

NYS FY 2024 Joint Legislative Budget Hearing on Mental Hygiene
Housing Works Testimony
February 16, 2023

Thank you for the opportunity to submit written testimony to the Joint Budget Hearing on Mental Hygiene on behalf of Housing Works, a healing community of people living with and affected by HIV/AIDS. Founded in 1990, Housing Works now provides a range of integrated services for over 15,000 low-income New Yorkers annually, with a focus on the most vulnerable and underserved—those facing the challenges of homelessness, HIV/AIDS, mental health issues, substance use disorder, other chronic conditions, and incarceration. In 2019, Housing Works and Bailey House merged, creating one of the largest HIV service organizations in the country. Our comprehensive prevention and care services range from medical and behavioral health care, to housing, to job training. Our mission is to end the dual crises of homelessness and AIDS through relentless advocacy, the provision of life saving services, and entrepreneurial businesses that sustain our efforts.

Housing Works is a founding member, and I sit on the Board of Directors, of the **New York State Harm Reduction Association** (NYSHRA), an association of drug treatment providers, prevention programs, people who use drugs and their family members, committed to addressing racism in systems addressing substance use, and to incorporating validated harm reduction approaches within prevention and treatment. We have come together to leverage our voices of advocacy, public policy, and clinical expertise in order to promote harm reduction in New York State as a scientifically based treatment appropriate for substance use disorder, as well as a lifestyle approach to people who use substances. Housing Works and NYSHRA are on the front lines of the overdose epidemic, providing a wide array of direct harm reduction services including syringe exchange programs, medication for opioid use disorder (MOUD), and naloxone distribution.

Housing Works is a founding member of three other important community coalitions formed to advance public health priorities and address health inequities: the **End AIDS NY Community Coalition**, a group of over 90 health care centers, hospitals, and community-based organizations across the State committed to realizing the goals of our historic New York State *Blueprint for Ending the Epidemic* (EtE), a set of evidence-based recommendations for ending AIDS as an epidemic in all New York communities and populations;¹ **Save New York's Safety Net**,² a statewide coalition of community health clinics, community-based organizations and specialized HIV health plans committed to serving vulnerable New Yorkers across the State, ending the epidemic, and saving the 340B Federal drug discount program in order to achieve those goals; and **iHealth NYS**,³ a collaborative of community-based organizations united to advocate for and negotiate on behalf of our communities, our members and the chronically ill healthcare recipients we serve and to represent those programs and people within the broader healthcare system. I am also proud to serve as a member of the New York State Hepatitis C (HCV) Elimination Task Force.

Housing Works operates the first substance use treatment program licensed by the NYS Office of Addiction Services and Supports (OASAS) to use a harm reduction approach, and we are pleased

¹ We address certain key EtE priorities in this testimony and have attached the full set of EtE Community Coalition *FY24 NYS Budget and Policy Priorities*.

² <https://www.savenysafetynet.com>

³ <https://www.ihealthnys.org>

that several other providers have adopted our policies and procedures to implement harm reduction in their own licensed programs. Our OASAS-licensed program includes short-term, goal-oriented treatment using evidence-based cognitive behavioral treatment models, as well as individual and group treatment strategies, and is fully integrated with all our other programs, including services funded by the NYS Office of Mental Health (OMH) and the Health Home program, facilitating referrals to and from primary care, case management, and other behavioral health services. This approach enables our providers to meet clients where they are and support clients in developing truly personalized recovery plans, allowing us to work with the most hard-to-reach and underserved populations.

For years, Housing Works has advocated for NYS to adopt treatment modalities for substance use disorder that are not rooted in abstinence, and we have applauded the increasingly progressive direction taken by OASAS in recent years. The agency has become a champion of harm-reduction approaches and patient-centered definitions of recovery, including adoption of regulations that allow for unprecedented expansion of treatment under a harm reduction modality. Through these regulations, service providers from clinicians to peers can offer appropriate care that is increasingly free of the harmful barriers contained in abstinence-only approaches. Equally important, the regulations require that all licensed treatment programs provide access to medication for opioid use disorder (MOUD), the gold standard of care for opioid use disorder. OASAS has also worked to facilitate co-location of substance use and health care services as well as the provision of mobile and other services without walls and has significantly increased the number of Certified Peer Recovery Advocates who work in treatment settings to motivate individuals to seek treatment and help those individuals navigate the service delivery system.

Scale-Up Harm Reduction Funding and Programming

Housing Works, NYSHRA, and the EtE Coalition welcomed the substantial commitment of funding in the FY 23 NYS Budget to address substance use disorder and the opioid crisis by increasing access to services, removing barriers to care, and embracing best practices including harm reduction approaches. We applaud the Administration for appropriating over \$200million in Opioid Stewardship Tax proceeds last year for investments in new initiatives to combat the opioid crisis, as well as appointment of an Opioid Settlement Fund (OSF) Advisory Board to help guide and oversee the use of monies realized through settlement of NYS litigation against opioid manufacturers and distributors.

