NYS 2022-23 Joint Legislative Budget Hearing on Health
Housing Works Testimony

February 8, 2022

Thank you for the opportunity to present testimony to the Joint Budget Hearing on Health. My name is Charles King, and I am the Chief Executive Officer of Housing Works, a healing community of people living with and affected by HIV/AIDS. Founded in 1990, we now provide a range of integrated services for over 25,000 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 part of the **End AIDS NY Community Coalition** (EtE Coalition), a group of over 90 health care centers, hospitals, and community-based organizations across the State. I was proud to serve as the Community Co-Chair of the State's ETE Task Force, and Housing Works is fully committed to realizing the goals of our historic New York State Blueprint for Ending the Epidemic (EtE)—a set of concrete, evidence-based recommendations for ending AIDS as an epidemic in all New York communities and populations. I am also a proud member of the **New York State Hepatitis C Elimination Task Force**.

Housing Works is a founding member of three other important community coalitions formed to advance public health priorities and address health inequities: the **COVID-19 Working Group – New York (CWG)**,[1] a coalition of doctors, healthcare professionals, scientists, social workers, community workers, activists, and epidemiologists committed to a rapid and community-oriented response to the SARS-CoV-2 pandemic; **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 drug discount program in order to achieve those goals; and the Harm Reduction Coalition of New York State, which is 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 incorporating validated harm reduction approaches within prevention and treatment.

None of us could have predicted how the unprecedented COVID-19 pandemic we are still struggling to understand and contain would jeopardize our progress on the State's longstanding HIV, hepatitis C (HCV), and opioid public health crises, while once again laying bare the stark and persistent health inequities experienced by the most vulnerable New Yorkers. We recognize and support steps taken by Governor Hochul to date to advance structural change in our healthcare systems to advance health equity, including declaring racism a public health crisis and proposing substantial investments in the healthcare system to reduce health disparities, remove barriers to

[1] For more information, see https://www.covid-19workinggroupnyc.org
[2] For more information, see https://www.savenysafetynet.com

healthcare access, and embrace a public health approach to substance use disorder and the opioid crisis. However, the Executive Budget leaves in place a policy change that poses a grave risk to the health of New Yorkers who rely on our health care safety-net and that, if not repealed, will undermine rather than advance greater health equity.

I will also focus on the status of our State's historic plans for Ending the HIV Epidemic and Eliminating HCV, including the critical need for greater investment in essential non-profit health and human services providers, and what COVID-19 has taught us about the need to radically rethink our response to homelessness, especially among people experiencing homelessness who have chronic and acute health needs.

Stop the Medicaid Pharmacy Benefit Carve-Out to Preserve Essential 340B Savings

Former Governor Cuomo put in place a change to the Medicaid pharmacy benefit that, if not repealed, will devastate New York State's network of safety-net providers that serve marginalized and medically underserved low-income New Yorkers, and whose programs are key to addressing health disparities and advancing public health objectives, including ending the HIV epidemic, eliminating hepatitis C, and containing the COVID-19 crisis for New Yorkers of every race, ethnicity and income bracket.

Language adopted in the FY20 NYS budget – a result of a rushed MRT II process – authorized the State to effectively eliminate safety-net providers' access to savings achieved through drug manufacturer discounts under the Federal 340B Drug Pricing Program. Specifically, the budget action authorized the State to carve the pharmacy benefit out of Medicaid managed care and into fee-for service, denying safety-net providers the savings realized through 340B discounts. The carve-out would strip an estimated $250million in annual 340B savings away from safety-net providers in all parts of NYS—drastically curtailing the scope and reach of services now available to medically underserved New Yorkers, undermining the fiscal stability of critical front-line community providers, and devastating a NYS safety-net system that is essential in order to address longstanding health inequities.

Housing Works operates four Federally Qualified Health Centers (FQHCs) located in medically underserved NYC communities, providing an integrated model of care that seeks to improve the emotional and physical health of the most vulnerable and underserved New Yorkers—people who are facing the challenges of homelessness, HIV and other chronic disease, mental health issues, substance use disorders, and incarceration. Like the other 70-plus FQHCs with over 800 locations across NYS, the State's Ryan White clinics, and other community-based health centers, our FQHCs are a critical component of the health delivery system, providing high-quality, patient centered, community-based primary care services to anyone who needs care, regardless of their ability to pay, as well as behavioral health services, dental care and substance use services delivered in a culturally and linguistically appropriate setting.

Our State's community-based safety-net providers have risen to the occasion over the past two years, providing free community COVID-testing services in hard-to-reach, heavily impacted communities, and mounting large-scale vaccination efforts in these same communities. Since April 2020, Housing Works has thrown our organization into 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. To do this COVID work, we have invested thousands of dollars to cover PPE, health education and outreach, and many other unfunded costs. But instead of assuring community health centers of the continued support necessary to address COVID-19 and other persistent health disparities, Housing Works and other safety-net providers continue to face an impending and devastating loss of Federal 340B drug discount savings. If the State proceeds with the pharmacy carve-out, **Housing Works and the patients we serve will lose at least $8 million in 340B savings annually**, at a time when our FQHCs are already facing new challenges and increased costs due to the ongoing COVID crisis.

We are grateful for the Legislature's intervention last year to pass language in the FY22 New York State budget (HMH Article VII) that delayed the pharmacy benefit carve-out from Medicaid Managed Care to Fee-for-Service until April 1, 2023. We call on Governor Hochul and the Legislature to act this year to *permanently* repeal the Medicaid pharmacy benefit carve-out, to preserve the mechanism that enables safety net providers to access savings from the 340B Federal drug discount program. 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 and are core components of the State's HIV response, including wrap-around HIV treatment supports, HIV prevention and care for uninsured persons, and interventions to address hunger, housing instability, and other "non-medical" factors that we know drive health inequities in medically marginalized communities.

