COMMUNITY HEALTH CARE ASSOCIATION of New York State

Senate Finance and Assembly Ways and Means
Joint Legislative Hearing on the
State Fiscal Year 2021-22 Executive Budget Health and Medicaid
February 25, 2021

The Community Health Care Association of New York State (the Association) is grateful for the opportunity to provide testimony on the Governor's State Fiscal Year (SFY) 2021-22 Executive Budget. The Association is the only statewide organization for New York's federally qualified health centers (FQHCs), also known as community health centers (CHCs), that serve approximately 2.3 million New Yorkers at over 800 sites each year.

Community Health Care Association: Supporting New York's Primary Care Safety Net Providers

The Association is the voice of CHCs which serve as leading providers of primary care in New York State. We represent more than 70 CHCs which operate more than 800 sites in medically underserved communities statewide. CHCs are non-profit, community run clinics that provide high-quality, cost effective primary and dental care, including behavioral health and social support services, to anyone seeking it, regardless of their insurance status or ability to pay. Each CHC is governed by a consumer-majority board of directors who seek to identify and prioritize the services most needed by their communities.

Most of our members' patients are extremely low income; 89% live below 200% of the Federal poverty level. Our members serve populations that have historically been failed by the traditional health care system: 71% are Black, Indigenous, or People of Color (BIPOC), 29% speak limited or no English, 15% are uninsured, and 4% are unhoused. Nearly 60% of our CHCs' patients are enrolled in Medicaid, CHIP, or are dually enrolled in Medicare and Medicaid. All CHCs provide robust enrollment assistance to patients and, although CHCs do not collect information on immigration status, it is likely that the vast majority of uninsured patients are not eligible for insurance coverage due to immigration status.

In short, CHCs are New York's primary care safety net, working tirelessly to provide a safe and welcoming primary care home to people who experience poverty, racism, and discrimination that inhibits their health, wellbeing, and ability to survive.

SFY 2020-21 Executive Budget Proposal

A. Reject the pharmacy benefit carve out

The Governor's budget reaffirms last year's budget initiative to carve the pharmacy benefit out of Medicaid managed care and into fee-for-service. Carving out the pharmacy benefit will make CHCs, HIV Ryan White providers and disproportionate share hospitals unable to fully benefit from the Federal 340B Drug Discount Program (340B). 340B allows covered safety net health care providers to access pharmaceutical drugs at reduced costs and enables them to reinvest those savings into initiatives that expand access to care. Thanks to 340B, safety net providers can offer free or extremely low-cost drugs to individuals without insurance coverage or who have high deductibles. 340B also allows safety net providers to address social needs that impact health and access to care. In fact, the Governor's robust COVID-19 vaccination program, currently underway, is supported by 340B reinvestments; many health

centers use 340B savings to cover unfunded costs such as: conducting vaccine related outreach and patient education; providing vaccinations to staff of behavioral health organizations; and holding vaccination events in communities of color, often at the request of state and local health departments.

The carve out will severely hamstring the healthcare safety net, which continues to provide care to communities that have been devastated by COVID-19. The Governor has publicly announced his commitment to improving health disparities in communities disproportionately impacted by COVID-19, namely low income, Black, and Brown communities. Yet, the carve out will harm those very same patients the Governor and his Administration have promised to protect.

Although the Department of Health has stated the carve-out will achieve $87M in State savings in FY22, it will result in recurring losses to the most vulnerable healthcare providers in the State. FQHCs, alone, stand to lose a collective $100M per year. A survey of 15 Ryan White clinics found they would lose $56M per year, and a small subset of hospitals reported that they would lose an additional $87M in the first year. Furthermore, a study published by the Menges Group refutes the State's projected savings and concludes that the State will ***lose*** $154M in the first year of the carve out and a total of $1.5B over five years.

In recognition of the negative financial impact the carveout will have on safety net providers, the budget includes a $102M investment to support community health centers that currently benefit from 340B savings. There is no methodology for distribution to date. However, $102M is woefully inadequate given the enormity of the losses that will be experienced by the safety net providers and it is also not a long-term solution for sustainability. Many of the 340B financed programs are located in poor communities of color, the same communities that have been ravaged by COVID-19. Now is not the time to further jeopardize those critical programs by removing access to savings generated by 340B.

The 340B program is a well-established mechanism created by Congress to ensure safety net providers have the necessary resources to ensure their patients have access to high-cost drugs and expand uncompensated care programs to adequately care for patients' health. It is unfathomable for New York to move forward with the carve out, thereby denying otherwise eligible healthcare providers access to these savings, during the most significant public health crisis in modern history. Including the pharmacy benefit carve out will threaten the comprehensive public health response to the novel coronavirus pandemic and will compromise the State's progress in ending the HIV epidemic.