We are encouraged by the Opioid Settlement Fund (OSF) Advisory Board Annual Report recommendations that all opioid settlement funds be issued through a Request for Applications (RFA) process that fairly evaluates each program. In our view, this would ensure the equitable distribution of funding to support programs and evidence-based practices with demonstrated effectiveness. We hope and expect that all OSF funds will be distributed in a manner that promotes equity and evidence-based practice, including Overdose Prevention Centers as described in the next section of this testimony.

While we have been pleased by this Administration's commitment to a public health approach that recognizes the importance of harm reduction strategies, we call upon OASAS to fully recognize harm reduction as a drug treatment modality and to encourage licensed providers to adopt this modality for treatment of substance use disorder. Important steps have been taken to enhance harm reduction services, health monitoring, and evidence-based community interventions by means of

collaboration between the NYSDOH and OASAS, including the creation of a Division of Harm Reduction within OASAS. Harm Reduction programs provide essential, evidence-based services for people who use drugs including medical care, education, counseling, referrals, medication for opioid use disorder, and syringe services. Harm reduction approaches to improve drug user health are in urgent need of reinvestment, and it is time to acknowledge and promote harm reduction as an evidence-based model of treatment for substance use disorder.

We continue to urge DOHMH and OASAS to establish and fund additional Drug User Health Hubs across the State, which offer a unique opportunity to provide on-demand care to people who use drugs, as well as Second-Tier Syringe Service Programs to serve hard to reach areas and individuals. Funding point of-care testing for HIV, sexually transmitted infections (STIs) and HCV in Syringe Service Programs and Drug User Health Hubs would substantially increase the capacity of the health system to screen for these infections to more rapidly engage people who use drugs in treatment and prevention. Finally, we believe it is essential to address disparities more directly in behavioral health treatment access and outcomes. As a first step, we strongly encourage OASAS to collect and report disaggregated data on treatment outcomes by race and ethnicity, and to explore collection of data by gender identity, sexual orientation, and other marginalized identities that may present barriers to seeking or receiving effective care. We look forward to continuing to work with OASAS and the DOHMH on scale up of the proven harm reduction strategies.

Employ the Full Range of Evidence-Based Strategies to Address the State’s Opioid Crisis

With preventable overdoses surging, and an ever more toxic drug supply, it’s time New York State employs all available evidence-based strategies to address the State’s heightened opioid crisis, reduce related health inequities, and promote drug user health—including Overdose Prevention Centers.

Authorize and Fund Pilot Overdose Prevention Centers (OPCs)

In addition to the harm reduction interventions and strategies described above, it is time for New York to implement another proven strategy for preventing avoidable drug overdose deaths—Overdose Prevention Centers (OPCs). We support the Safer Consumption Services Act (S603/A224) and strongly urge the Hochul Administration to approve and the Governor and Legislature to enact legislation to allow and fund OPCs co-located with Syringe Service Programs across NYS.

Impacts from COVID-19, from physical distancing to wide-ranging unemployment, have led to isolation, stress, and despair among many people, including people who use drugs. These factors increase the risk of infectious disease and other poor health outcomes, but the most tragic outcome of increased opioid use is the dramatic and unprecedented acceleration in overdose deaths. The national increase in drug-related mortality has hit New York hard. Over 6,080 New Yorkers died from a preventable overdose in 2021 alone - the second record breaking year in NYS history. Across the State, a New Yorker dies from overdose every hour and 26 minutes, with overdose taking more New Yorkers’ lives than car accidents, suicides, and homicides combined. But the COVID crisis simply accelerated the upward trend in overdose deaths. The NYC Department of Health and Mental Hygiene (DOHMH) reports an almost four-fold increase in the age-adjusted rate of drug poisoning deaths in the City over the ten-year period from 2010 (8.2 deaths per 100,000 persons) to 2020 (30.5 deaths per 100,000), with the largest increases in the rate of overdose deaths between 2019 and 2020 among Black New Yorkers, Latinos of Puerto Rican heritage, and residents of very

high poverty neighborhoods.⁴ Based on the instability of the drug supply and preliminary CDC data trends, it is likely that every year will continue to break NYS records until we significant scale up every evidence-based harm reduction strategy, including OPCs.

OPCs are hygienic spaces in which persons can safely inject their pre-obtained drugs with sterile equipment while also gaining access, onsite or by referral, to routine health, mental health, drug treatment and other social services. OPCs provide controlled settings for people to use pre-obtained drugs under the supervision of trained professionals who can intervene in case of an overdose or other medical event. OPCs are an evidence-based intervention proven to reduce overdose deaths while increasing access to health care and substance use treatment. Over 120 Overdose Prevention Centers operate effectively worldwide, and numerous studies have shown that they are highly effective in both reducing drug-related overdose deaths and increasing access to health care and substance use treatment. OPCs are endorsed by many local and national medical and public health organizations, including the American Medical Association and the American Public Health Association. Two OPCs that opened with NYC approval in November 2021 have intervened to prevent over 600 overdoses in one year of operation. New York should follow the lead of Rhode Island and pass legislation permitting the operation of OPCs and the use of State and local public funding to support their operation, including Opioid Settlement Fund (OSF) resources.