Any proposal to address the devastating loss of 340B savings with distribution of State-funded grant funding to providers is woefully inadequate and no substitute for the 340B program. The $102million proposed last year represents less than half of estimated savings lost, so providers could not be made whole. Nor is it true, as claimed, that the State worked with providers and other stakeholders to develop this plan to "mitigate" the loss of 340B savings. The community advisory group formed to provide recommendations was so ignored that it informed DOH that it refused to make recommendations. Moreover, such funds would have to be appropriated each year, so would be subject to the annual NYS budget process with no guarantee that providers would continue to be compensated for lost 340B savings. Importantly, 340B program savings are not government funding, but instead drug manufacturer discounts designed to generate ongoing savings to providers for reinvestment to improve the health of medically underserved people. Were NYS to truly hold safety-net providers harmless, it is hard to understand how the State would realize the savings that are the purported rationale for the carve-out.[3]

Provisions of Governor Hochul's Executive Budget to establish a new Pharmacy Benefits Bureau to license and provide oversight of Pharmacy Benefit Managers (PBMs) will address the State's stated concerns regarding transparency and controlling administrative costs. The same NYS controls and oversight could be placed on third-party administrators. It is possible to curb pharmacy costs by regulating these entities without threatening the stability of the healthcare safety net or our hard-

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[3] Indeed, an independent study by the Menges Group has refuted the State's projected savings, calculating that the State will actually **lose $154 million** in the first year of the carveout and a total of **$1.5 billion over five years**, largely due to increases in avoidable emergency and inpatient costs. Available at https://nyhpa.org/wp-content/uploads/2020/10/Menges-Rx-Carve-Out-Report-10-1-20-1.pdf

fought efforts to end the HIV epidemic and reduce health inequities. The 340B resources at risk 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. It is time to permanently repeal the Medicaid pharmacy benefit carve-out.

Support Renewed Efforts for Ending the HIV Epidemic and Eliminating Hepatitis C

I will now turn to comments that relate specifically to Ending the Epidemic and Hepatitis C Elimination. I urge members of the Assembly and Senate Health Committees to review all if the important issues addressed in the ***End AIDS New York Community Coalition Ending the Epidemic New York State Budget and Policy Priorities*** for fiscal year 2022-2023 that I have attached to my testimony. I will highlight some of these issues in this testimony.

When NYS HIV surveillance data for 2019 was released in December 2020 it revealed the tremendous progress we had made by the end of 2019 towards our EtE goals. But this data did not reveal the deep setbacks to our efforts caused by the co-occurring COVID-19 pandemic — setbacks that have and will continue to require redoubled effort in the months and years ahead. We know from 2020 data that HIV testing declined dramatically after March 2020, that COVID posed new barriers to PrEP and PEP access, that overdose deaths have increased dramatically, and that NYS research shows that people with HIV are at significantly higher risk of COVID-19 hospitalization and mortality.

While Housing Works and the EtE Coalition are pleased to note that EtE funding is sustained through at least 2024 in the FY23 Executive Budget, as described above we are deeply concerned by the continued threat of the devastating impact of the planned Medicaid pharmacy benefit carve-out described above on the community health centers and HIV service providers that are the backbone of our EtE efforts in the low-income Black and Latino/Hispanic communities hardest hit by HIV, HCV, and now COVID-19. A survey of just 15 of the hundreds of HIV/AIDS safety-net providers that rely on 340B found that this small group alone will lose over $56M annually in critical funding if the carve-out moves forward.[4] Management of the Medicaid pharmacy benefit through Managed Care also allows for better patient care by HIV Special Needs Plans, because Plans play an important role in helping members manage the complex drug regimens required to address the multiple chronic conditions many PWH live with, and Plans can work closely with providers to quickly identify and address gaps in medication adherence. Current 340B savings realized from drug manufacturer discounts that are reinvested in the otherwise unfunded "wrap-around" services for medically vulnerable groups have made our EtE efforts possible, and that are essential to addressing persistent and ongoing HIV health inequities based on race, ethnicity, gender identity, and other forms of oppression.

Indeed, the positive data on our overall EtE progress also reveals persistent inequities in HIV health outcomes that must be eliminated if we are to meet our goal to end HIV for every New York community. By most indicators, we are seriously lagging by race and ethnicity, with people of color generally falling behind by one degree or another. We are also lagging with certain key populations, most especially transgender women, and are falling short of EtE goals to improve drug user health

[4] See [The 340B Drug Discount Program is the Bedrock for Community Services Necessary to End New York's HIV Epidemic, Fight COVID-19, and Reduce Persistent Health Inequities]

and eliminate new HIV infections attributed to injection drug use. Finally, most of the State is lagging by many measures behind New York City. At the end of 2019, 70% of all NYC residents with HIV were retained in continuous care, compared to just 55% in the rest of the State; and the rate of viral load suppression was 77% among all NYC residents with HIV, compared to 64% viral suppression among New Yorkers with HIV outside NYC.[5]

These disparities are driven in large part by former Governor Cuomo's refusal to fulfill key *ETE Blueprint* recommendations. Despite repeated promises to fully implement the *Blueprint* recommendations of an appointed 64-person EtE Task Force, Governor Cuomo remained unwilling to expand meaningful HIV rental assistance to homeless and unstably housed people HIV/AIDS living outside of NYC, to expand overdose prevention and other harm reduction efforts to stop deaths and prevent new HIV and hepatitis C infections, and move forward with plans to eliminate HIV/HCV co-infection among PWH, all of which must happen to truly end the epidemic.

Provide equal access to HIV housing assistance in every part of New York State

The most significant difference driving HIV health disparities between NYC and the rest of the State is the lack of housing assistance outside NYC. As the *EtE Blueprint* recommends, housing assistance for PWH experiencing homelessness or housing instability must be provided as a critical support for effective HIV care. The *Blueprint* housing recommendations have been fully implemented in New York City since 2016, where the local department of social services employs the longstanding NYS HIV Enhanced Shelter Allowance (ESA) program to offer every income-eligible person with HIV access to a rental subsidy sufficient to afford housing stability, as well as a 30% rent cap affordable housing protection for those who rely on disability benefits or other income too low to support housing costs.

Upstate and on Long Island, however, as many as 4,000 low-income households living with HIV remain homeless or unstably housed, because current State law limits the 30% rent cap to residents of NYC, and the 1980's regulations governing HIV ESA rental assistance set maximum allowable rent at just $480 per month for an individual – far too low to secure decent housing anywhere in the State. Only the NYC local department of social services provides meaningful HIV ESA rental subsidies in line with fair market rents and other low-income housing programs.[6] Every low-income New Yorker with HIV experiencing homelessness or housing instability should have equal access to critical NYS resources that support the safe and stable housing repeatedly shown to be critical in order to benefit from HIV treatments, to reduce ongoing HIV transmissions, and to address the stark and persistent HIV health inequities that prevent us from ending our New York State HIV epidemic in every community and population.

The COVID-19 crisis has added a new level of urgency for action to ensure that every New Yorker with HIV is able to secure the safe, appropriate housing required to support optimal HIV health. A large-scale analysis by the NYS Department of Health found that New Yorkers with HIV have

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[5] Ending the Epidemic Dashboard NY. Retrieved December 10, 2021, from www.EtEdashboardny.org/. Recently released 2020 data show continued but slightly narrowed disparities, with 61% retained in continuous care and 78% virally suppressed in NYC compared to only 56% and 74% in the balance of the State. However, the NYS and NYC departments of health caution that data for the year 2020 be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, care-related services, and case surveillance activities.

