COMMUNITY HEALTH CARE ASSOCIATION of New York State

Senate Finance and Assembly Ways and Means
Joint Legislative Hearing: Health
State Fiscal Year 2023-24 Executive Budget Health and Medicaid
February 28, 2023

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to provide testimony on the Governor's State Fiscal Year (SFY) 2023-24 Executive Budget. CHCANYS is the primary care association 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.

Background

CHCANYS is the voice of more than 70 community health centers – the standard bearers of primary and preventive care for medically underserved communities across the state. CHCs are non-profit, community run clinics that provide high-quality, cost-effective primary care as well as behavioral health, dental care, and social support services, to everyone, regardless of their insurance status or ability to pay. Each CHC is governed by a consumer-majority board of directors who identify and prioritize the services most needed by their communities.

The majority of CHC patients are extremely low income; 89% live below 200% of the Federal poverty level. Our CHCs serve populations that the traditional healthcare system has historically failed: 68% are Black, Indigenous, or People of Color (BIPOC), 28% speak limited or no English, 13% 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 a crucial safety net for New York's residents of both rural and urban areas, working tirelessly to provide healthcare and social services for people who experience poverty, racism, and discrimination that inhibits their health, well-being, and ability to survive.

CHCANYS SFY 2023-24 Budget Priorities

A. Repeal or replace the pharmacy benefit carve out.
B. Update CHC reimbursement rates to reflect changes to care delivery and inflationary pressures.
C. Provide full reimbursement parity for telehealth visits, regardless of patient or provider location, for all care delivered via telehealth by CHCs.
D. Enact policies to expand healthcare workforce and support scope of practice expansions.
E. Support Essential Plan expansions for all New Yorkers, including undocumented immigrants.
F. Support infrastructure investments and protect dollars for community-based providers.

A. Repeal or replace the pharmacy benefit carve out.

In 2021, CHCANYS and other advocates successfully worked alongside the Legislature to delay the implementation of the pharmacy benefit carveout from the Medicaid Managed Care program until April 1, 2023. We thank our legislative partners for sharing our concerns and demonstrating understanding of the catastrophic impact on safety-net providers like CHCs, Ryan White providers, and disproportionate share hospitals if these providers were no longer able to access Federal 340B drug discount savings. CHCANYS again looks to the legislature to revisit implementation of this proposal which will have immediate and severe impacts on access to care.

The 340B program allows covered safety net healthcare providers to access pharmaceutical drugs at reduced costs and enables them to reinvest those savings into initiatives that expand access to care. In alignment with Federal and State incentives, CHCs use 340B savings to better serve vulnerable communities. The program has allowed CHCs to fund the following types of programs:

- Free medications to the uninsured and underinsured,
- School-based health centers,
- Mobile clinics,
- Expanded dental services in communities without any Medicaid-accepting providers,
- Nursing and nursing triage,
- Support for clinical pharmacy services,
- Enhanced social care for patients such as nutrition services and transportation vouchers,
- Addressing homelessness and providing housing security,
- Combatting the opioid epidemic, and
- Services for individuals living with HIV.

At a time when CHCs are facing increases in operating costs, the end of Federal COVID-relief dollars, and Medicaid eligibility redeterminations that will surely drive up the number of CHC patients who are uninsured,[1] 340B is more essential than ever to ensuring access to these vital services.

CHCANYS has estimated that the carve out will cut health center funding by at least $260M annually. If the carve out is implemented on April 1, these funds will immediately stop flowing to health centers – there will be no tapering down. The loss of these funds will impact CHCs' ability to leverage other funding as well, including the ability to borrow money or refinance existing loans.

The Medicaid budget scorecard includes a $125 million non-federal share ($250M total assuming federal match) annual reinvestment for community health centers and other diagnostic and treatment centers. This reinvestment falls short of the amount needed to sustain community health centers. Additionally, there is no assurance of funding stability for future years. Many questions remain unanswered: how and when will the funds be distributed; how will health center specific allocations be determined; how will funding be made available beginning April 1st; and how will annual inflationary adjustments be made. A similar initiative was implemented in California and health centers have not seen a single penny since the California carve out was implemented on January 1, 2022.

[1] https://geigergibson.publichealth.gwu.edu/potential-effect-medicaid-unwinding-community-health-centers

The State's goals around the carve out are important and ones shared by CHCs and CHCANYS - to control drug pricing and increase transparency in the Medicaid pharmacy program. However, any state savings generated from the pharmacy benefit carve out will come at the expense of low-income and disenfranchised individuals who would lose access to programs supported by the reinvested 340B savings. We welcome the opportunity to work collaboratively to achieve the State's policy goals without decimating care for underserved communities.

B. Update CHC reimbursement rates to reflect changes to care delivery and inflationary cost pressures.

The Governor's proposed budget rightly acknowledges a need for significant investment in primary care by proposing to benchmark primary care Medicaid rates to 80% of Medicare rates, increase reimbursement for dental providers and school-based health centers and allow for reimbursement of community health workers. These primary care investments do not apply to CHCs, which have a unique reimbursement methodology pursuant to federal law. Reforms to Medicaid reimbursement rates and Medicaid billing providers must include CHCs.