Housing Works, NYSHRA, and the EtE Community Coalition were deeply disappointed and strongly denounce Governor Hochul's rejection of the OSF Advisory Board's recommendation to employ opioid settlement funds to support overdose prevention centers. This decision, along with the accompanying statement from OASAS, were both incorrect and incompatible with the Governor's stated commitment to address the pain caused by the overdose crisis. It is simply not true that the State lacks the legal authority to authorize and fund OPCs. Indeed, the Governor has the power to direct the Commissioner of Health to authorize OPCs to protect the public health, and Biden Administration officials have indicated that the Justice Department would not take action to challenge that authority or the operation of OPCs.⁵ We urge the Legislation to strongly support the OSF Advisory Board's well-considered recommendation that OPCs are an appropriate, evidence-based use of Settlement Funds. Supporting OPCs with OSF funding will save countless lives and continue NYS's longstanding leadership in the opioid response.

Decriminalize lifesaving buprenorphine

Remove this essential MOUD medication from the list of substances it is illegal to have in one's possession.

Ensure access to medication for opioid use disorder (MOUD) in prisons and jails

MOUD is the accepted standard of care for opioid use disorder, demonstrated to decrease opioid use, opioid-related overdose deaths, drug-related criminal activity, and infectious disease transmission. We urge the Governor and Attorney General to enforce the mandate to provide MOUD to ensure immediate implementation of MOUD programs consistently in all New York state prisons and county jails. Community Supervision (DOCCS) is the single largest treatment provider in the State, and county jails routinely detain people who experience substance use

⁴ *Drug overdose deaths in New York City during 2020*. Briefing by the NYC DOHMH Bureau of Alcohol and Drug Use Prevention, Care and Treatment, February 2022.

⁵ Associated Press, February 9, 2022. *Justice Dept. signals it may allow safe injection sites and harm reduction programs to protect against overdoses*. <https://www.marketwatch.com/story/justice-dept-signals-it-may-allow-safe-injection-sites-and-harm-reduction-programs-to-protect-against-overdoses-01644435249>

disorder. People who are incarcerated and are opioid dependent are often forced to inhumanely withdraw without appropriate medical care, and following this detox, are offered limited, if any, treatment or recovery services. It is time for the correctional system to provide healthcare commensurate with modern medical standards and of a quality acceptable within prudent professional standards.

Fund and implement the New York State Hepatitis C Elimination Plan

While we were extremely pleased by the November 2021 release of the [New York State Hepatitis C Elimination Plan](#), a set of concrete recommendations developed with broad community and expert input under the direction of a [Statewide HCV Elimination Task Force](#) (HCV TF), we are deeply concerned that a full year has passed since the Plan's release without adequate funding to support action to implement the Plan's comprehensive set of draft recommendations, and that the FY 23 NYS Budget continued to flat fund HCV initiatives at only \$5M per year and did not include any new funding to support HCV elimination. It is imperative to fully implement the *HCV Elimination Plan*, completed in 2019, without further delay. We call on Governor Hochul to formally adopt the *NYS HCV Elimination Plan*, and for the Governor and the Legislature to provide at least \$10M in additional funding for HCV elimination in the FY 24 budget (bringing total HCV funding to at least \$15M annually), to enable the NYSDOH to support implementation of this lifesaving initiative. Given the continuous evolution of knowledge and expertise on HCV prevention and treatment, and the critical importance of community engagement to successful implementation of the Plan, we also call upon the NYSDOH to work with community members to develop a process and structure that will ensure continued community input on the development of any updates to *HCV Elimination Plan* recommendations, to engage community members in oversight and monitoring of Plan implementation, and to include community perspectives on key metrics for assessing progress, monitoring outcomes, and identifying areas for improvement.

Improve Coordination of OMH Services to Support Integrated Models of Care

In contrast to OASAS, OMH has often been the least cooperative partner in efforts to coordinate and co-locate services in order to integrate care and has taken a more restrictive approach to certifying peers, including denying eligibility for people with histories of criminal justice involvement and requiring a New York State High School Equivalency diploma (formerly GED).