[6] We are extremely pleased that the NYC Human Resources Administration recently announced that the NYC payment standard for HIV Emergency Shelter Allowance rental assistance has been increased to 108% of HUD FMR, in line with Section 8 Housing Choice Vouchers and other low-income housing assistance, to ensure that PWH are not disadvantaged in the housing market.

experienced significantly higher rates of severe COVID disease requiring hospitalization and of COVID-related mortality than the general population. Overall, PWH with a COVID-19 diagnosis died in the hospital at a rate 2.55 times the rate in the non-PWH population, and rates of severe COVID-19 disease resulting in hospitalization were found to be highest among PWH not virally suppressed and those with lower CD4 counts, suggesting that less controlled HIV virus increases COVID-19 severity and death.

Language included in the last three enacted NYS budgets and continued in this year's Executive Budget purports to extend access to the same meaningful HIV housing supports across the State, but as currently written has failed to assist even a single low-income household living with HIV outside NYC. To finally provide equitable Statewide access to HIV housing supports, we urge Governor Hochul and the Legislature to correct the relevant Aid to Localities language and enact necessary Article VII legislation to: i) ensure that every local department of social services provides low-income PWH experiencing homelessness or housing instability access to HIV Enhanced Shelter Allowances for rent reasonably approximate to up to 110% of HUD Fair Market Rates (FMR) for the locality and household size (the standard for Section 8 Housing Choice vouchers and other low-income rental assistance programs); ii) make the NYC-only HIV affordable housing protection available Statewide to cap the share of rent for low-income PWH at 30% of disability or other income; and iii) notwithstanding other cost-sharing provisions, recognize the fiscal reality of communities outside NYC by providing NYS funding to support 100% of the costs of HIV Shelter Allowances in excess of those promulgated by OTDA, and of additional rental costs determined based on limiting rent contributions to 30% of income.

Fund and implement the New York State Hepatitis C Elimination Plan
The EtE Community Coalition is extremely pleased that on November 17, 2021, Governor Hochul authorized the 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) led by the NYSDOH and a community co-chair. The 28 individuals appointed to serve on the HCV TF represent diverse backgrounds and expertise such as HCV prevention, clinical care and treatment, research and public health policy, as well as lived experience. Although the Task Force completed its work in June 2019 on a comprehensive set of draft recommendations to eliminate hepatitis C across NYS, the former Governor chose not to release or fund the *HCV Elimination Plan*. Now that the Plan is released, it is imperative to begin implementation of its recommendations without further delay, so are deeply concerned that the FY23 Executive Budget does not include any new funding to support HCV elimination. We call on Governor Hochul to formally adopt the *NYS HCV Elimination Plan*, and urge the Governor and the Legislation to provide at least $10M in new funding to enable the NYSDOH to begin implementation of this critical and lifesaving initiative.

Scale-up harm reduction funding and programming
The EtE Community Coalition welcome and urge the Legislature to support the substantial commitment of funding in the Executive 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 $200 million in Opioid Stewardship Tax proceeds for investments in new initiatives to combat the opioid crisis, as well as additional monies realized through settlement of NYS litigation against opioid manufacturers and distributors. We urge the legislature to support the full range of new investments and initiatives such as expansion of mobile treatment services to expand access to Medication

Assisted Treatment, and new funding allocated to the NYSDOH AIDS Institute for additional harm reduction services ($9million recurring) and Naloxone distribution ($8million in FY 2023 and $10million thereafter).

We are particularly pleased by the Administration's commitment to a public health approach 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 exchange. Harm reduction strategies to improve drug user health, including syringe exchange programs, and peer support, are in urgent need of this reinvestment. The dedicated AIDS Institute funding for naloxone will increase access to this highly effective medication for reversing an opioid overdose. We 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 Exchange Programs to serve hard to reach areas and individuals. Funding point of-care testing for HIV, STIs and HCV in Syringe Exchange Programs and Drug User Health Hubs would substantially increase the capacity of the health system to screen for these infections in order to more rapidly engage people with use drugs in treatment and prevention. We look forward to working with OASAS and the DOHMH on scale up of the proven harm reduction strategies funded in the Executive Budget.

Approve and fund overdose prevention centers

Impacts from COVID-19, such as physical distancing and wide-ranging unemployment, have led to isolation, stress, and despair among many people, including people who use drugs and people engaged in sex work. These factors, which increase the risk of overdose, infectious disease, and other poor health outcomes, have been compounded by COVID-related barriers to accessing and implementing harm reduction strategies. It is not surprising that in 2020 the CDC[7] alerted public health departments, healthcare professionals, harm reduction organizations and other first responders of a substantial increase and concerning acceleration in overdose deaths across the United States, including New York.

In addition to the harm reduction interventions and strategies outlined in the Executive Budget, we strongly urge the Hochul Administration to approve and the Governor and Legislature to fund establishment and evaluation of five planned pilot Overdose Prevention Centers (OPCs) across the State to operate over at least two years. The proposed two-year pilot project would authorize five existing community-based Syringe Exchange Programs (four in New York City and one in Ithaca) to expand their services to include supervised consumption services—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. Overdose Prevention Centers operate effectively worldwide, have been shown to be effective in both reducing drug-related overdose deaths and increasing access to health care and substance use treatment, and are endorsed by many local and national medical and public health organizations, including the American Medical Association and the American Public Health Association. Significantly, two OPCS that opened with NYC approval in November 2021 report that as of February 3rd they had already reversed 124 overdoses. Yet, despite the overwhelming evidence and a 2018 promise from Governor Cuomo to authorize the pilots, the State has failed to act. We call on Governor Hochul

[7] https://emergency.cdc.gov/han/2020/han00438.asp

and the Legislation to authorize and fund the pilots this year. Supporting these efforts with funding from the Opioid Settlement Fund will save countless lives and continue New York State's longstanding leadership in the opioid response.

Exempt Lifesaving HIV Antiretroviral Drugs from Prior Authorization and Other Restrictions
We oppose and are deeply concerned by the Executive Budget proposal to discontinue Prescriber Prevails in Medicaid fee-for-service and managed care. Elimination of Prescriber Prevails and utilization tools such as prior authorization and step therapy can restrict access to medically necessary drugs. These barriers are harmful to patient access and can prevent individuals from receiving the medication they need in a timely manner. Delaying access to these medications for individuals who currently have, or are seeking to avoid, HIV/AIDS can be life threatening and stall the State's EtE progress. We urge the Governor and Legislature to preserve Prescriber Prevails for all Medicaid enrollees. At a minimum, we call on them to amend insurance law and § 272 of the Pub. Health Law to add new language that provides: "Antiretroviral drugs prescribed to a person enrolled in a public or private health plan for the treatment or prevention of the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) shall not be subject to a prior authorization requirement, step therapy, or any other protocol that could restrict or delay the dispensing of the drug."

