NYS 2024 Joint Legislative Budget Hearing on Health
Housing Works Testimony

February 28, 2023

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 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 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.[1] 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: **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; the **Harm Reduction Coalition of New York State** (NYSHRA), 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; 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.

None of us could have predicted how the unprecedented COVID-19 pandemic we are still struggling to 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

[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] For more information, see https://www.savenysafetynet.com
[3] https://www.ihealthnys.org

health equity, including declaring racism a public health crisis and proposed improvements in the healthcare system to reduce health disparities, remove barriers to healthcare access, and embrace a public health approach to substance use disorder and the opioid crisis. However, this year's Executive Budget includes several proposals that threaten to undermine rather than advance greater health equity. The Governor's budget leaves in place the Medicaid pharmacy "carve-out" that poses a grave risk to the health of New Yorkers who rely on our health care safety-net proposes aggressive, proposes aggressive and ill-considered cuts that would decimate the Health Home care coordination program for low-income New Yorkers with chronic conditions, and abandons the Governor's previous commitment to seek federal funding to expand health insurance for immigrants between the ages of 18 and 65.

In addition to these issues, I will 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 about the need to radically rethink our response to homelessness, especially among people experiencing homelessness who have chronic and acute health needs.

<u>Protect the Healthcare Safety Net</u>

Savings realized by safety net providers under the federal 340B drug discount program support otherwise unfunded services essential to meeting the 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.

Former Governor Cuomo put in place this "carve out" of the Medicaid pharmacy benefit from managed care to fee-for-service that, if implemented as planned on April 1st as planned, 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 addressing health disparities based on race, poverty, and marginalization.

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. The carve-out would strip millions 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 created 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 mental health and substance use services, all delivered in a culturally and linguistically appropriate setting. If the State proceeds with the pharmacy carve-out, **Housing Works and the patients we serve will lose at least $10 million 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.

The carve-out was delayed by the Legislature 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, yet the Executive Budget has proposed moving forward with the carve-out that will decimate safety net providers. 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.

Protect New York's Health Home Program and the Low-Income New Yorkers It Serves

We also call on the Legislature to stop the ill-considered Executive Budget proposal to make aggressive changes to the Health Home Program that were developed without provider or consumer input and 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.[4] 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.

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

[4] https://hhcoalition.org/wp-content/uploads/2021/11/HH-Facts-Sheet-2023.pdf

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.

Expand Health Insurance Coverage for Immigrant New Yorkers

Housing Works asks the Legislature to correct the Governor's inexplicable failure to seek Federal funding to provide access to health insurance for an estimated 250,000 immigrant New Yorkers who are currently prohibited from enrolling in Medicaid, the Essential Plan, or public health programs due to their immigration status.

Health care is a basic human right and Housing Works stresses our belief that what is really needed to meet the health needs of all New Yorkers while saving and transforming our health care system is a universal single payer system with lower costs and better coverage. Short of that, we must continue to act to expand coverage for uninsured immigrants, so we are extremely disappointed that Governor Hochul's Executive Budget proposal backs away from her post-budget promise last year to expand immigrant coverage for adults ages 19 through 64 through NYS's 1332 waiver application under the Affordable Health Care Act. We understood that the Waiver application would propose using the existing federal-funded Basic Health Plan/Essential Plan Trust Fund to pay for immigrant coverage and an increase the Essential Plan income eligibility for all New Yorkers up to 250% of the FPL. We find it inexplicable that the Governor would abandon a plan to ask the federal government to pay for health insurance for immigrants at no cost to the State. CMS has already

granted Colorado and Washington permission through 1332 waivers to use the Trust Fund, which has an $8 billion surplus and can only be used to pay for health insurance coverage, to pay for immigrant health insurance.

Failing to expand health coverage for immigrants is not only wrong, but also fiscally irresponsible, as NYS spends $544 million on Emergency Medicaid (NYS DOB data) for immigrants every year—$544 million could be repurposed for other priorities.

We urge the Legislature to include expanded coverage for adult immigrants in your one-house budget bills.

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 2024 that I have attached to my testimony. I will highlight some of these issues in this testimony.