One area of particular concern is the lack of coordination between the OMH system and HIV prevention and health care. Unaddressed behavioral health needs negatively affect access to HIV prevention and care, and there is a significant need for integrated, affordable, high-quality and culturally sensitive medical and behavioral health care in New York.⁶ People living with or at heightened vulnerability to HIV are more likely than the U.S. population as a whole to have mental health challenges, and these mental health issues can have a significant impact on an individual's ability to access and benefit from HIV prevention and care services—delaying diagnosis and linkage to HIV care, and/or resulting in interruption of treatment as people with HIV move in and out of mental health service settings.⁷ A 2019 NYC DOHMH analysis found that, when compared to the overall group of people with HIV in NYC, 1,326 individuals with serious mental illness and diagnosed HIV identified through a data match were less likely to be receiving HIV care (82% vs.

⁶ Remien RH, et al. Mental health and HIV/AIDS: The need for an integrated response. *AIDS*, 2019; 33(9):1411-1420.

⁷ See: Feldman MB, et al. Utilization of Ryan White-funded mental health services and mental health functioning among people living with HIV in New York City, *Journal of HIV/AIDS & Social Services*, 2018; 17(3): 195-207.

93% overall), less likely to be prescribed antiretroviral therapy (79% vs. 90% overall), and far less likely to be virally suppressed (68% vs. 83% overall).⁸ For many reasons—including restrictive policies and funding streams—identifying and treating behavioral health needs among people affected by HIV have not been prioritized and/or have been difficult to implement at the required scale. Likewise, while mental health care settings can be a venue for reaching people most impacted by HIV, such settings often lack the staff or training to provide HIV testing, access to PrEP and a space to discuss sexual health.

Protect New York’s Essential Health Home Program

We call on the Legislature to stop the ill-considered Executive Budget proposal to make aggressive changes to the Health Home Program developed without provider or consumer input that would decimate the program infrastructure and arbitrarily terminate vulnerable participants from the community-based care coordination that has been demonstrated to improve health outcomes among the most vulnerable low-income New Yorkers.

The Governor’s FY Executive Budget contains an ill-considered and extremely harmful proposal misleadingly described as a plan to “Recalibrate the Health Home Program to Improve Care Management for Vulnerable Populations.” In fact, the proposal seeks to cut Health Home funding by \$100M over two years (\$30M in FY24 and \$70M in FY25) by abruptly disenrolling 70,000 adult New Yorkers with serious mental illness, active substance abuse disorder, and significant chronic health conditions including HIV/AIDS—almost half of the approximately 145,000 adults currently receiving Health Home care management—which would decimate the Health Home infrastructure and create disruptions in care causing an increase in emergency department ED visits, in-patients stays, and failure to address the social determinants of poor health outcomes for thousands of the most vulnerable New Yorkers.

The Health Home program and the statewide infrastructure that has been built to support it, has proven to play an important role in reducing avoidable hospitalizations and ED visits, improving health outcomes, and addressing the social determinants that drive health inequities among low-income New Yorkers dealing with one or more chronic illnesses. The NY Health Home Coalition and the NYS Care Management Coalition report that Health Home participants enrolled in the program for nine months or more experienced significant reductions in hospitalizations (37%) and preventable hospital readmissions (17%), and improvements in the post-discharge follow up after mental illness related hospitalizations (11%). In addition to contributing to improved health outcomes and decreased hospitalizations for high-cost Medicaid recipients, Health Home also coordinates client care across the shelter system (43% of HH participants experiencing homelessness secured housing), the behavioral health system (8.4% increase in compliance with anti-psychotic medications), and the criminal justice system (one cohort of Health Home participants showed a 37.5% reduction in incarceration from 2018 to 2019) – each of which are epicenters of social determinant issues.⁹ The statewide Health Home infrastructure will be essential to our ability to address social determinants of health issues going forward, including meeting the goals of New York’s proposed 1115 waiver.

⁸ Khosa P. *Persons with Serious Mental Illness Referred to Select Bureau of Mental Health Services and Matched to the NYC HIV Registry*. NYC HD, Bureau of HIV, 2019.

⁹ <https://hhcoalition.org/wp-content/uploads/2021/11/HH-Facts-Sheet-2023.pdf>

Specifically, the Executive Budget proposes an aggressive change in Health Home program eligibility to require a hard cut-off of services (described as “graduation”) after 9 to 12 months for persons in the “low-need” and “high-need” categories of services—without any individual evaluation and regardless of actual need. The NYS Department of Health has projected the estimated \$100M cut in funding based on termination of an estimated 70,000 adults in the low-need category and a step down in level of care for an additional 32,000 enrollees in just two years. We note that these savings may prove illusive, since some “low-need” participants arbitrarily discharged will decompensate without continued care coordination, requiring re-admission to Health Home with the additional administrative burdens associated with such “churning.” What is guaranteed, however, is significant disruption of the Health Home infrastructure and no guarantee that sufficient staffing and services will remain to meet real need.