Ensure Adequate and Timely Rates for HIV Special Needs Plans
New York's Medicaid Managed Care HIV Special Needs Plans (HIV SNPs) are highly effective in addressing the needs of PWH and those at heightened risk of HIV infection, achieving high rates of viral load suppression and dramatically lowered inpatient and acute care costs. However, rate setting delays and inadequate rates threaten to undermine their effectiveness. HIV SNPs receive rates as late as 21 months after their effective date, and limits imposed by the global cap have reduced SNP rates at a time when membership has expanded to include people of trans experience and other medically vulnerable groups. We support the Executive Budget's proposals to increase SNP rates to the middle or high end of the rate range and to increase all Medicaid rates by 1% to support increased pay for health care workers. We also support the Executive Budget proposal to restore the 1.5% Medicaid across the board cuts to fee-for-service providers implemented in the FY21 budget, These measures will help sustain the effective care management provided by HIV SNPs, and must be coupled with timely rates. Rates that are late and inadequate negatively impact the SNPs, providers, and most importantly, SNP members, by limiting the available provider network which impedes access and quality of care. Timely and adequate HIV SNP rates are essential to EtE efforts and greater health equity.

Repeal the Medicaid Global Spending Cap
The Medicaid global cap was introduced in 2011 as a mechanism to limit growth in Medicaid spending and instill discipline in Medicaid budgeting. The cap was set at an arbitrary, fixed moment in time and not designed to keep pace with program growth. Medicaid is a critical safety net program and is a lifeline for PWH. It should be afforded the opportunity to grow in times of economic downturn or hardship, such as the COVID pandemic, to meet real need. We note that the Executive Budget changes the Global Cap indexed growth metric in an effort to more accurately reflect changes in enrollment and utilization. However, any cap on the Medicaid program remains arbitrary as it does not reflect actual need or real growth. Continuing to place a cap on Medicaid spending disproportionately impacts people living with disabilities, under-resourced communities of color and safety net providers, like community health centers and HIV service programs that rely upon

Medicaid as a significant coverage source for their patient base. It is time to repeal the Medicaid global cap.

Address severe under-investment in the workforce and infrastructure of nonprofit providers
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 to in order for community-based nonprofit providers to prepare for, negotiate, and participate in coming value-based payment arrangements for service delivery.

We welcome the 5.4% Cost of Living Adjustment (COLA) for human services providers included in the Executive budget, but while critical, this step will not 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, and for the same 5.4% COLA for the workers in the Health Home Care Coordination program, which is flat-funded in the Executive Budget. 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 taking action 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.

Transform New York's Response to Homelessness

From our beginning, Housing Works has understood that housing is health care, and 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 founded Housing Works early in the AIDS crisis, to meet the needs of New Yorkers with HIV whose lack of safe housing left them at risk of TB and other infections unavoidable in crowded congregate shelters or living on the street. We have evolved in response to client needs from an initial 40-unit NYC-funded HIV housing program in 1990, into a large multi-service organization that offers integrated medical, behavioral health and supportive services, and over 700 units of housing, including Housing Works-developed community residences that serve people with HIV who face particular barriers to both the housing market and retention in effective HIV care.

In 2020, we found ourselves in the midst of another deadly pandemic that, like HIV, poses a particular threat to persons experiencing homelessness, who have no safe place to shelter from exposure to the virus, or to recover from COVID-19 disease. When the COVID crisis began in March 2020, approximately 70,000 persons were sleeping in City shelters each night, including over 19,000 single adults in congregate settings where numerous persons 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 resources typically provided by drop-in centers and other settings that were rapidly closing to them.

Responding to this new crisis, Housing Works is grateful to have the opportunity to operate a NYC DHS Isolation Hotel, opened in April 2020 with 170 rooms to provide a safe, private space for New Yorkers experiencing homelessness to recover from COVID-19, supported by 24-hour medical staff, three meals a day, and behavioral health care as needed. We have served over 2,500 guests so far, applying lessons learned from years of providing harm reduction housing for people with HIV. As noted earlier in this testimony, Housing Works also expanded our services to provide medical and behavioral health care at other DHS Isolation Hotels and at hotels operated by the NYC Mayor's Office of Criminal Justice (MOCJ).

We have learned a great deal from this experience, including the critical importance of a true harm-reduction approach – even down to providing unhealthy snacks and cigarettes for smokers, so that residents don't need to go down the street to the bodega – and that voluntary isolation is critical to successful contact tracing and disease management, so that vulnerable folks are not afraid to be tested or to share their contacts for purposes of tracing. 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 are also key. Most of our isolation residents show up with multiple untreated or undertreated chronic conditions that present health issues as serious or more serious than COVID-19 infection. Finally, we've 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 means refusing to transfer a resident until an appropriate discharge plan is in place.

Most significantly for Housing Works, once we became involved for the first time in the City's homeless response, what we came to deeply appreciate is how awful and dehumanizing the City shelter system is, and we increasingly came to believe that the Coronavirus is providing us with an opportunity to transform the way homeless people are treated in New York City and State.

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. Ensuring equitable access to housing assistance across voucher programs is one step towards this goal, and Housing Works commends the NYS Legislature for passing legislation recently signed by Governor Hochul to increase the value of State Family Homelessness and Eviction Protection Supplement Program (State FHEPS) vouchers, to create a more meaningful pathway for low-income families to enter safe and stable housing. NYC has taken important steps this year to align the value of City FHEPS vouchers and

allowable rents under the HIV Enhanced Shelter Allowance rental assistance program with the value of Section 8 Housing Choice vouchers and other low-income housing assistance programs. We believe that setting a uniform payment standard for all low-income housing assistance programs is critical to ensure that no population is left behind in the increasingly challenging rental market. Increased NYS investment in high-quality, affordable housing is even more critical, including supportive housing for those who need it. Housing Works is pleased to see the introduction of a five-year affordable housing plan in the Executive Budget, including $25billion for the creation and preservation of 100,000 affordable homes, including 10,000 supportive housing units. We also support continued support and funding for the conversion of hotels and commercial spaces for residential use, and urge the Legislature and the Hochul Administration to take action to facilitate use of this funding, prioritizing this resource for creation of permanent housing with deep affordability, as well as permanent supportive housing units.