CHCs' reimbursement rates were created over 20 years ago, based on costs in 1999 and 2000, and are among the oldest cost basis among all New York State Medicaid provider types. CHC rates have been limited to marginal increases over time – often less than 2% annually and are further suppressed by arbitrary rate ceilings. As a result, the CHC reimbursement rates have not kept up with inflation, nor significant changes to the way health care is delivered in a comprehensive, whole patient model. Costs today for personnel, benefits, equipment, medical supplies, and office space are significantly higher than they were decades ago and have risen exponentially since the pandemic. The outdated methodology does not account for the current model of comprehensive primary care including behavioral health services, oral health services, reproductive health services, and addressing social needs like housing and food insecurity.

Because CHCs' reimbursement rates have not kept up with costs, CHCs braid and blend many kinds of funding, including state and federal grants, traditional patient-based reimbursement, philanthropic funding, and 340B. CHCs' insufficient reimbursement rates undermine their ability to engage in long term sustainability and expansion planning.

CHCANYS requests the legislature to direct the Department of Health (DOH) to assess CHCs' costs over the last 5 years and direct DOH to work with CHCs and CHCANYS to create and implement new, updated Medicaid reimbursement rates to be effective October 1, 2024.

C. Provide full reimbursement parity for remote visits, regardless of patient or provider location, for all care delivered via telehealth by CHCs.

The SFY22-23 enacted budget language states that if a facility fee is not incurred during the course of a telehealth visit, no reimbursement for such fees shall be made by Medicaid. The SFY22-23 budget language makes exceptions for Article 31 and 32 licensed providers, which bill a bundled rate and do not bill separate facility fees. Providers delivering care under those licenses can bill Medicaid for the full in-person visit rate, regardless of patient or provider location. CHCs are also reimbursed a bundled rate, via their Prospective Payment System (PPS), and do not bill as separate facility fees, but CHCs that are

licensed as an Article 28 facility are NOT entitled to receive their full in-person visit rate for services delivered when both the patient and provider are offsite. More than one- third of CHCANYS member CHCs are dually licensed, with many health centers obtaining Article 31 and/or 32 licenses through the Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) in addition to their Article 28. There should be no disparity between payment policy among Article 28, 31, or 32 licensed CHCs.

Given the increased need for behavioral health services since the beginning of the pandemic, recruitment for behavioral health providers is extremely competitive. The ability to provide visits remotely has enhanced health centers' ability to attract behavioral health providers, most notably in areas that would otherwise go unserved. Some health centers have hired professionals living in urban areas to serve rural sites via telehealth. Others share providers across organizations to ensure their patients have access to specialty care. If financial incentives do not align with flexible work location, health centers will be forced to cut back on behavioral health.

Telehealth has allowed FQHCs to expand behavioral health departments and increased access for all types of visits. Because telehealth alleviates the demand for physical exam rooms, behavioral health does not compete for space used for physical health care. Full telehealth payment parity is needed regardless of provider and patient location to ensure that CHCs have flexibility to recruit and retain providers and to meet the care needs of patients.

Health centers should receive their full in person rate for all audiovisual and audio only telehealth visits just as they would for in person services, regardless of patient or provider location.

D. Enact policies to expand healthcare workforce and support scope of practice expansions.

1. *Support the Governor's workforce expansion initiatives.*

CHCANYS applauds Governor Hochul's workforce initiatives and sustained investments in workforce career programs. The proposed investments in the Doctors Across New York program, Nurses Across New York Program, and Diversity in Medicine Program will benefit communities served by CHCs.

CHCANYS is supportive of the proposed scope of practice reforms for physician assistants, specifically allowing PAs with more than 8,000 practicing hours to operate in primary care without supervision of a physician. We are also supportive of lifting limits on the number of PAs one physician may supervise. CHCANYS is supportive of expanded scope of practice for physicians, PAs, and NPs related to patient and non-patient specific standing orders and regimens.

CHCANYS is also supportive of the Governor's proposals to join the interstate medical licensure compact and nurse licensure compact, and temporary permits to allow out of state licensed providers to practice in NY. CHCs have long experienced hurdles to employment for out-of-state providers, leaving an untapped workforce that could ameliorate workforce shortages. Many CHCs have also highlighted that the same challenges exist for dental and behavioral health workforce who move to New York from other states. While there are no existing interstate licensure compacts for those professions, New York should consider dental and behavioral health providers among the first to be granted temporary permits to practice upon meeting NYS licensure requirements.

2. *Allow certified medical assistants (MAs) to perform select clinical and administrative tasks -- including vaccinations -- pursuant to their education and training.*

In 49 other states, certified MAs are recognized and permitted to perform tasks such as providing injections and administering vaccines under the supervision of physicians, nurse practitioners, or physician assistants. Certification as an MA is often the initial exposure to the rewards of a career in healthcare and the first rung on a career ladder which can result in advancement in the medical field to other certifications or licensures.