What is particularly alarming is that this “recalibration” of the Health Home program was developed without the collaboration or even input of Health Home providers and consumers. This is even more disturbing given the system’s attempts to work with the NYS DOH to improve and “right size” the program to improve the delivery of care. We agree that clients who are stabilized because of their participation in Health Home should be “graduated” from the program. However, we reject the proposal to move participants out after a certain number of months and instead recommend participants be reviewed or assessed for ongoing need. In 2020, iHealth proposed a methodology to review all participants who had not recently interacted with an emergency department, had multiple inpatient admissions (hospital, detox, behavioral health), or been involved with the criminal justice system, to determine appropriateness for graduation or discharge. The recommendation for discharge or attestation of need for continued care would be reviewed and approved or rejected by the Lead Health Home organizations. This proposed methodology would ensure that only participants with demonstrated ongoing need would stay in the program, thereby reducing unnecessary costs to Medicaid. However, iHealth received no formal response to this proposal from the Department of Health.

The reality is that the Health Home system is an essential element of New York’s continuum of care for the most vulnerable Medicaid recipients, providing a unique community-based service that cannot be provided by managed care organizations or any other part of the medical and behavioral health infrastructure. Health Home care management providers deliver over 1,000,000 face-to-face visits annually with high need enrollees – meeting them in their homes and communities – where they are supplementing telephonic care management efforts employed by most MCOs. For individuals who have serious behavioral health needs and chronic medical conditions, just getting to healthcare services can be difficult if not impossible. At Housing Works, our Health Home program regularly receives requests from MCOs who are unable to reach high-need members. Health Home care managers are finding, engaging, and supporting individuals that MCOs and others have failed to find and engage, leading to more stable housing, increased food security, and connections to needed integrated healthcare.

Providers and consumers are ready and eager to work with the Department of Health on a revisioning of the Health Home program that will not harm vulnerable Medicaid recipients and will improve rather than undermine our current infrastructure for delivering effective and cost-saving care coordination. We strongly urge the Legislature to stop the ill-conceived and potentially devastating Executive Budget proposal so that we can work collaboratively to improve rather than destroy our essential Health Home program.

Protect the Healthcare Safety Net

Savings realized by safety net providers under the federal 340B drug discount program support otherwise unfunded services essential to meeting the behavioral health needs of the most vulnerable low-income New Yorkers. We call on the Senate and Assembly to take action in your one-house budgets to either permanently repeal the Medicaid pharmacy benefit carve-out or include the alternative advanced by Health Committee Chairs Rivera and Paulin that achieves all of the State's goals for the carve-out while keeping the pharmacy benefit in whole person managed care and preserving the 340B mechanism that generates savings that are essential to sustain the State's safety net providers and protect the vulnerable low-income New Yorkers they serve.

Transitioning the pharmacy benefit to fee-for-service will eliminate the mechanism that enables safety net providers to access savings from the federal drug discount program known as 340B. HIV service providers and community health clinics rely on 340B savings to support otherwise unfunded or underfunded services that are essential for effective health care for the most vulnerable low-income New Yorkers, including HIV treatment supports that are a core component of New York's HIV response. The federal 340B program enables safety-net providers to care for uninsured and underinsured persons and provide critical services such as low-cost medications, food/nutrition programs, transportation, school-based health centers, mobile dental clinics, and STI prevention programs to New York's most underserved residents—critical wrap-around services that address the social determinants that drive poor health outcomes. 340B resources are critical to achieving Ending the Epidemic and other public health goals and are key to addressing health inequities based on race, poverty, and marginalization.

The carve-out was delayed for two years so stakeholders could find a solution to support Safety Net providers and Medicaid HIV Special Needs Plans (SNPs). We are now weeks away from the April 1 deadline and no further along. Meanwhile, the Executive Budget has proposed moving forward with the carve-out which will decimate safety net providers. Housing Works' four federally qualified health centers (FQHCs) will lose at \$10million in 340B savings annually that is reinvested to support otherwise unfunded services, and it is estimated that the State's FQHCs would lose at least \$260million each year. Despite references in the budget briefing book to "backfilling the loss of 340B revenues" and "making the [safety net providers] whole" there is no detail on how the state would implement the "reinvestment" in the safety net providers, even if the dollar amount included in the Medicaid scorecard was sufficient, which it is not.

The alternative legislation being carried by Senator Rivera and Assembly member Paulin will satisfy each of the State's stated goals for the carve-out without devastating the health care safety net and disrupting patient care. It will:

- Improve patient and provider experience;
- Enhance State bargaining power with drug manufacturers;
- Create drug supply chain transparency;
- Curb restrictive and anti-competitive pharmacy benefit manager (PBM) business practices; and
- Address any DOH concerns regarding fees paid to third-party middlemen.

We urgently ask that you support the health chairs who will be introducing the draft bill language and include the alternative in the legislature's one-house budget bills.

Transform New York’s Homelessness Response

Housing Works urges the Governor and Legislature to facilitate and promote innovative, harm reduction, approaches to address our homeless crisis and to streamline the process for converting underutilized hotels and commercial properties into affordable housing, including supportive housing units.