Meanwhile, homelessness remains at record levels in NYC, with some 50,000 people sleeping in shelters each night, and thousands more New Yorkers struggling to survive on the streets or other places not intended for sleeping. Housing Works has formed an internal visioning committee to research and explore models of support and housing assistance for New Yorkers experiencing homelessness. Let me share some of our ideas, including the stabilization model we hope to open soon to serve unsheltered New Yorkers.

Add to the current 1115 waiver application new Medicaid investments in housing as health care
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 1115 waiver applications:

1) **Comprehensive Care for the Street Homeless: From Street to Home.** This proposed wavier would seek a Medicaid match to existing City and State homeless service dollars to support the development and operation of programs that would 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 healthcare and stabilization services needed to move them along the housing continuum from the street to permanent housing.

2) **Medical Respite.** Housing Works fully supports DOH licensed medical respite pilot programs for people experiencing, or at risk, of homelessness who have a medical condition that would otherwise require a hospital stay or who lack a safe option for discharge and recovery. To advance this much-needed model of care, we propose a waiver to authorize a Medicaid match to existing City and State homeless service dollars that would allow use of Medicaid dollars to support program costs for room and board as necessary components of effective medical care. Medical Respite programs 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.** A third Medicaid waiver would authorize the State to create and operate Medically Enriched Supportive Housing (MESH) programs to

comprehensively meet the needs of individuals experiencing homelessness who have complex chronic 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 will 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.

Even short of such a Medicaid waiver, we at Housing Works are 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.

Pilot models that re-envision our response to the experience of homelessness
Housing Works is even now working to combine funding sources to shortly open 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 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, these stabilization hotels do not receive funding to provide medical or behavioral health care, despite residents' demonstrated need for services to address multiple co-morbidities.

Housing Works is close to finalizing a contract with DHS to support an integrated Stabilization Center 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. Located in an underutilized hotel, 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 people experiencing street homelessness by providing low-threshold services delivered in a respectful manner using a harm reduction approach. We plan to evaluate the pilot rigorously, both to continue to build our own competence to offer effective services, and to provide the evidence necessary to support advocacy for system-wide change. We are actively exploring opportunities presented to repurpose other underutilized hotels and commercial spaces to create deeply affordable housing, including supportive housing programs.

We cannot end homelessness in New York unless we address its drivers. Those include the gross lack of affordable house, 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. And we certainly 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. In a world grappling with the COVID pandemic and its aftermath, we must insist on policies, investments and innovation that treat people who find themselves unhoused 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 homelessness response, and to address the social and structural drivers of homelessness in order to meet real housing need in a manner that supports every person's basic human rights.

Continue to Expand Access to Health Coverage

Finally, Housing Works stresses that what is really needed to meet the health needs of all New Yorkers while saving and transforming our health care system is the universal health care system proposed by Assembly Member Gottfried and Senator Rivera. Short of that, Housing Works is pleased that this year's Executive Budget continues to reduce barriers to Essential Plan coverage. To live up to this moment in history, we must continue to act to expand coverage for uninsured immigrants in New York while also advancing the transition to a single payer system with lower costs and better coverage.

In conclusion, Housing Works calls on the Governor and the Legislature to continue to be bold when it comes to addressing the State's unprecedented public health crises. Our historic progress towards ending the State's HIV epidemic shows us what can be achieved by implementing evidence-based policies.

Thank you for your time.

Sincerely,

Charles King

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End AIDS NY Community Coalition

Ending the Epidemic New York State Budget and Policy Priorities
State Fiscal Year 2022 – 2023

Updated February 7, 2022

It is time for substantial reinvestment in the Plan to End New York's HIV/AIDS epidemic.

We have made significant progress implementing the 2015 *Ending the Epidemic (EtE) Blueprint* recommendations developed collaboratively by HIV community members, providers, advocates, and New York State and local public health authorities. HIV surveillance data shows that, by the end of 2019, EtE efforts enabled us to "bend the curve" by decreasing HIV prevalence in NYS for the first time since the epidemic began, and to bring new HIV infections to an all-time low. However, the data also shows that while HIV health outcomes have improved across all communities, vexing and unacceptable disparities persist in HIV's impact on Black, Indigenous and people of color (BIPOC), and that EtE progress in Upstate New York lags behind New York City. The COVID-19 pandemic has further exacerbated these inequities. While the HIV provider community has been agile and committed to mitigating the impact of the COVID crisis on our EtE efforts, barriers to HIV prevention and care posed by the pandemic suppressed HIV prevention, testing, and connection to care, and there has been a steep increase in premature mortality among people with HIV (PWH) due to heightened vulnerability to severe COVID-19 disease. The COVID-19 crisis has also brought tragic increases in substance use disorder and opioid overdose at a time when we are already falling short of EtE goals to improve drug user health and eliminate new HIV infections attributed to injection drug use, and thousands of New Yorkers with HIV continue to experience homelessness and housing instability in the face of a new and deadly risk of COVID infection.

Confronting these challenges to *end the HIV epidemic for all New York communities* requires bold new action to advance health equity, including structural changes in our HIV service delivery systems to address racism and implicit bias, meaningful investments on the social and structural determinants that we know drive HIV health inequities, and concrete efforts to improve drug user health, support sexual health and wellbeing, and end the co-occurring hepatitis C epidemic. In her State of the State address, Executive Budget, and recently signed legislation, Governor Hochul has signaled her recognition of the significant challenges faced by New York's most marginalized communities in accessing healthcare and a willingness to make the investments and take the steps necessary to make concrete change in New York's healthcare system.

The End AIDS New York Community Coalition acknowledges and appreciates the steps taken by the Governor to date, including declaring racism a public health crisis, making substantial investments in the healthcare system to help address health disparities and access issues and to address substance use disorder and the opioid crisis, and continuing core Ending the Epidemic funding through 2024. There are, however, significant additional financial and political investments necessary to fully implement the *EtE Blueprint* and end AIDS as an epidemic in every region of New York State and for all New Yorkers.

To advance health equity and end AIDS for all communities, the End AIDS New York Community Coalition submits the following three-pronged policy agenda and related budgetary proposals.

Address Racism as a Public Health Crisis and Make Health System Investments to Promote Equity

Recommit to EtE by Addressing Housing Access and other Key Social Determinants of Health

Arrest the Worsening Injection Drug Use and Opioid Overdose Epidemics

Address Racism as a Public Health Crisis and Make Health System Investments to Promote Equity

Invest in Concrete Actions to Address Racism as a Public Health Crisis

We applaud Governor Hochul for recently signing legislation that declares racism a public health crisis in New York State (NYS) and establishes a racial equity working group within the NYS Department of Health (NYSDOH) and support the Executive Budget proposal to rename the Office of Minority Health to the Office of Health Equity and expand its scope to focus on healthcare disparities, health equity, and social determinants of health. Stark and persistent disparities in the impact of HIV on New York's BIPOC communities demonstrate that the public health emergency of racism continues to impede our Ending the Epidemic efforts. A growing body of research demonstrates that centuries of racism in the United States has had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded and this creates inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These social determinants of health are key drivers of health inequities within communities of color, placing those within these populations at greater risk for poor health outcomes. While public acknowledgment of racism as a public health crisis is a critical first step, effectively addressing the emergency will require a whole of government response that identifies the multi-sector policies and practices that drive health inequities, and makes the necessary ongoing investments to advance racial equity as a core principle and priority.

