HARLEM UNITED

Testimony of Jacquelyn Kilmer, Chief Executive Officer

2024 Joint Legislative Public Budget Hearing on Health

January 23, 2024

Thank you for the opportunity to provide written testimony on the FY2025 Executive Budget on behalf of Harlem United. For over 35 years, Harlem United's mission has remained the same: to advance health equity in Upper Manhattan and the Bronx through healthcare, housing, and harm reduction services. Each year, Harlem United conducts 20,000 medical visits, provides housing for over 800 formerly homeless people, and provides 24,000 meals and pantry boxes to low-income New Yorkers.

We are providing this testimony to address (1) amendments to Section 2781 of the Public Health Law related to HIV testing set forth in Part T, Section 4, of the FY2025 Executive Budget, (2) the proposed cut to Health Home funding in the amount of $228,356,000 set forth in the FY2025 Executive Budget Aid to Localities Budget Bill, and (3) the need to increase Medicaid rates for community health centers (CHCs).

Amendments to Section 2781 of the Public Health Law (HIV Testing)

Harlem United supports amending Section 2781 of the Public Health Law to facilitate HIV testing as a part of routine healthcare in order to expedite timely diagnosis and linkage to care. The FY2025 Executive Budget, Part T, Section 4, does include amendments to Section 2781, however, those amendments don't go as far as necessary to effect the kind of change that will improve and expand HIV testing in meaningful ways. Harlem United urges the Governor and legislature to take the steps necessary to conform the amendments in Part T, Section 4, to the language in A.8475 (Paulin)/S.7809 (Hoylman-Sigal) or to include A.8475/S.7809 in the Assembly and Senate One-House Budget Bills.

Currently, Section 2781 of the Public Health Law requires that the notice of an HIV test be provided orally. Both Part T, Section 4 of the FY2025 Executive Budget and A.8475/S.7089 would amend Section 2781 to provide that the required notice that an HIV- related test will be performed shall be made by means readily accessible in multiple languages, and to expand such means of providing notice to include verbal,

written, the use of prominently displayed signage, by electronic means, or by other appropriate form of communication. In addition, both the Executive Budget and A.8475/S.7089 provide that such notice must specify that HIV testing is voluntary, and that a refusal of the test shall be noted in the individual's record. These changes will bring New York law in line with CDC guidance which, since 2006, has provided that the notice of an HIV test could be made orally or in writing.

Where Part T, Section 4 of the Executive Budget and A.8475/S.7089 differ, however, is that A.8475/S.7089 authorizes the required pre-test information (including information regarding HIV infection, transmission, treatment, and laws protecting confidentiality and prohibiting discrimination based on HIV status) to be given in the same manner as the notice of the test—verbally, in writing, through the use of prominently displayed signage, by electronic means, or by other appropriate form of communication. This change brings the law in line with the 2018 guidance of the New York State Department of Health AIDS Institute to enable health care facilities to better operationalize and increase HIV testing.

The reason that it is critical for Section 2781 to be clear that both the notice of the HIV-test AND the pre-test information may be provided by appropriate means other than only verbally is a practical one. Many of the patients most vulnerable to HIV infection use emergency care settings as their sole point of contact with the healthcare system. In busy emergency care settings, time is short and being able to provide the necessary information in writing or by signage or other appropriate means will remove a remaining barrier to increased testing and early diagnosis. In addition, with all of the advancements in care and treatment of HIV infection over the years, there is no longer a reason treat an HIV test any differently than any other test performed on blood draws as part of routine health care.

Rates of concurrent diagnoses (an AIDS diagnosis either simultaneously with an HIV diagnosis or within 30 days of an HIV diagnosis) remain unacceptably high, comprising 18% of all new diagnoses in 2022 (18% in NYC; 23% in the rest of the State). Over half of the persons newly diagnosed with HIV across the State are over 50, and over one-third of those receive a concurrent diagnosis. Each missed testing opportunity and concurrent diagnosis is a missed opportunity for early treatment, which can lead to viral load suppression, eliminating the risk of transmission and reducing the severity of complications associated with AIDS (thus reducing costs of future care and treatment). Many, if not most, patients at risk for HIV infection are unaware of specific HIV testing requirements and assume that when their blood is drawn for lab work, they are being tested for HIV along with the myriad other tests that are part of routine blood work. When they are not given an HIV diagnosis, they assume they tested negative.

Expanding HIV testing advances health equity. The people least likely to be tested are those who are most at risk of infection—youth 13-29, men who have sex with men, transgender women and communities of color, especially African American and the Hispanic/Latinx populations. Additionally, people over 50 are often the subject of bias and a healthcare provider's perception that they are not sexually active and therefore not at risk for infection and not in need of an HIV test.

Incremental changes to Section 2781 of the Public Health Law have been made over the years as the epidemic and treatment options have changed and best practices have evolved. These changes have helped to increase HIV testing. However, the additional changes in A.8475/S.7809 will remove barriers to routine HIV testing while maintaining the voluntary nature of HIV testing and ensuring that every person who is the subject of an HIV test receives critical information regarding HIV treatment, prevention, and individual rights.

