New York City Council

Oversight - Health Access in New York City

and

The Roll Out of NYC Care

Committee on Health
&
Committee on Hospitals

October 31, 2019

Good Morning Speaker Johnson, Chairperson Levine, Chairperson Rivera, and members of the Committee on Health and the Committee on Hospitals. I am Dr. Mitchell Katz, President and CEO of NYC Health + Hospitals (Health + Hospitals), and I am joined by Marielle Kress, the Executive Director of NYC Care. Thank you for the opportunity to update you on the implementation of NYC Care – a key component of the City's commitment of guaranteed health care for all, which would not be possible without the efforts from the last two years to make systemic changes in the public hospital system by modernizing our operation, and stabilizing our finances.

Before providing an update on the successes of NYC Care since its launch in the Bronx on August 1, I'd like to begin my testimony by saying no one should go without the health care they need in New York City. Health care is a human right, and in this City we're going to make that a reality. According to the Census, it is estimated that almost 600,000 of New York City residents remain uninsured and half of them are ineligible for health insurance, and as such lack the access needed to maintain and improve their health. This is why I strongly support a single payer health system at the federal or state level, or in the meantime expanding eligibility for the Essential Plan at the state level, which would provide coverage to more uninsured New Yorkers. As the chief executive of Health + Hospitals – the largest public health care system in the nation that serves over one million patients each year, of which 375,000 are uninsured – and a primary care doctor, I believe implementing a single payer system would support our mission to provide high quality health care services to all New Yorkers regardless of their immigration status or ability to pay.

While the single payer debate continues, New York City will do its part and provide access to health care for the hundreds of thousands of people who need it. In January, I was proud to join the Mayor in his announcement of the launch of the largest, most comprehensive initiative in the nation to guarantee health care for every New Yorker. No one should live in fear of getting sick, and not having a trusted health care provider they can turn to because they are poor, or they are an immigrant. There are two components of NYC's Guaranteed Care commitment. The first component is to enroll everyone who is eligible for insurance because it's always better to have coverage. A great option is the City's public health insurance option – Health + Hospital's health plan MetroPlus, which is the plan of choice for over half a million New Yorkers and has a five-star rating based on the State's 2018 Consumer's Guide to Medicaid and Child Health Plus Managed Care Plans in New York City. The second is to enroll those who do not qualify for or cannot afford health insurance into NYC Care, which will be available across the five boroughs by the end of 2020.

NYC Care builds on two prior initiatives I previously spearheaded – Healthy San Francisco and My Health LA. The difference here is NYC Care provides more expansive services to all New Yorkers who cannot afford coverage or are ineligible. While it is not insurance, NYC Care provides access to comprehensive primary care and specialty services at Health + Hospitals facilities, including at our Gotham Health Federally-Qualified Health Center (FQHC) network – the largest FQHC in NYC and the country – on a sliding fee scale based on the patient's income and household size. There are no membership fees or monthly fees. Distinctly, NYC Care provides members with a guaranteed first appointment with their regular primary care provider within two weeks of enrollment. NYC Care has a 24/7 member services hotline to assist patients in navigating our system, as well as 24/7 access to affordable prescription drugs, including extended pharmacy hours in the

evenings and on Saturday or Sunday. NYC Care issues a membership card that lists the member's primary care provider name and fees.

On August 1, Health + Hospitals launched NYC Care in the Bronx. In the first three months alone, we have enrolled 7,500 New Yorkers who hail from every zip code in the Bronx and are well on track to reach the Bronx enrollment goal of 10,000 patients in the first six months. In January, we will launch the program in Brooklyn and Staten Island, and NYC Care will be in every borough by the end of 2020.

I am very pleased to share with you that in the Bronx, in the first two months, 100 percent of NYC Care members continue to be offered a first appointment within two weeks with a primary care provider, and in the first two months of the program, there were over 3,000 low-cost prescriptions filled during the new extended pharmacy hours – life-saving prescriptions that patients did not have timely access to before the program launched. To prepare for the program launch, the seven Health + Hospitals facilities in the Bronx hired new providers, and added new clinics with evening and weekend hours to accommodate patients. There are now more than 70 primary care providers in the Bronx who coordinate the care of NYC Care members, including referrals for specialty care, diagnostic testing, and management of chronic diseases.