Invest in Structural Health Systems Changes

Continue to invest in HIV delivery systems changes that focus on structural competency, which examines larger social conditions, public policies and elements of our service delivery systems that give rise to unequal access and health equities. Investments need to be sustained to enable NYSDOH and the AIDS Institute to identify health equity metrics, collect social determinants of health data, train clinicians, etc.

Protect the Healthcare Safety Net

Protecting the healthcare safety net is critical to addressing racism as a public health crisis. Language in the FY22 New York State budget (HMH Article VII) delayed the pharmacy benefit carve-out from Medicaid Managed Care to Fee-for-Service until April 1, 2023. We call on Governor Hochul and the Legislature to act this year to *permanently* repeal the Medicaid pharmacy benefit carve-out, as transitioning the pharmacy benefit to fee-for-service would 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 wrap-around HIV treatment supports that are a core component of New York's HIV response. 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. Management of the Medicaid pharmacy benefit through Managed Care also allows for better patient care, especially by HIV Special Needs Plans, because Plans play an important role in helping members manage the complex drug regimens required to address the multiple chronic conditions many PWH live with, and Plans can work closely with providers to quickly identify and address gaps in medication adherence. Provisions of Governor Hochul's Executive Budget to establish a new Pharmacy Benefits Bureau to license and provide oversight of Pharmacy Benefit Managers (PBMs) will address the State's stated concerns regarding transparency and controlling administrative costs. The same NYS controls and oversight could be placed on third-party administrators. It is possible to curb pharmacy costs by regulating these entities without threatening the stability of the healthcare safety net or our hard-fought efforts to end the HIV epidemic and reduce health inequities.

Adopt and Implement the New York State Hepatitis C Elimination Plan $10M

The EtE Community Coalition is extremely pleased that on November 17, 2021, Governor Hochul authorized the 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) led by the NYSDOH and a community co-chair. The 28 individuals appointed to serve on the HCV TF represent diverse backgrounds and expertise such as HCV prevention, clinical care and treatment, research and public health policy, as well as lived experience. Although the Task Force completed its work in June 2019 on a comprehensive set of draft recommendations to eliminate hepatitis C across NYS, the former Governor chose not to release or fund the *HCV Elimination Plan*. Now that the Plan is released, it is imperative to begin implementation of its recommendations without further delay, so are deeply concerned that the FY23 Executive Budget does not include any new funding to support HCV elimination. We call on Governor Hochul to formally adopt the *NYS HCV Elimination Plan*, and urge the Governor and the Legislation to provide at least $10M in new funding to enable the NYSDOH to begin implementation of this critical and lifesaving initiative.

Expand Hepatitis C Testing

Expanded hepatitis C testing must be an essential element of any effective NYS hepatitis C elimination strategy. To improve identification and treatment of New Yorkers with hepatitis C, amend the NYS hepatitis C testing law to: i) require the provision of a one-time hepatitis C test for every individual age 18 and older, and for individuals younger than 18 if there is evidence or indication of risk activity; ii) require a hepatitis C screening test for all pregnant persons during each pregnancy; iii) require that if a hepatitis C screening test is reactive, a hepatitis C RNA (diagnostic) test be performed to confirm diagnosis of current infection; and iv) make the law permanent with no sunset date.

Repeal the Medicaid Global Spending Cap

The Medicaid global cap was introduced in 2011 as a mechanism to limit growth in Medicaid spending and instill discipline in Medicaid budgeting. The cap was set at an arbitrary, fixed moment in time and not designed to keep pace with program growth. Medicaid is a critical safety net program and is a lifeline for PWH. It should be afforded the opportunity to grow in times of economic downturn or hardship, such as the COVID pandemic, to meet real need. We note that the Executive Budget changes the Global Cap indexed growth metric in an effort to more accurately reflect changes in enrollment and utilization. However, any cap on the Medicaid program remains arbitrary as it does not reflect actual need or real growth. Continuing to place a cap on Medicaid spending disproportionately impacts

people living with disabilities, under-resourced communities of color and safety net providers, like community health centers and HIV service programs that rely upon Medicaid as a significant coverage source for their patient base. It is time to repeal the Medicaid global cap.

Ensure Adequate and Timely Rates for HIV Special Needs Plans

New York's Medicaid Managed Care HIV Special Needs Plans (HIV SNPs) are highly effective in addressing the needs of PWH and those at heightened risk of HIV infection, achieving high rates of viral load suppression and dramatically lowered inpatient and acute care costs. However, rate setting delays and inadequate rates threaten to undermine their effectiveness. HIV SNPs receive rates as late as 21 months after their effective date, and limits imposed by the global cap have reduced SNP rates at a time when membership has expanded to include people of trans experience and other medically vulnerable groups. We support the Executive Budget's proposals to increase SNP rates to the middle or high end of the rate range and to increase all Medicaid rates by 1% to support increased pay for health care workers. We also support the Executive Budget proposal to restore the 1.5% Medicaid across the board cuts to fee-for-service providers implemented in the FY21 budget. These measures will help sustain the effective care management provided by HIV SNPs, and must be coupled with timely rates. Rates that are late and inadequate negatively impact the SNPs, providers, and most importantly, SNP members, by limiting the available provider network which impedes access and quality of care. Timely and adequate HIV SNP rates are essential to EtE efforts and greater health equity.

Exempt Lifesaving HIV Antiretroviral Drugs from Prior Authorization and Other Restrictions

We oppose and are deeply concerned by the Executive Budget proposal to discontinue Prescriber Prevails in Medicaid fee-for-service and managed care. Elimination of Prescriber Prevails and the imposition of utilization tools such as prior authorization and step therapy can restrict access to medically necessary drugs. These barriers are harmful to patient access and can prevent individuals from receiving the medication they need in a timely manner. Delaying access to these medications for individuals who currently have, or are seeking to avoid, HIV/AIDS can be life threatening and stall the State's EtE progress. We urge the Governor and Legislature to preserve Prescriber Prevails for all Medicaid enrollees. At a minimum, we call on them to amend insurance law and § 272 of the Pub. Health Law to add new language that provides: "Antiretroviral drugs prescribed to a person enrolled in a public or private health plan for the treatment or prevention of the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) shall not be subject to a prior authorization requirement, step therapy, or any other protocol that could restrict or delay the dispensing of the drug."