From our beginning, Housing Works has been committed to a low-threshold, harm reduction approach to housing assistance, where admission and retention in housing is based on behaviors, rather than status as a drug user, person with mental health issues, or other condition. Residents are held accountable, as we all are, for the behaviors and conditions necessary to live safely with neighbors, are entitled to privacy within their own home, and are encouraged to feel safe to share behavioral health needs or crises without concern about jeopardizing housing security or being required to engage in a particular course of treatment. We have employed a “Housing First” approach for over 30 years and are pleased that it is now widely acknowledged as an evidence-based model that is endorsed as best practice by HUD and HRSA.

Housing Works has evolved in response to client needs from an initial 40-unit city-funded housing program in 1990, into a large multi-service organization that offers integrated medical, behavioral health and supportive services, and over 750 units of housing, including Housing Works-developed community residences that serve people with HIV who face specific barriers to both the housing market and retention in effective HIV care.

Then came 2020, with New Yorkers experiencing homelessness at particular risk of COVID-19 disease and poor COVID outcomes. When the COVID crisis began in March of 2020, approximately 70,000 people were sleeping in City shelters each night, including over 19,000 single adults in congregate settings where numerous people sleep in a single room and share bathrooms and other common areas. Thousands more New Yorkers were struggling to survive on the streets or other places not intended for sleeping, while contending with a drastic reduction in access to food, bathrooms, showers, and other resources typically provided by drop-in centers and other settings that were rapidly closing to them.

From April 2020, Housing Works joined in the COVID response, operating a NYC Department of Homeless Services (DHS) funded hotel to provide people experiencing homelessness a place to recover from COVID-19, expanding to provide medical and behavioral health services to residents of other quarantine and Mayor’s Office of Criminal Justice (MOCJ) hotels, and delivering COVID tests and vaccines to our consumers, our neighbors, and NYC Human Resources Administration-funded supportive housing staff and residents. Our DHS Isolation Hotel provided 170 rooms to provide a safe, private, and supported space for people experiencing homelessness to recover from COVID-19 illness. This program served over 2,500 guests before the isolation hotels were closed in June 2021, applying lessons learned from years of providing harm reduction housing for people with HIV.

We learned a great deal from our COVID experience, including the critical importance of a true harm-reduction approach – even down to providing unhealthy snacks and cigarettes for smokers, so that they don’t need to go down the street to the bodega – and that private rooms are both humane and necessary – especially for people with mental health issues who cannot manage a shared space

with a stranger. Onsite medical and behavioral health services were also key, as most of our isolation residents show up with multiple chronic conditions that have been untreated or undertreated and present health issues as serious or more serious than COVID-19 infection. Finally, we learned that good case management, even during a short (14+ day) stay, can be life-altering if we take the opportunity to identify needs and explore options. Sometimes this meant refusing to transfer a resident until an appropriate discharge plan was in place.

Most significantly, we have come to deeply appreciate how awful and dehumanizing the City shelter system is and have come to believe that we must transform the way homeless people are treated in New York City. What is needed to transform our homeless response? Resources of course, but what is perhaps more vital are new approaches, a new vision for what is acceptable, and of course, collaboration to build and sustain the political will for systemic change.

Of course, we cannot end homelessness in New York unless we address the gross lack of housing that is affordable and accessible to low-income households, and we welcome renewed commitment at the State level to affordable housing development and expanded access to voucher programs that employ meaningful and uniform payment standards across low-income housing assistance programs to ensure that no population is left behind in the increasingly challenging rental market. Especially critical is the creation of permanent housing units with deep affordability, including supportive housing units. While we strongly agree that there is an urgent unmet need for quality housing and services for people with substance use disorder who lack stable housing, we oppose any policy that limits housing for people with substance use disorder to only those who have achieved abstinence. The reality is that people require stable housing to even attempt substance use treatment. Treating safe housing as a prize for abstinence rather than the fundamental baseline for addressing behavioral health issues is not an evidence-based approach and is directly at odds with the embrace of a public health, harm-reduction approach to substance use.

A strong body of evidence supports “housing first” approaches that do not condition access to safe housing and behavioral health care on abstinence from substances or acceptance and compliance with a course of treatment. Stable housing without preconditions, combined with the availability of a robust range of behavioral health services, has been shown to result in clinical and social stabilization that occurs faster and is more enduring when compared to abstinence-based models of care. In fact, it is critically important that all transitional facilities that serve people with behavioral health problems must offer a full array of patient-centered behavioral health services, including medication therapy and supports for treatment adherence. We have too often seen the tragic results when individuals with serious behavioral health issues are unable to find an entry point into care and instead repeatedly bounce off a system not designed nor equipped to meet the complex and persistent needs of our most vulnerable citizens.¹⁰