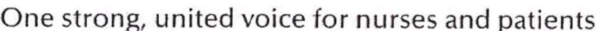
Stakeholder Engagement Strategy: The launch of NYC Care is a huge accomplishment, and a lot of the success is due to Health + Hospitals' collaborative spirit and strategy to engage stakeholders and partners. We collaborated with the Mayor's Office of Immigrant Affairs and the Mayor's Fund to Advance New York City to engage key constituencies and thought leaders to reach potentially eligible New Yorkers. The health system has contracted with five community based organizations in the Bronx to hire 15 full-time staff members – BronxWorks,

Emerald Isle Immigration Center, Northwest Bronx Community and Clergy Coalition, Mekong NYC, and Sauti Yetu Center for African Women. The staff at these organizations speak 10 different languages, and they identify, recruit, and refer uninsured New Yorkers in the Bronx for insurance screening and enrollment in NYC Care in a culturally appropriate and sensitive manner. In preparation for the launch of NYC Care in Brooklyn and Staten Island in January, we have already announced an RFP opportunity for community based organizations for NYC Care outreach in those boroughs. Responses to the Brooklyn and Staten Island RFP must be submitted by Friday, November 8. Health + Hospitals is also leveraging GetCoveredNYC's existing outreach to uninsured New Yorkers in the Bronx to refer eligible people to NYC Care for enrollment. We are also working with MetroPlus – its network of locations provide another access point for potentially eligible NYC Care members. New Yorkers who apply for insurance and are found ineligible or are unable to afford any options are directed to NYC Care.

Public Awareness Campaign: We launched a multilingual and multiplatform public awareness campaign to promote NYC Care launch in the Bronx. The campaign includes paid advertisement and special partnerships in 20 ethnic and community outlets. The ads in all campaign platforms were issued in Spanish in addition to English to target high percentage of Spanish speaking New Yorkers in the Bronx potentially eligible for NYC Care. All the campaign ads and collateral are available in 14 languages on our website and are being distributed to ethnic communities borough wide by our internal and external stakeholders. As the program rolls out in other boroughs by the end of 2020, we plan to replicate this and additional approaches to ensure we continue to work with ethnic and community media to reach key communities in every borough.

Collaboration with non - Health + Hospitals FQHCs: Health + Hospitals has been meeting and working very closely with non-Health + Hospitals FQHCs. We met with other FQHCs themselves – CEOs and senior leaders from FQHCs across the Bronx to ensure the patients of non-Health + Hospitals FQHCs are redirected back to their primary care providers if they call the NYC Care contact center, but may enroll in NYC Care for specialty services. The non-Health + Hospitals FQHCs developed a call center process and scripting for Health + Hospitals to ensure that their patients were redirected back to them. We have since met with them again to ensure the process is working. Additionally, primary care providers external to the Health + Hospitals system are listed as 'community provider' on NYC Care members' cards. We have modernized our external referrals process so that external providers can refer their patients to specialty care services at Health + Hospitals through EPIC Care Link, which is web visible and available to any outside provider.

While more work needs to be done, I am proud of the progress we've made thus far in rolling out NYC Care. Thank you for the opportunity to testify before you today and I look forward to taking your questions.



New York City Council – October 31, 2019

Health Committee and Hospital Committee Joint Hearing

Health Access in New York City, and the Roll Out of NYC Care

Position Statement by the New York State Nurses Association

Falling Medicaid enrollment and NYC Care

NYC Care is an especially important project for the City's 300,000 uninsured immigrant residents. It needs to reach as many of them as possible. Enrollment barriers that make this harder to do should be removed.

132,000 fewer New Yorkers are enrolled in Medicaid than were on the day Donald Trump took office. [See graph below] Explanations for the decline in enrollment include the following: fewer are eligible because the $15/hour wage pushed people out of poverty status, there are fewer poor people living in NYC or, the most likely, many eligible people are reluctant to enroll because of the Trump administration's proposed changes to the definition of 'public charge.' Under the new Trump administration rule, someone deemed a public charge is likely to be denied permanent resident immigration status. The steep drop in Medicaid enrollment began in March 2018, when the intent to draft new "public charge" regulations became known.

It is likely fear of being labeled a "public charge" that is causing many eligible immigrants to abandon Medicaid. A very recent study conducted by the Kaiser Family Foundation found this to be a problem across the country. In a brief published on October 15, 2019 Kaiser reported that half of US health centers noted that immigrant patients refused to enroll themselves in Medicaid, adding that a third said that some patients dropped coverage.[1] A month earlier, Kaiser analysts argued that "Beyond potential disenrollment, the rule may also deter new enrollment among some of the nearly 1.8 million uninsured individuals who are eligible for Medicaid and CHIP but not enrolled and are noncitizens themselves or live in a household with a noncitizen."

NYC Care should not care about immigration status, only need. Anything that implies otherwise will discourage enrollment. As suggested on the NYC Care website (https://www.nyccare.nyc/), applicants are subject to a financial aid interview and the production of documents. Why is that a problem? Because of the implied connection between participating in the interview and receiving care. That link needs to be broken.