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. Our EtE efforts enabled us to "bend the curve" of the epidemic by the end of 2019, decreasing HIV prevalence in NYS for the first time, and recently released 2021 surveillance data show this trend continues and that the number of persons newly diagnosed with HIV in NYS decreased 46% from 2011 to 2021. However, the 2021 data also show that stark and unacceptable disparities persist in HIV's impact on Black, Indigenous and people of color (BIPOC) communities, transgender New Yorkers, and young men who have sex with men, with the rates of new HIV diagnoses among non-Hispanic Black and Hispanic New Yorkers 7.4 and 4.1 times higher, respectively, than the rate for non-Hispanic Whites. Additional financial investments and policy changes are necessary to fully implement *EtE Blueprint* recommendations to end AIDS as an epidemic in every region of the State and for all New Yorkers—including protection and improvement of HIV service delivery systems that serve the most vulnerable low-income New Yorkers and meaningful new investments to address the social and structural determinants that we know drive HIV health inequities.

While Housing Works and the EtE Coalition are pleased to note that core EtE funding is sustained through at least 2024 in the 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 and HCV. 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.[5] 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

[5] 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

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.

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 as HIV health care in every part of NYS

Lack of access to safe, stable housing for PWH who live outside NYC is a key factor driving health inequities in low-income BPOC communities in the rest of the State. We call upon the Senate and Assembly to include in your one-house budgets the adjustments to relevant Aid to Localities language necessary to provide equal access to meaningful HIV housing supports for people with HIV experiencing homelessness or unstable housing in all parts of NYS.

Safe, stable housing is essential to support effective antiretroviral treatment that sustains optimal health for people with HIV (PWH) and makes it impossible to transmit HIV to others.[6] Indeed, NYS data show that unstable housing is the single strongest predictor of poor HIV outcomes and health disparities.[7] For that reason, NYS's 2015 *ETE Blueprint* recommends concrete action to ensure access to adequate, stable housing as an evidence-based HIV health intervention.[8]

The *Blueprint's* housing recommendations have been fully implemented in New York City since 2016, where the local department of social services employs the longstanding NYS HIV Emergency Shelter Allowance program to offer every income-eligible person with HIV experiencing homelessness or housing instability access to a rental subsidy sufficient to afford housing stability, as well as a 30% rent cap affordable housing protection for PWH who rely on disability benefits or other income too low to support housing costs.

Upstate and on Long Island, however, as many as 2,500 households living with HIV remain homeless or unstably housed because the 1980's NYS regulations governing the HIV Emergency Shelter Allowance (HIV ESA) set maximum rent for an individual at just $480 per month – far too low to secure decent housing anywhere in the State, and local districts are not required to provide the 30% rent cap affordable housing protection. Only the NYC local department of social services

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[6] Aidala, et al (2016). Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review. *American Journal of Public Health*, 106(1), e1–e23.

[7] Feller & Agins (2017). Understanding Determinants of Racial and Ethnic Disparities in Viral Load Suppression: A Data Mining Approach. *Journal of the International Association of Providers of AIDS Care*, 16(1): 23

[8] NYS Department of Health AIDS Institute, 2015. New York State's Blueprint for Ending the Epidemic. Available at https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf

works with NYS to approve "exceptions to policy" to provide meaningful HIV ESA rental subsidies in line with fair market rents and other low-income rental assistance programs.[9]

Access to "Rest of State" HIV housing assistance was a top priority of Housing Works and members of the EtE Community Coalition for years even before the EtE Blueprint and our historic plan to end the New York AIDS epidemic were adopted in 2015. The ongoing failure for many years to meet the housing needs of New Yorkers with HIV who live outside of NYC undermines the individual health of New Yorkers with HIV, HIV prevention efforts, and our statewide EtE goals. Every low-income New Yorker with HIV experiencing homelessness or housing instability should have equal access to critical NYS public assistance benefits 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 NYS HIV epidemic in every community and population. The HIV Emergency Shelter Allowance program was established by NYS regulation in the 1980's. Action to make the program work for New Yorkers living with HIV in communities outside NYC is long overdue.