All steps that we can take to increase HIV testing and make it part of routine health care are necessary to end the HIV/AIDS epidemic in New York. Harlem United urges the Governor and legislature to take the steps necessary to conform the amendments in Part T, Section 4, to the language in A.8475 (Paulin)/S.7809 (Hoylman-Sigal) or to include A.8475/S.7809 in the Assembly and Senate One-House Budget Bills.

<u>Funding Cut to Health Home Program</u>

The NYS Medicaid Health Home program is designed to coordinate and manage care for individuals with complex medical needs, particularly those with chronic conditions, including HIV and Hep C, substance use disorder, and/or serious mental health issues. Individuals in the Health Home program suffer from complex, challenging conditions and rely on the Health Home program to help coordinate their care and avoid expensive emergency room visits and unnecessary hospitalizations. The Health Home program is a critical component in the State's efforts to achieve health equity, increase access to care, and address the social determinants of health.

Over the past several years, the Health Home program has been subject to substantial budget cuts, resulting in agencies closing or being forced to consolidate, and clients losing access to care. In the FY2024 budget, the Health Home program experienced a $100 million cut over two years, with $30 million cut in FY2024, and another $70 million targeted for cuts in FY2025. In addition to these cuts, in the FY2025 Executive Budget, the Health Home program is facing yet another cut. Funding in last year's budget was approved in the amount of $424,380,000 (which included the $100 million cut over two

years). Based on the appropriation in the Aid to Localities Budget Bill in the FY2025 Executive Budget, funding for the Health Home program is $196,024,000 – a staggering cut of $228,356,000 over last year.

It is important to note that just three years ago, in FY2023, the Health Home program was funded in the amount of $524,010,000. With the cut proposed this year, the Health Home program will experience a cut of $327,986,000 over three years. These cuts will decimate the Health Home program, causing care management agencies to drastically reduce their Health Home care management services or close their programs altogether, resulting in staff layoffs and the elimination of critically necessary services for the most vulnerable, medically frail New Yorkers. If the proposed cuts go through, Harlem United is one of the many agencies that will be faced with the very difficult decision to cut its Health Home program and lay off staff in order to avoid the continuing drain this program has on its overall fiscal viability.

In addition to the substantial funding cuts faced by the Health Home program, this program was excluded from the 4% COLA that many programs funded by OMH, OASAS and OPWDD received in the FY2024 budget. Because Health Home agencies have been struggling with the same reimbursement rates for years, they have been faced with major staffing shortages and higher caseloads, leaving clients unconnected to care. To help resolve this challenge, S.7793 (Persaud and Cleare)/A.8437(Hevesi) would add certain human services programs, including Health Homes, to the designated human services programs eligible for a COLA. This COLA is critically necessary to help support the continued operations of the Health Home agencies.

We urge the legislature to restore the $70 million in funding cut in the FY2024 budget, reject the $228 million in cuts proposed in the FY2025 Executive Budget, and provide Health Home agencies with the same 4% COLA that was afforded other components of the human services sector in FY2023.

<u>Increasing Medicaid Reimbursement Rates for Community Health Centers</u>

Federally Qualified Health Centers (also known as Community Health Centers or CHCs) are the primary care safety net for New York's most underserved populations, serving more than 2.3 million patients in 800+ locations throughout the State. CHCs serve everyone, regardless of insurance, immigration status, or ability to pay. Of the patients served by CHCs, 68% identify as Black, Hispanic/Latinx, Asian American Pacific Islander, Indigenous or other people of color; 62% are enrolled in Medicaid or Child Health Plus, 12% are uninsured and 73% live in poverty.

CHC Medicaid reimbursement rates were last set in 1999. Since that time, not only has the cost of care increased dramatically, but there have been significant, necessary changes to the way health care is delivered which are not reflected in the rates. Current CHC rates cover just 70% of CHCs' costs. Costs for personnel, benefits, equipment, medical supplies, information technology, and space are significantly higher than they were two decades ago. Work force shortages—long a problem for CHCs—have been greatly exacerbated by the pandemic.

Without adequate reimbursement rates, Harlem United, like all other CHCs, is unable to compete with the salaries that big private hospital systems and private practices are able to pay healthcare providers, leaving us short-staffed and challenged to recruit and retain the number of providers that are necessary for us to meet the increasing needs of the communities we serve. Additionally, the outdated reimbursement methodology does not take into account the current model of comprehensive care provided by Harlem United and all other CHCs, including primary care, behavioral health services, dental care, and services addressing the social needs of our patients, such as housing, food and nutrition, and transportation vouchers.

It is critically important to the long-term sustainability of CHCs that Medicaid reimbursement rates be increased. S.6959 (Rivera) /A.7560 (Paulin) would amend Section 2807(8) of the Public Health Law to compel the Department of Health to change its payment methodology, creating new, sustainable Medicaid rates for CHCs, taking into account stakeholder input, updated annual adjustments, increased costs of care, and changes in care models.

These changes are necessary to ensure that every New Yorker continues to have access to high quality, comprehensive and culturally effective healthcare throughout the State and that CHCs are sustainable and able to meet the needs of the communities they serve, now and in the future. By their very nature, CHCs support health equity, meaning that an investment in CHCs is an investment in New York's health equity agenda. For these reasons, Harlem United urges the legislature to take the steps necessary to ensure that Medicaid reimbursement rates are increased.

For any questions or follow up, please feel free to contact me directly at 917-428-0049 or by email at jkilmer@harlemunited.org. Thank you.