Address Severe Under-Investment in the Workforce and Infrastructure of Nonprofit Organizations

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 to in order for community-based nonprofit providers to prepare for, negotiate, and participate in coming value-based payment arrangements for service delivery. We welcome the 5.4% Cost of Living Adjustment (COLA) for human services providers included in the Executive budget, but while critical, this step will not 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, and

for the same 5.4% COLA for the workers in the Health Home Care Coordination program, which is flat-funded in the Executive Budget. 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 taking action 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.

Recommit to EtE by Addressing Housing Access and other Key Social Determinants of Health

It is well understood that the challenges posed by homelessness and housing instability, food insecurity, lack of employment, stigma, and other social and structural factors drive inequitable access to HIV testing, prevention, and care. Ample evidence also demonstrates that these factors are amenable to effective intervention that significantly improves HIV health outcomes. For that reason, the *EtE Blueprint* recommends concrete action to address social determinants of HIV health equity.

Provide Equal Access to Meaningful HIV Housing Supports Across New York State $10M

Over 4,000 households living with HIV outside NYC remain homeless or unstably housed because *EtE Blueprint* recommendations to ensure access to safe housing as an evidence-based HIV health intervention have been fully implemented in NYC since 2016, but not in any Upstate or Long Island community. Every low-income New Yorker with HIV experiencing homelessness or housing instability should have equal access to critical NYS resources that support housing access and stability repeatedly shown to be critical in order to benefit from HIV treatments, to reduce ongoing HIV transmissions, and to address the stark and persistent HIV health inequities that prevent us from ending our New York State HIV epidemic in every community and population. Language included in the last three enacted NYS budgets and continued in this year's Executive Budget purports to extend access to the same meaningful HIV housing supports across the State, but as currently written has failed to assist even a single low-income household living with HIV outside NYC. To finally provide equitable Statewide access to HIV housing supports, we urge Governor Hochul and the Legislature to correct the Aid to Localities language and enact necessary Article VII legislation to: i) ensure that every local department of social services provides low-income PWH experiencing homelessness or housing instability access to HIV Enhanced Shelter Allowances for rent reasonably approximate to up to 110% of HUD Fair Market Rates (FMR) for the locality and household size (the standard for Section 8 Housing Choice vouchers and other low-income rental assistance programs); ii) make the NYC-only HIV affordable housing protection available Statewide to cap the share of rent for low-income PWH at 30% of disability or other income; and iii) notwithstanding other cost-sharing provisions, recognize the fiscal reality of communities outside NYC by providing NYS funding to support 100% of the costs of HIV Shelter Allowances in excess of those promulgated by OTDA, and of additional rental costs determined based on limiting rent contributions to 30% of income.

Expand Peer and Other Employment Opportunities $4M

To increase opportunities for employment, vocational services, peer workforce placement, and economic mobility for PWH: i) increase OTDA funding to expand career readiness and job search assistance services and benefits counseling to PWH across NYS; and ii) establish a Peer Workforce Pilot Initiative through paid Peer Worker placements in health and social services organizations that will connect and maintain New Yorkers in medical care and housing. Peer workforce development investments address health disparities among PWH and achieve EtE goals by dramatically reducing new infections, increasing viral load suppression, and improving access to HIV treatment and care.

Expand Women-Focused HIV Services $2M

Expand women-focused HIV testing, prevention, and early treatment access to reach women who test positive for sexually transmitted infections (STIs), survivors/victims of domestic violence, and women leaving correctional facilities, and establish a linkage and retention in care program for women with HIV outside of NYC.

Require LGBTQ+ Cultural Competency Training for All Licensed Providers $1M

To advance health equity for LGBTO+ New Yorkers, we urge the Legislature and Governor to amend Education Law §6507(3)(a) to allow the commissioner to establish standards requiring that all persons applying on or after April 1, 2022, to obtain or renew a license, certification, or registration for a limited permit to complete at a minimum two hours of coursework or training regarding LGBTQ+-related health care and overall LGBTQ+-related cultural competence. The following providers would be subject to these standards: physician, physician assistant, registered professional nurse, licensed practical nurse, chiropractor, dentist and dental hygienist, perfusionist, physical therapist and physical therapy assistant, professional midwife, podiatrist, optometrist, ophthalmic dispenser or optician, psychologist, social worker, massage therapist, occupational therapist, certified dietician, speech-language pathologist and audiologist, acupuncturist, athletic trainer, mental health practitioner, respiratory therapist and respiratory therapy technician or applied behavioral analysis.

Mandate HIV testing on an Opt-Out Basis in All Licensed Art. 28, 31, and 32 Facilities $1M

Rates of concurrent HIV and AIDS diagnoses remain unacceptably high, especially among New Yorkers with limited access to primary care who may only interact with the health system in emergency departments or other institutional health settings. Amend the HIV testing law to facilitate true opt-out testing protocols with meaningful patient education and opportunity to decline testing, require that all licensed facilities employ opt-out HIV testing, and make technical assistance and/or consultation available from the AIDS Institute to assist with development of opt-out testing systems and protocols.

Expand NYS Sexual Health Clinics and Capacity to Provide PEP and PrEP $10M

Sexually transmitted infections (STIs) continue to rise in NYS and nationwide, are too often undetected and untreated, and are linked to increased vulnerability to HIV. Expand STI, hepatitis C, and HIV testing and treatment and access to PrEP and PEP by increasing the number of Sexual Health Clinics in New York State and funding PEP and PrEP navigation at health care centers and community-based organizations, with a focus on increasing access to PEP and PrEP for African-American and Latina women, Asian and Pacific Islanders, and young adults, and through telehealth services to reach rural communities.

Broaden At-Home STI Testing $1M

During the COVID-19 outbreaks of Spring 2020 in NYS, sexual health clinics across the state temporarily closed and significantly reduced hours which reduced access to STI testing. Meanwhile, STIs are projected to continue to increase. Although self-testing technology has advanced considerably there are barriers to its effective use. Direct NYSDOH to work with experts to identify current laws and regulations that pose barriers to home-based testing services (such as physical examination requirements), seek revisions to such laws and regulations to facilitate home testing, and establish and evaluate a pilot project of at-home STI screening.