Indeed, language included in the last four enacted NYS budgets ***purports*** to extend access to the same meaningful HIV housing supports across the State, but as written has failed to assist even a single low-income household living with HIV outside NYC, despite evidence that the estimated additional costs to NYS of the public assistance benefit (less than $2.5M in FY24) will be more than offset by savings realized from reduced Medicaid spending on avoidable acute and emergency care and averted HIV infections.[10] This failed language, unfortunately carried over again in the recently released Executive Budget, allows but does not require local departments of social services to provide meaningful HIV housing assistance, and provides no NYS funding to support the additional costs to local districts outside NYC.[11]

To finally provide equitable Statewide access to HIV housing supports, we urge the Legislature and Governor to correct the relevant Aid to Localities language on public assistance benefits and enact Article VII legislation necessary to: i) ensure that every local department of social services provides low-income PWH experiencing homelessness or housing instability access to the NYS HIV Emergency Shelter Allowance program to support 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 extremely 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 their costs for providing 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.

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[9] The NYC Human Resources Administration's current payment standard for HIV Emergency Shelter Allowance rental assistance is 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.

[10] Ample evidence shows that dollars spent on HIV rental assistance generate Medicaid savings from avoided emergency and inpatient care that offset the cost of housing supports. See, e.g., Basu, et al. (2012). Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care. *Health Services Research*, 47(1 Pt 2): 523-543.

[11] Likewise, a rest-of-state HIV housing pilot project included in past NYS budgets was designed to fail. The pilot would have leveraged NYS investments with dollar-for-dollar matching funds from regional MCOs or other health payors who would partner with local districts with to cover additional costs of meaningful HIV housing assistance, but the budget language included "poison pill" provisions that disincentivized partnership, so no pilots were proposed and not a single PWH was housed.

If this is not accomplished in the FY24 NYS budget, we call upon the Legislature to pass legislation introduced in the Senate (S183/Hoylman-Sigal) and Assembly (A2418/Bronson) to finally implement *EtE Blueprint* housing recommendations in the rest of the State outside NYC. The EtE Community Coalition stands ready to work closely with sponsors and allies to educate members of the Legislature on the critical need for and importance of this legislation.

At Housing Works, we have seen firsthand the healing power of safe, secure housing—especially for persons who face the most significant barriers to effective HIV treatment. Currently, over 90% of the residents of our HIV housing programs are virally suppressed, including housing serving vulnerable groups such as HIV-positive LGBTQ+ youth, transgender women, and women recently released from incarceration. We believe that every homeless or unstably housed New Yorker with HIV deserves the same equal access to life-saving housing supports, regardless of which part of New York State they call home.

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.

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 NYSDOH 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 NYSDOH on scale up of the proven harm reduction strategies.

Approve and fund overdose prevention centers
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.[12] 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.[13] 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.

Exempt Lifesaving HIV Antiretroviral Drugs from Prior Authorization and Other Restrictions
We oppose and remain deeply concerned by any 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

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[12] *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.
[13] 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

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 have received 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 welcomed provisions in the FY 23 Budget that resulted in some much-needed increases in SNP rates and that restored the 1.5% Medicaid across the board cuts to fee-for-service providers implemented in the FY 21 budget. Additionally, we understand that improved processes have resulted in timelier rate setting, although delays remain an issue and there is still work to be done to sustain and build on this progress. 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. Although last year's NYS Budget changed the Global Cap indexed growth metric in an effort to more accurately reflect changes in enrollment and utilization, 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
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 and increasing the amount of the COLA proposed for this year, 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 to 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. The Governor's FY24 budget includes a 2.5% COLA increase across the human service sector. While we support the 2.5% increase and are extremely pleased to see for the first time in in recent history two consecutive years of a COLA increase, we join the Mental Health Association in New York State (MHANYS) and other advocates in calling for an 8.5% COLA increase that is based on the Consumer Price Index and in line with real need.

However, COLA adjustments for human services providers, although critical, do 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. 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.

<u>Transform New York's Response to Homelessness</u>

Finally, 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.[14]

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 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

[14] *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

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 urges the NYSDOH to employ authority under the pending 1115 waiver to support innovative new strategies as part of our homeless response. We have proposed the following 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 NYSDOH 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 – 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.

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 and persistent and unacceptable health inequities. 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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