Meanwhile, although new permanent housing opportunities are imperative, homelessness has risen to record levels in NYC, with some 70,000 people sleeping in NYC shelters each night, and thousands more New Yorkers struggling to survive on the streets or other places not intended for sleeping. Bailey House and Housing Works have been working for two years to secure an

¹⁰ *Decades Adrift in a Broken System, Then Charged in a Death on the Tracks: Martial Simon, mentally ill and homeless, spent years in and out of hospitals before being accused of shoving Michelle Go in front of a subway train.* New York Times, published February 5, 2022 and updated February 9, 2022. Available at: <https://www.nytimes.com/2022/02/05/nyregion/martial-simon-michelle-go.html>

underutilized hotel to house an exciting new pilot “street to home” program with support from the NYC Department of Homeless Services – our Comprehensive Stabilization Services Pilot Program. In response to the COVID crisis, DHS has funded stabilization hotels for homeless single adults, both to de-densify congregate shelters, and for those who sleep on the street because they refuse placements in city shelters. However, existing stabilization hotels do not receive funding to provide medical or behavioral health care, despite residents’ needs for services to address multiple co-morbidities.

Housing Works hopes to open an integrated Stabilization Center this year under contract with DHS that combines stabilization hotel beds and a drop-in center with onsite health and supportive services. Our harm reduction stabilization hotel will operate 24/7/365 and offer residents private rooms, intensive case management services, access to onsite medical and behavioral health services, and peer supports at the co-located drop-in center. The Stabilization Center will offer primary care and behavioral healthcare services, case management support, housing placement assistance, and navigation and referral services. The overarching goal of the Stabilization Center – like all Housing Works services – is to improve the health and well-being of clients experiencing street homelessness by providing low-threshold “Housing First” emergency housing and services delivered in a respectful manner using a harm reduction approach. We plan to evaluate the pilot rigorously, to continue to build our own competence to offer effective services, and to provide the evidence necessary to support advocacy for system-wide change.

Housing Works believes that this is the kind of innovation that is essential to a more humane and effective homeless response, and we are hopeful and actively working to secure and repurpose an underutilized hotel in Queens to begin operations this Spring. But we have already lost potential sites due to avoidable hurdles, setbacks, and politics, contributing to an unacceptable delay of almost two years in opening this critically needed intervention. It is imperative that the State and City take meaningful action to facilitate and streamline the process for converting underutilized hotels and commercial spaces to create affordable housing, including supportive housing programs. And equally important to support and fund innovative strategies designed to meet real need while rejecting approaches that instead criminalize and harass people experiencing homelessness.

Seeing the COVID crisis as a pivotal opportunity for new Medicaid investments to improve health outcomes and reduce costs among people with chronic medical and behavioral health issues who are experiencing homelessness, Housing Works has proposed to the NYS DOH three potential Medicaid funded models:

- 1) **Comprehensive Care for the Street Homeless: From Street to Home** – A Medicaid match to existing City and State homeless service dollars to support the development and operation of programs like the Housing Works Stabilization Center, that combine key elements of existing street-based medicine, drop-in centers, and Safe Haven programs operating in NYC to create a single, holistic model that supports individuals experiencing homelessness on the streets, subways or other place not intended for sleeping to receive community-based medical and behavioral care and stabilization services needed to move them along the housing continuum from the street to permanent housing.
- 2) **Medical Respite** – A Medicaid match to existing City and State homeless dollars to support program costs for room and board, to advance creation of DOH licensed medical respite programs to provide a safe place for homeless individuals to recuperate following an acute

inpatient stay or to recover from a medical or behavioral health condition that cannot be effectively managed in a shelter or on the street but does not require inpatient hospitalization.

- 3) **Medically Enriched Supportive Housing** – Authorize the State to employ Medicaid funding to create and operate Medically Enriched Supportive Housing (MESH) programs to comprehensively meet the needs of individuals experiencing homelessness who have complex chronic medical and/or behavioral health conditions and histories of repeated hospitalizations or stays in a medical respite, by placing them in supportive housing staffed by a team of integrated health care professionals. MESH programs address the needs of individuals who need more intensive services than those available in supportive housing but who do not qualify for far more costly assisted living programs or skilled nursing facilities.

We at Housing Works are particularly excited by the prospect of moving towards value-based Medicaid reimbursement models that will allow greater flexibility to provide the care, including housing, required to improve health outcomes among people with chronic conditions who are experiencing homelessness.

We cannot end homelessness in New York unless we address its drivers. Those include the gross lack of affordable housing, mass incarceration that removes people from the workforce and deprives them of access to low-income housing, and the insistence on treating mental illness and substance use disorder among low-income New Yorkers of color as criminal justice rather than public health issues. We do nothing to help homeless people by warehousing them in mass congregate shelters designed to strip them of their autonomy and even of their dignity. We must insist on policies, investments and innovation that treat people who find themselves homeless as people worthy of dignity, autonomy, respect, and care. We look forward to working with all of you towards this vision of a transformed New York State and City homeless response.

