NYC Council Committee on Health and Subcommittee on COVID Recovery and Resiliency
Public Hearing: Oversight - COVID-19: Looking Ahead
February 23, 2022

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to provide written testimony to NYC Council Committee on Health and Subcommittee on COVID Recovery and Resiliency. CHCANYS is the statewide primary care association representing New York's 70+ federally qualified health centers (FQHCs), also known as community health centers (CHCs).

Located in medically underserved communities, CHCs provide high quality primary care to everyone, regardless of ability to pay, insurance coverage, or immigration status. NYC's community health centers serve 1.2 million patients at 490 sites in the communities hardest hit by COVID-19. Community health centers are a vital safety net for quality affordable healthcare services for many New Yorkers who otherwise wouldn't have access to healthcare. Among NYC health center patients, 40% are Hispanic, 33% are Black, 17% are White, and 10% are other people of color.

Disparate impact of COVID-19 on communities of color

The COVID-19 pandemic has exposed and exacerbated the longstanding inequities that low-income communities, communities of color, and people with comorbidities have faced for years. Due to the pervasive structural inequities that CHC patients regularly encounter, they are at the highest risk for severe negative health consequences resulting, not only from COVID-19, but also from a lack of access to health care and social support services generally. For New Yorkers who otherwise wouldn't have access to healthcare services due to being uninsured or underinsured, their immigration status, or lack the ability to pay, community health centers provide life-saving quality healthcare services.

CHCs are trusted by their communities, making them a high value source of care in communities who have a long history and good reason to distrust traditional healthcare systems. Communities trust health centers because they are community-run, with over 50% of Board members comprised of patients of the health center. Moreover, CHCs hire staff from the very communities they serve. The providers, nonclinical staff, and patients patronize the same grocery stores, have children who attend the same school, and ride the same transit lines. The trust between CHCs and the communities they serve has enabled CHCs to address health issues as they arise in the community. Beyond providing healthcare services, many CHCs also act as a center for connecting patients to services to address social needs, understanding that addressing social determinants health is key to improving health and reducing health disparities. However, it is clear that more work needs to be done to advance health equity and ensure that all New Yorkers are connected to high quality comprehensive care.

Lessons learned and support needed in future pandemics

Throughout the pandemic and into today, CHCs have conducted thousands of COVID-19 tests, provided patients and community members with COVID-19 vaccination and treatment, and continue to serve patients by the modalities that best suit their needs. Throughout the pandemic, CHCs partnered with New York City to stand-up high-volume testing and vaccination sites. Some CHCs set up sites at temporary locations within their communities and others did so in their own parking lots.

However, at the height of the pandemic, CHCs' ability to provide access to in person care was limited by the major supply shortages of personal protective equipment (PPE). This exacerbated existing access problems for health center patients - the challenge to source and purchase adequate PPE to conduct in-person services and maintain a stockpile in the event of another surge hindered CHCs' ability to plan for delivery of healthcare services (i.e., in the case of dental services, PPE must be changed between each patient). Inadequate access to PPE also prohibited some health centers from expanding community testing. When considering future emergency response at the city level, it is imperative that CHCs be designated as high priority sites for receipt of PPE.

Looking ahead, challenges persist

A. Workforce shortages are at unprecedented levels

Community health centers re-invest in the communities they serve by hiring individuals who live in the communities they serve. However, CHCs are facing difficulty in maintaining delivery of services due to the COVID-19 pandemic exacerbating existing health care provider shortages. In the summer of 2021, CHCANYS surveyed CHCs on top workforce-related challenges and priorities and CHCs reported immediate staffing needs across occupations including Licensed Clinical Social Workers/Licensed Professional Counselors, Psychiatrists, Nurses, Family Physicians/Internal Medicine, Nurse Practitioners/Physician Assistants, Dental Providers, and Case Managers. CHCs also reported insufficient educational pipelines, uncompetitive wages, and high clinical/case load requirements as some of the reasons for recruitment and retention challenges. Many CHCs are concerned that staffing shortages may cause them to postpone or delay patient care.

To ensure that CHCs can continue to provide quality accessible healthcare services for the underserved communities, there needs to be significant investment in healthcare workforce. Investments could include funding for existing workforce programs, developing new loan repayment programs for nursing and behavioral health staff, especially in communities of color, expanding loan repayment programs for individuals living in medically underserved communities, and increasing workforce development opportunities in medically underserved communities and communities of color.

B. Telehealth must be supported to encourage access to care

Telehealth (audio visual and telephonic) has proven to be crucial to ensuring patients and providers could safely connect amidst an unprecedented health crisis. When NYS issued the stay-at-home order, CHCs quickly pivoted to telehealth to ensure that patients could continue to receive healthcare services. Telehealth enabled CHCs to take care of many patients with coronavirus from home, keeping fewer sick patients out of the overwhelmed hospitals and reducing community spread of the virus. The greatest contribution of telehealth, especially telephonic, is how it has expanded access to healthcare services by decreasing barriers that would usually inhibit the ability to visit a provider, like lack of transportation, childcare issues, or time off from work. According to a recent survey by CHCANYS, CHCs are seeing fewer no shows for remote visits, especially for behavioral health visits, and CHCs predict that about 37% of patients will request remote visits over the next year. Today, about 25% of CHC visits occur via telehealth. For providers, the ability to deliver care through telehealth modalities was a much-welcomed flexibility. CHCs continually report that the ability to offer remote working options to their providers has

increased their ability to recruit new providers who, without that option, would not be interested in working for the CHC.

Currently, and through the duration of the Federal Public Health Emergency (PHE), CHCs are reimbursed for audio-visual telehealth visits on par with face-to-face visits, but at a lower rate for services delivered via the telephone. Telehealth payment parity beyond the pandemic, regardless of modality and regardless of patient and provider location, is needed to ensure that CHCs can continue to provide telehealth services and to recruit new providers.

C. The State's pharmacy benefit carveout proposal will hurt CHCs and their patients

The Federal Public Health Service Act 340B drug discount program was enacted in 1992 by Congress to allow safety net providers, including CHCs, access to pharmaceutical drugs at reduced costs and to reinvest the savings to expand access to health care in medically underserved communities. Community health centers rely on the savings generated through the 340B program to fund life-saving programs and initiatives that have no other funding sources. Many CHCs used 340B savings to conduct vaccine related outreach and patient education, provide, 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. Many of the beneficiaries of the 340B program have multiple chronic conditions and other risk factors – those most likely to visit a hospital emergency department or suffer serious complications from COVID-19. However, the 340B program is currently under threat due to the State's proposal to carve the Medicaid pharmacy benefit out of managed care and into fee-for-service, which would result in an annual $61M lost across NYC-based health centers. The pharmacy benefit carveout will not only cause unprecedented disruptions for the safety net community but will also threaten the comprehensive public health response to the COVID-19 pandemic.

In 2021, the NYC Council adopted Res. 1529, calling on the New York State Legislature to pass, and the Governor to sign, S.2520/A.10960, legislation to protect New York State's safety net providers and Special Needs Health Plans by eliminating the Medicaid pharmacy carve-out. Again, we look to the NYC Council to protect community health centers by calling on the State to repeal the pharmacy benefit carve out.

Conclusion

CHCANYS is thankful for the opportunity to submit this testimony to highlight the impacts of COVID-19 on community health centers and the challenges that CHCs continue to face. CHCANYS is hopeful that this is the first of several discussions to mitigate health disparities exacerbated by COVID-19 and advance health equity for all New Yorkers. For questions or follow up, please contact Marie Mongeon, Senior Director of Policy, mmongeon@chcanys.org.