The Association respectfully requests that the Senate and the Assembly reject the pharmacy benefit carve out. At a minimum, we ask legislators to delay the carve out for 340B covered entities and special needs health plans for three years while these entities continue to provide vital services needed to prevent, recover and restore from the devastation of COVID-19. We commend the Chairs of the Senate and Assembly Health Committees for sponsoring legislation (S.2520/A.1671) that would accomplish that goal, and we urge both houses to advance the Rivera/Gottfried bill as part of budget negotiations.

B. Support and expand the Governor's telehealth initiatives to ensure payment parity among all remote visit types

The COVID-19 pandemic has encouraged the State to implement policies that increase access to remote care options across a variety of health care services. Those new policies and flexibilities created a vital

lifeline allowing many health care consumers to remain connected to care. At one point during the pandemic, more than two-thirds of New York's CHC visits were occurring remotely. Last summer, the Association and our partner, the NYS Council for Community Behavioral Healthcare, presented to the Governor's Reimagine New York Commission on needed change to ensure sustained telehealth adoption in the post pandemic period. Our recommendations centered around four key principles: a full range of telehealth modalities should be utilized to increase access and promote health equity; regulatory flexibilities must be maximized to sustain adoption; clinicians, in collaboration with patients, determine when a telehealth visit is appropriate; and, reimburse remote care on par with in-person visits to ensure an integrated continuum of care.[1]

The Association was pleased that the Governor included many of these recommendations in his 2021 State of the State address and in the Executive budget proposal. However, telehealth utilization could unintentionally exacerbate health disparities -- rather than alleviate them -- if the State does not take an equity-oriented approach to remote care. Access to audio-visual telehealth is severely limited by a patient's access to broadband internet/Wi-Fi and their technical literacy. Many health center patients lack a smartphone or a computer or have phone plans with limited data and minutes. Although most providers agree that audio-visual visits are the gold standard of remote care, in instances where a patient cannot or does not have access to all the elements needed for a video connection, telephonic visits are critical to ensuring continuity of care.[2] Therefore, the State must reimburse telephonic and audio-visual telehealth visits on par with in-person visits to ensure that all remote options remain viable alternatives to in person care.

As telehealth usage becomes more widespread, patients and providers alike will need training, education, and IT support to bolster remote visit capacity and increase technical literacy. The Association encourages the State to take proactive actions to improve access to broadband internet, free wi-fi, and other technology to ensure that telehealth mitigates and not exacerbates, health inequities. We support the Governor's proposal to create open-source training materials for providers and patients to increase capacity for remote care.

New York can, and should, be a leader in utilizing telehealth. In interviews the Association conducted with behavioral health service providers, providers and patients viewed remote visits positively. However, there are some limitations. For example, patients with hearing challenges might opt for a video-facing platform, while others may prefer telephone since it is more portable, allowing them to seek the privacy needed for a behavioral health visit. Gender nonconforming patients and patients with autism spectrum disorder also noted that video visits were "uncomfortable," and often opted for a telephonic version. Regardless of visit type, patients and providers should be empowered to choose the modality of care best suited for their needs.[3]

Prior to the pandemic, NYS applied restrictions to the types of CHC providers that could provide visits remotely, despite that provider's ability to be reimbursed for services delivered in person, i.e. Licensed

[1] https://www.chcanys.org/sites/default/files/2021-01/Telehealth%20White%20Paper_June%202020.pdf
[2] https://www.chcanys.org/sites/default/files/2021-01/Ensuring%20Sustained%20Access%20to%20Telehealth%20Post%20Pandemic_0.pdf
[3] https://www.chcanys.org/sites/default/files/2021-01/Ensuring%20Sustained%20Access%20to%20Telehealth%20Post%20Pandemic_0.pdf

Clinical Social Workers (LCSWs). During the pandemic, those restrictions do not apply and no-show rates for LCSW visits have declined, with providers successfully serving patients unable to come into an office. The Association recommends that NYS continue this practice and allow any FQHC provider authorized to bill for in-person services to be authorized to deliver care remotely.

We applaud the Governor's initiative to eliminate "obsolete" telehealth location requirements and allow services to be reimbursed regardless of where the patient or provider is located. We implore the Governor to expand this flexibility to FQHCs serving the Medicare/Medicaid dually eligible populations; currently, Medicaid is only allowing FQHCs to deliver remote services to duals during the public health emergency.

C. Ensure level funding for providers participating in the Patient Centered Medical Home (PCMH) program

The PCMH model of patient-centered care is associated with improved health outcomes and reduced costs. New York developed its own PCMH standard in 2018, incorporating many practice capabilities that are central to the CHC model, such as providing a coordinated, patient-centered medical home; promoting population health and using health information technology to deliver evidence-based care. NY PCMH also requires that providers participate in value-based payment arrangements.