Address Years of NYS Under-Investment in Non-Profit Service Providers

Effectively addressing behavioral health needs, ending the AIDS epidemic, and addressing persistent medical and behavioral health inequities also requires action to address years of severe under-investment in the workforce and infrastructure of nonprofit providers. Housing Works urges the Governor and Legislature to take action in this year's State budget to address urgent issues that threaten to undermine the stability and effectiveness of the State's essential health and human services organizations—by broadening the applicability of the COLA for State contracted human services workers, establishing a \$21/hour minimum wage for State funded health and human services workers; and increasing the indirect rate on NYS contracts to a nonprofit's established federally-approved indirect rate.

Nonprofit service organizations that have been on the front lines of both the HIV and COVID responses face ongoing and new challenges as the result of years of severe under-investment in their workforce and essential infrastructure needs – leaving them struggling to attract and retain staff while also dealing with inadequate or outdated systems for information technology, electronic data, financial management, human resources, and other key functions. Inadequate State contract reimbursement rates have resulted in poverty-level wages for human services workers, who are predominantly women and people of color, and limit the ability to invest in critical systems. Essential human services workers are among the lowest paid employees in New York's economy,

resulting in high turnover and serious disadvantage in an increasingly competitive labor market. Building infrastructure capacity is not only essential to effective and efficient service delivery but will be required in order for community-based nonprofit providers to prepare for, negotiate, and participate in coming value-based payment arrangements for service delivery.

The New York State FY23 budget included an essential 5.4% cost-of-living adjustment for State contracted human services workers by funding the Cost-of-Living Adjustment (COLA) statute. This statute was first authorized in the FY07 budget but was deferred for the last ten years before being funded by Governor Hochul in FY23. However, programs created after the statute was enacted are not included in the FY23 COLA budget language, and so many workers under contract with the State may be left out. For example, the Health Home Care Coordination program was flat funded in the FY23 budget. It is vital to broaden the applicability of the COLA. No worker should be left out due to technicalities, and all human services workers deserve the most basic COLA to keep up with inflation.

Nor do COLA adjustments for human services providers, although critical, address the fundamental issue of inadequate compensation. We call for a \$21/hour minimum wage for all New York State funded health and human service workers and a comprehensive wage and benefit schedule comparable to compensation for State employees in the same field. We also urge the Governor and Legislature to invest in the infrastructure needs of nonprofits providing critical services for the most vulnerable New Yorkers—at a minimum by acting in this year's budget to increase the indirect rate on NYS contracts from the current 10% to a nonprofit's established federally-approved indirect rate.

Justice for Nushawn Williams

In 1999, Nushawn Williams, a young, HIV+ Black man, pled guilty to reckless endangerment and statutory rape, arising from allegations that he had sex with several young women while knowing that he was HIV positive. On April 9, 2010, four days before the end of Mr. Williams' 12-year prison sentence, then-New York State Attorney General Andrew Cuomo filed an application to have him indefinitely civilly committed at Central New York Psychiatric Center in Marcy, New York, as a "dangerous sex offender" based almost entirely on the fact that he was sexually active while HIV- positive. Mr. Williams' first review since being involuntarily and indefinitely civilly confined was January 14-15, 2021, eleven years after his original release date, and he was denied, despite a pledge by Housing Works to provide appropriate housing, health services, and behavioral health care upon his release. Nushawn Williams has now been confined for 25 years – over twice the length of his prison sentence. This case marks the first and only time in New York State, and possibly the country, that a person has been civilly confined based largely on HIV status.

The National HIV/AIDS Strategy acknowledges that HIV criminalization impedes our progress in ending the epidemic and calls for an end to all HIV criminalization laws across the country. New York State has no HIV criminalization laws, but the State is effectively criminalizing Nushawn Williams indefinitely for being HIV-positive. As part of the Free Nushawn Coalition, Housing Works calls upon New York State Attorney General Letitia James to use her authority to end the state's endless prosecution of Nushawn Williams and to support his release from confinement. We seek the support of the Legislature to ensure justice for Nushawn Williams.

Conclusion

In the harm reduction field, we talk of the continuum of prevention, harm reduction drug treatment, and recovery services. Currently all providers of services within the substance use disorder continuum are adopting harm reduction principles (i.e., “person-centered approaches) in engaging problematic drug use. Housing Works knows from the experience, struggle, and wisdom of its client members that treatment rooted in harm reduction offers the best possibility for compassionate care. It is a movement for social justice that respects the rights of people with behavioral health issues and strives to overcome the barriers faced by communities most impacted by poverty, marginalization, stigma, and other social determinants. We urge our State’s leadership to take the lessons learned from harm reduction policy, practice, and research to advance the transformative potential of self-directed individual change.

Sincerely,

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