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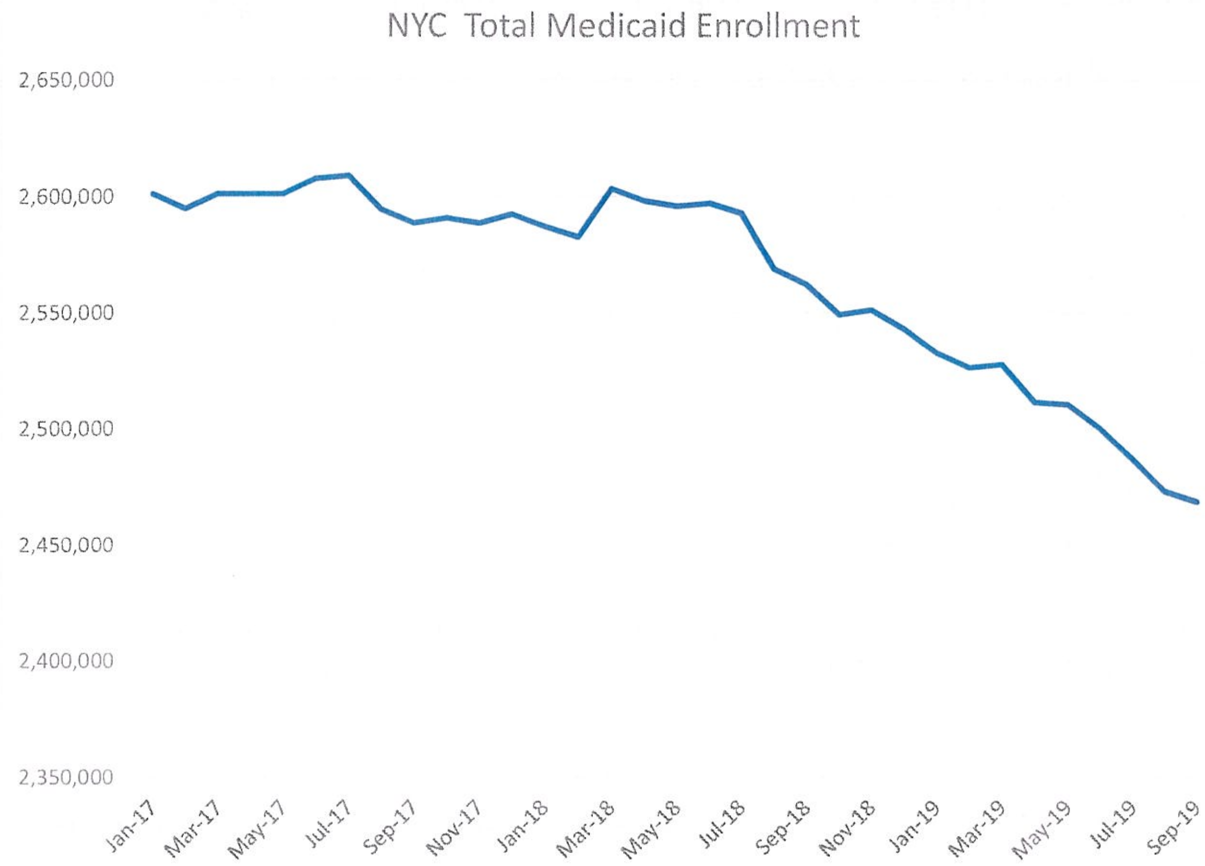
[1] https://www.kff.org/medicaid/press-release/many-community-health-centers-report-that-immigrant-patients-are-declining-to-enroll-in-medicaid-or-renew-their-coverage-amid-concerns-about-changes-to-public-charge-rules/

Instead of documents and eligibility interviews, NYC Care enrollment should require a declaration of eligibility and need. "I have lived in NYC for more than 6 months." "I am uninsured." Will some ineligible people enroll? So, what? Few will choose a limited, sliding scale health benefit over Medicaid or affordable health insurance. If a simplified enrollment encourages more people to receive needed care, they and our entire community will benefit at a nominal cost. [2]

We strongly urge the Council to address the problem of declining Medicaid enrollment and the successful implementation of NYC Care by making it easy for the uninsured to access NYC Care.



Source: Medicaid Managed Care Enrollment Reports by County
https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

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[2] The NYC H+H requires uninsured patients meet with an insurance eligibility specialist. So far, these interviews have produced very little. H+H's Transformation Plan had claimed that half of the uninsured were eligible for coverage. But according to Arnie Saperstein, retiring CEO of MetroPlus, only 13% were found eligible. The others were either working class undocumented (not poor enough to qualify for emergency Medicaid) or not entitled to Medicaid, an ACA-subsidy plan, or employer-based coverage.