Any reduction to PCMH funding will directly impact health centers' ability to continue to provide high quality comprehensive primary care services and to engage in value-based arrangements and care models. Coordinated care management is especially critical in light of COVID-19, as primary care practices work to keep their patients with chronic conditions out of overcrowded emergency rooms, provide post-COVID-19 hospitalization follow-up, and ensure second doses of COVID-19 vaccination are received.

The Association thanks the Legislature for consistently ensuring that the PCMH funding has remained stable, and respectfully requests that the Legislature, again, protect the PCMH program funding – consistent with the Governor's proposal -- at the 2020 levels.

D. Maintain level funding for the D&TC Safety Net Pool

The Governor and Legislature have historically supported funding for the Safety Net Pool to help cover CHCs' cost of caring for the uninsured. As in prior years, this year's Executive Budget includes $54.4M in state funding, which would draw down a federal match of an equal amount. This funding partially reimburses CHCs for the cost of caring for the uninsured, the rate of which is three times higher at CHCs than in the general New York State population. However, at some health centers, more than half of the patients are uninsured. Funding provided through the Safety Net Pool provides vital assistance to community health centers, thereby helping to off-set the overall cost of caring for the uninsured. Maintaining Safety Net Pool funding levels is aligned with the State's focus on ensuring access to primary care, reducing unnecessary hospitalizations and improving health outcomes for all New Yorkers, not just those who have access to insurance coverage.

The Association urges the Legislature to maintain the Safety Net Pool at current funding levels and ensure that all New Yorkers, regardless of insurance status, continue to have access to high- quality, community-based primary care.

G. Maintain Support for Health Centers Serving Migrant & Seasonal Farm Workers

The Association supports maintaining level funding for health centers that operate migrant health care programs across New York State. Migrant Health Care funding allows health centers and other eligible providers to serve over 24,000 migrant and seasonal agricultural workers and their families, a population that is integral to New York State's agribusiness and especially vulnerable to infection with COVID-19. It is estimated that 61% of farmworkers live in poverty, with a median income of less than $11,000 annually. New York's migrant health centers keep farmworkers healthy by providing primary and preventive health care services, including culturally competent outreach, interpretation, transportation, health education, dental care and now, COVID-19 vaccines. The Association urges the Legislature to maintain $406,000 in funding for the Migrant Health Care program.

H. Maintain Level Funding for School Based Health Centers

New York's 260+ school-based health centers (SBHCs), over half of which are operated by CHCs, provide comprehensive primary care, including mental health and dental services, on site at schools to over 250,000 children throughout the State. For many children, especially those who are undocumented, uninsured and/or those in underserved areas, the SBHC is a critical point of care. The Association urges the Legislature to maintain current SBHC grant levels, which remain level in the Executive budget.

E. Restore Level Funding for Doctors Across New York

Since 2008, the Doctors Across New York (DANY) program has provided loan repayment and practice support funding to improve physician recruitment and retention in locations throughout the State that lack sufficient capacity to meet community needs. While DANY has helped place physicians in communities across the state, the number of placements has not kept pace with the growing physician shortage. In the 13 years since DANY became law, there have been seven solicitation cycles, with the program historically receiving more applications than awards available. COVID-19 has exacerbated workforce strains across the State, especially in the primary care setting. Yet, the Governor's budget proposed to cut DANY by more than $1.8M, allocating just $7.252M to the program. The Association asks the Legislature to restore DANY to last year's appropriation of $9.065M to ensure that community health centers have support in recruiting high quality primary care providers in all areas of the State, but especially in those hardest hit by COVID-19.

F. Restore Full Investment in Health Homes

New York's Health Home program was established in the Governor's SFY 2011-12 budget. The program funds enhanced care coordination for eligible populations. Health Home enrollees are some of the sickest New Yorkers; to be eligible, individuals must have: two or more chronic conditions; be living with HIV/AIDS; or have serious mental illness. Medicaid members enrolled in the Health Home program are provided intense care management to ensure they spend less time in the hospital and are able to manage their conditions before they result in a health care emergency. The Governor's budget cuts the

Health Homes program by $34M. The Association respectfully asks the Legislature to restore the program to last year's funding level: $279M.

Conclusion

To support the primary care safety net and ensure ongoing access to comprehensive community- based care for all New Yorkers, the Community Health Care Association respectfully urges the Legislature to:

- ✓ Reject:
  - The pharmacy benefit carve out for at least 3 years
- ✓ Enhance:
  - Payment parity for clinically appropriate audio-only remote care
- ✓ Protect:
  - Level per member per month PCMH payments to certified providers
  - Level funding for the D&TC Safety Net Pool
  - Level funding for health services for migrant and seasonal farmworkers
  - Level funding for school-based health centers
- ✓ Restore:
  - Full investment in primary care workforce through Doctors Across New York
  - Full investment in Health Homes