There is no statutory recognition of MAs in New York. Existing New York State Education Department (NYSED) guidance[2] restricts unlicensed persons, including MAs, to low-level tasks, such as measuring vital signs, conducting administrative duties, and assisting with collection of laboratory specimens.

Certified MAs should be lawfully recognized in NYS so that they can be deployed in healthcare delivery and relieve the workforce shortage pressures being faced by many providers. CHCANYS recommends the adoption of legislation that recognizes MA certification and allows for the performance of specified tasks for which MAs are trained and certified, including providing immunizations.

E. Support Essential Plan expansions for <u>all</u> New Yorkers, including undocumented immigrants.

CHCANYS is supportive of the Governor's proposed changes to the Essential Plan expanding eligibility to individuals with incomes up to 250% of the Federal Poverty Level and to extend coverage for all persons one year postpartum, regardless of income. However, we ask the Legislature to include **<u>all</u>** New Yorkers with incomes up to 250% of the Federal Poverty Level in this initiative, ensuring low-income undocumented New Yorkers have coverage options as they do in Washington, Colorado, and California.

The Governor's budget directs DOH to contract with an independent actuary to study and recommend reimbursement methodologies for increasing rates in the Essential Plan. CHCANYS is supportive of these efforts and encourages the State to include CHCs in this initiative. Currently, community health centers receive an all-inclusive, bundled rate for all Medicaid beneficiaries, but only for "lawfully present" immigrants under the Essential Plan. CHCANYS encourages the State to reimburse health centers at the community health center bundled rate (PPS) for all Essential Plan enrollees.

F. Support infrastructure investments and protect dollars for community based providers.

The continuation of the state's capital infrastructure investments are crucial resources for CHCs to open new and renovate existing sites. CHCANYS is supportive of the Governor's proposal to allocate $1B in a fifth round of Statewide Health Care Facility Transformation grants. We ask the legislature to ensure that 25% of those funds are reserved for community-based providers.

[2] http://www.op.nysed.gov/prof/med/medmedicalassistants.htm

G. Continue funding key health initiatives.

1. *Patient Centered Medical Homes and Health Homes*

The patient centered medical home (PCMH) model of primary 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 coordinating patient-centered care delivery, promoting population health, and using health information technology to deliver evidence-based care.

PCMH funding helps CHCs provide high quality comprehensive primary care services and prepare to engage in value-based payment arrangements and care models. CHCANYS thanks the Legislature for protecting PCMH funding in the past and requests continued support for full PCMH program funding. We are supportive of the Governor's addition of $12M to the annual PCMH appropriation.

New York's Health Home program enhances care coordination for eligible populations. Health Home enrollees have two or more chronic conditions, live with HIV/AIDS, or experience serious mental illness. Once enrolled in the Health Home program, individuals are provided with intense care management to avoid hospitalizations and manage their conditions to prevent healthcare emergencies. The Governor's budget administratively reduces appropriations to Health Homes by almost $100M. CHCANYS requests a restoration of these funds.

2. *Diagnostic & Treatment Center (D&TC) Safety Net Pool*

The Governor and Legislature have historically supported funding for the D&TC 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. While New York has dramatically reduced statewide uninsured rates, at some CHCs, more than half of the patients are uninsured. Funding provided through the Safety Net Pool provides vital assistance to CHCs, offsetting costs of caring for the uninsured. Safety Net Pool funding promotes access to primary care, reducing unnecessary hospitalizations and improving health outcomes for all New Yorkers, not just those who have health insurance coverage. CHCANYS supports the Governor's proposal to keep the Safety Net Pool at current funding levels.

3. *Health Care for Migrant & Seasonal Farm Workers*

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

4. *School Based Health Centers (SBHCs)*

New York's 260+ 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, or otherwise don't have access to care, the SBHC is a critical point of care. CHCANYS supports the Governor's proposal and urges the Legislature to maintain current SBHC grant levels.

5. *Rural Health Access Networks & Area Health Education Centers (AHECs)*

Both the Rural Health Access Network funding and AHEC funding are important resources for rural communities. Rural Health Access Networks are critical coordinators of local health planning and work closely with AHECs to address healthcare workforce needs through partnerships with institutions that train health professionals. CHCANYS supports full funding for both the Rural Health Access Networks and AHECs to ensure rural communities are supported in health planning, including combating COVID-19 and enhancing workforce development opportunities.

Conclusion

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

- ✓ Enhance:
  - Medicaid & Essential Plan reimbursement rates for CHCs
  - Telehealth payment parity
- ✓ Reject:
  - The pharmacy benefit carveout
- ✓ Support:
  - Workforce expansion
  - Coverage expansion
  - Funding for:
    - Statewide Capital Transformation Grants, with community-based set aside
    - Patient Centered Medical Homes
    - D&TC Safety Net Pool
    - Migrant & Seasonal Farmworkers Program
    - School-Based Health Centers
    - Rural Health Access Networks
    - Area Health Education Centers
- ✓ Restore:
  - Essential Plan coverage for undocumented immigrants
  - Health Homes funding

With questions or follow up, please contact Marie Mongeon, Senior Director of Policy: mmongeon@chcanys.org.