 million to \$18 million.
 - Alternatively, replacing the bottom tier of the sales tax with an income tax on higher earners would transform the bottom tier portion of the \$973

million dollars DC residents currently pay in general sales tax, into a tax that is deductible from federal income tax.

- This would return as much as \$341 million dollars to the District's residents, serve as a tax break on the lower and middle class, and give DC businesses a competitive advantage over Maryland and Virginia, all while saving the District money.
- **Where is the tax amnesty income to be reinvested?** DC Chief Financial Officer Natwar M. Gandhi announced that the DC tax amnesty program collected \$20.8 million in back taxes and interest from 11,518 delinquent taxpayers, exceeding the 2010 budget estimate.
- **Combined, this represents more than \$50 million in revenue for the District, and a positive adjustment (less the proposed \$6.3 million bed fee) of more than \$44 million from the budget gap proposal.** Use this money to offset budget cuts that disproportionately affect the poor. Mayor Fenty's budget proposal includes \$43 million in cuts to low-income programs: TANF \$4.6 million; Adult Job Training \$6.3 million; Grandparent Caregivers \$2.7 million; Child Care Subsidies \$2.7 million; Interim Disability Assistance \$1.2 million; Local Supplement \$3 million; Access to Justice \$1.7 million; etc.
- **Maintain funding levels at the DC Department of Health, DC Department of Mental Health, and DC Department of Health Care Finance.** To ensure a healthy, productive workforce, DC needs to fully invest in its health care programs. Moreover, to realize the maximum federal match on the local Medicaid dollar, agencies need to implement quality programs, and be staffed at sufficient capacity to take advantage of opportunities presented in health care reform. The current budget shortfall comprises approximately \$50 million less in sales tax revenue. One way to increase revenue to support these agencies would be through tax increases. As of October 1, 2010, sales tax was increased to 6 percent and cigarette tax was increased from 10¢ to 12.5¢ per cigarette. The FY2011 revenue estimate on alcoholic beverages is \$5 million (the District's lowest source of tax revenue). Increase the tax on alcoholic beverages to support DC health and human services agencies. The District brings in approximately 10 times this amount through cigarette taxes.

Lastly, the District cannot continue to strip its finances bare by pouring money into the United Medical Center (UMC). Many of us remember very clearly the District's experience with DC General Hospital – a sprawling charity hospital that became a fiscal black hole for the District, swallowing tens of millions of dollars a year in taxpayer funds before Mayor Anthony A. Williams pulled the plug on inpatient care in 2001. CFO Gandhi counseled against the District taking over UMC stating that "it is likely that the

District will have to continue to subsidize the hospital" – by \$4 million to \$15 million per year, according to his estimates. The District has already invested more than \$40 million in UMC, including the brand new pediatric emergency room. Other estimates have shown that the District has invested upwards of \$100 million in taxpayer funds to modernize it in the past 2 ½ years. Additionally, in taking over the hospital, the District reduced the estimated \$55 million debt that the previous owner, Specialty Hospitals of America, LLC owed to the District. Previously, the hospital had been losing approximately \$1 million a month, and a recent budget showed that the 120-bed nursing facility, a separately licensed unit within the hospital, is projected to lose approximately \$900,000 next year. The DC government should not be in the business of owning and managing a hospital.

CLOSING

Chairman Gray, I would like to thank you for the opportunity to testify at this public oversight hearing before the Committee on the Whole. DCPCA remains firm in our commitment to advocate for all District residents. We have worked diligently to make sure all low-income individuals receive the health care they are seeking at the right time, in the right place, and their basic human rights are met with dignity and integrity. Together, as we move forward in addressing the budget challenges in the District, let us remember those whose voices will never be heard or faces never seen but from the dais, you make their presence known. Thank you for the opportunity to testify on this important issue. I am happy to answer any questions you may have.