Eliminate Congenital Syphilis in New York State by the End of 2030 $1M

We support the Executive Budget proposal to require syphilis testing of all pregnant patients in their third trimester, in addition to the existing requirement to test at the initial visit. While this is a good step, there is still a need to establish and implement a comprehensive plan to eliminate congenital syphilis in NYS by the year 2030. Rates of syphilis in NYS continue to exceed the national average, ranking 11th in the nation in 2019. Left untreated syphilis can cause serious health problems such as tumors, blindness, nerve damage, and even death. However, if syphilis is identified quickly, it is curable with common antibiotics. We urge the Governor to authorize NYSDOH to convene a statewide taskforce to develop comprehensive recommendations to improve syphilis screening, public and provider education, prevention, and care.

Address HIV Health Disparities Experienced by Youth

Young New Yorkers, especially LGBTQ+ youth and young adults of color, continue to be disproportionately affected by HIV. Specific actions necessary in order to promote HIV health equity for youth and young adults include:

- ***Require Comprehensive Sexual Health Education*** $22M
  Require all NYS public and charter schools to provide students in grades K-12 with integrated, comprehensive, developmentally appropriate, medically accurate and unbiased sexual health and HIV prevention education using a youth development approach, building on the strengths and capacities of young people.

- ***Implement a Condom Media Campaign*** $2M
  Condoms are the only available primary prevention method against STIs for sexually active people. Condom usage in NYS declines every year, while STI rates increase.

- ***Increase Funding for LGBTQ Youth Services*** $3M
  Increase grant funding available to providers serving LGBTQ youth.

- ***Develop and Deploy Novel Programs*** $2M
  Novel strategies are needed to reach and engage young people in sexual health services. Youth rely on technology to meet their needs related to socialization, information, and even healthcare. Promising preliminary results from home HIV testing programs suggest that offering testing through mobile means is effective at reaching persons who otherwise cannot access testing through traditional channels. Telemedicine has the potential to make healthcare visits related to HIV and STI screening, as well as accessing PrEP/PEP, more convenient for persons who are unable to access these services because of transportation, stigma, fear, or other barriers.

Identify and Meet the Complex Needs of Older People with HIV $2M

At the end of 2019, people aged 50 and older accounted for more than half of PWH living in NYS, underscoring the importance of identifying and addressing the more complex medical and social service needs of older PWH. Targeted strategies are required to provide access to comprehensive and integrated health care that is responsive to often-complex medical comorbidities, increase engagement of older PWH with behavioral health care, and develop programming to address social isolation, nutrition, exercise, mobility limitations, and other health maintenance needs.

Decriminalize Adult Sex Work

The criminalization of sex work does not protect sex workers or advance public health goals, but rather perpetuates the social stigma that treats sex work as an inherently harmful activity and keeps sex workers from seeking health care and other supportive services, including HIV prevention and care. Data show that sex workers are highly vulnerable to HIV acquisition, report low rates of awareness and uptake of PrEP, and face an increased risk of exposure to violence, due in large part to stigma and discrimination in health care settings, socioeconomic disadvantage, and the inability or reluctance to seek protection from law enforcement. We call on Governor Hochul and the Legislature to support the Stop Violence in the Sex Trades Act (A.8230/S.6419), which amends statutes so that consenting adults who trade sex, collaborate with or support sex working peers, or patronize adult sex workers will not be criminalized. The bill would also amend the law so that people can trade no-longer-criminalized sex in spaces where legal businesses are permitted, while upholding current law that maintaining exploitative workplaces where coercion and trafficking take place is a felony. This bill aims to decriminalize the industry—including sex workers, clients and managers—while carefully continuing to protect minors and trafficked people.

Commit to Continue Core NYS EtE Funding Through at Least FY2025 $15M ($30M/2 years)

When year 2020 EtE goals were set in 2015, no one could have imagined the challenges presented by the COVID-19 pandemic or the impact of the COVID crisis on a range of related public health goals, from ending the HIV epidemic to addressing the opioid crisis. It is anticipated that year 2020 HIV surveillance data will show an artificially low number of new HIV diagnoses and a tragic increase in mortality due to severe COVID illness among PWH. We thank Governor Hochul for her statement on World AIDS Day 2021, confirming her Administration's commitment to the ongoing work of Ending the New York AIDS Epidemic, and for continuation of $15 million a year ($30 million over two years) in Medicaid funding in the recently released Executive Budget to support EtE strategies through at least fiscal year 2024. Maintaining this commitment and funding through at least FY2025 is essential to regain momentum and complete the work necessary to end AIDS as an epidemic and move closer to HIV health equity.

Arrest the Worsening Injection Drug Use and Opioid Overdose Epidemics

Scale-Up Harm Reduction Funding and Programming

The EtE Community Coalition welcomes and urges the Legislature to support the substantial commitment of funding in the Executive 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 for investments in new initiatives to combat the opioid crisis, as well as additional monies realized through settlement of NYS litigation against opioid manufacturers and distributors. We urge the legislature to support the full range of new investments and initiatives such as expansion of mobile treatment services to expand access to Medication Assisted Treatment, and new funding allocated to the NYSDOH AIDS Institute for additional harm reduction services ($9million recurring) and Naloxone distribution ($8million in FY 2023 and $10million thereafter). We are particularly pleased by the Administration's commitment to a public health approach 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 exchange. Harm reduction strategies to improve drug user health, including syringe exchange programs, and peer support, are in urgent need of reinvestment. The dedicated AIDS Institute funding for naloxone will increase access to this highly effective medication for reversing an opioid overdose. We 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

Exchange Programs to serve hard to reach areas and individuals. Funding point of-care testing for HIV, STIs and HCV in Syringe Exchange Programs and Drug User Health Hubs would substantially increase the capacity of the health system to screen for these infections in order to more rapidly engage people with use drugs in treatment and prevention. We look forward to working with OASAS and the DOHMH on scale up of the proven harm reduction strategies funded in the Executive Budget.

Approve and Fund Pilot Overdose Prevention Centers (OPCs) $3M (Opioid Settlement Fund)

In addition to the interventions and strategies outlined in the Executive Budget, we strongly urge the Hochul Administration to approve and the Governor and Legislature to fund establishment and evaluation of five planned pilot Overdose Prevention Centers (OPCs) across the State to operate over at least two years. The pilot program will allow community-based organizations to operate OPCs, which offer sterile supplies and controlled settings for people to use pre-obtained drugs under the supervision of trained medical professionals who can intervene in case of an overdose. OPCs are an evidence-based intervention proven to reduce drug-related overdose deaths and increasing access to health care and substance use treatment. Significantly, two OPCS that opened with NYC approval in November 2021 report that as of February 3rd they have reversed 124 overdoses. Supporting these efforts with funding from the Opioid Settlement Fund will save countless lives and continue New York State's longstanding leadership in the opioid response.