Testimony by LegalHealth a division of the New York Legal Assistance Group on Proposed Resolution No. 918-A - An act to amend the Social Services law, in relation to coverage for healthcare services under the basic health program for individuals whose immigration status renders him or her ineligible for federal financial participation

October 31, 2019

Chairpersons Rivera and Levine, Council Members and staff, good morning and thank you for the opportunity to share our support for Resolution 918-A. My name is Domna Antoniadis, and I am a Senior Staff Attorney in the LegalHealth Division of the New York Legal Assistance Group (NYLAG,) a nonprofit law office dedicated to providing free civil legal services to low income New Yorkers. NYLAG serves immigrants, seniors, veterans, the home bound, families facing foreclosure, renters facing eviction, low- income consumers, those in need of government assistance, children in need of special education, domestic violence victims, people with disabilities, patients with chronic illness or disease, low-wage workers , low income members of the LGBTQ community, Holocaust survivors, as well as others in need of free legal services.

LegalHealth is the nation's largest medical legal partnership, providing general legal assistance in the healthcare setting to patients of hospital and community health centers. We complement healthcare with legal care to address the non-medical needs of individuals with serious health conditions. LegalHealth has legal clinics at 36 health facilities and our staff has

LegalHealth, I staff the legal clinic at the Bellevue Cancer Center. Over the past 5 years, I have witnessed firsthand how one's immigration status is a social determinant of health

NYC is home to over 3.1 million immigrants and over 500,000 are undocumented[1]. These individuals are integral members of our community and help make New York the diverse city we are so proud of. But these members of our community are denied a basic need, the ability to access comprehensive health insurance. Adult undocumented immigrants are barred from purchasing most insurance or qualifying for public insurance. In 2011, 71% of undocumented immigrants were uninsured; the remainder were primarily insured through employment.[2]

Leaving such a large population uninsured has profound implications on safety net hospitals and the local government and private sources that fund these institutions. This plays out in a lack of access to preventative care, mental health services and lifesaving treatments such as transplants or clinical trials. In the case of the latter, a premature death can mean economic instability for a family who relied on the decedent to support them and shifting the burden to the larger community. My testimony will focus on undocumented immigrant access to such lifesaving treatment.

Physicians at acute care facilities routinely refer undocumented immigrants to our legal clinics because in many situations, without insurance, the medical team cannot treat the patient following normal standards of care. In essence, healthcare providers must shift the burden of care to a legal service provider for solutions to the treatment dilemma. This is particularly

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[1]State of Our Immigrant City, March 2018. Available at: https://www1.nyc.gov/assets/immigrants/downloads/pdf/moia_annual_report_2018_final.pdf

[2] As of 2015, 72% of the undocumented immigrant population was between age 18 to 44; just 17% of unauthorized immigrants were age 45 to 64. Only 1% of these immigrants were age 65 or older, versus 13% of the total U.S. population. In: Capps R, Fix M, Van Hook J, et al. A Demographic, Socioeconomic, and Health Coverage Profile of Unauthorized Immigrants in the United States. Migration Policy Institute; May 2013.

problematic because the time necessary to appropriately address complex immigration and insurance legal issues is substantially longer than most patients have.

These occurrences are not new or unique. In the past 5 years alone, I have worked with over 200 patients whose providers could not provide medically appropriate lifesaving or life improving treatment without my legal involvement . In this same time period, LegalHealth has worked with over 1,750 patients in a similar position. Let me describe several clients to illustrate this further.

One client, a 34-year-old named Luis , had lived in the United States for nearly 20 years and was the proud father of 4 young children. He was diagnosed with acute leukemia - an aggressive cancer but was an ideal candidate for a donor-based stem cell transplant and possible clinical trial enrollment. However, because he was uninsured and undocumented his treatment was irregular until he was finally referred to Bellevue, where I met him. We ultimately, successfully applied for a rare humanitarian request to the Department of Homeland Security called deferred action. It took many months of intense legal advocacy before Luis was able to be referred to a transplant hospital. But it was too late. He was quickly relapsing and died without ever getting the transplant. His wife , who never used food stamps or public assistance for their children, was forced to apply for every type of benefit available just so they could survive.

Cases like this have a profound impact on healthcare providers. A recent study published in the Annals of Internal Medicine found, "that providing undocumented patients with suboptimal care because of their immigration status contributes to professional burnout and moral distress." [3] In this study, the researchers identified that many providers intentionally

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[3] Cervantes L, Richardson S, Raghavan R, et al. Clinicians' Perspectives on Providing Emergency-Only Hemodialysis to Undocumented Immigrants: A Qualitative Study. Ann Intern Med. 2018;169:78–86. [Epub ahead of print 22 May 2018]. doi: 10.7326/M18-0400

remain detached from patients or were so distressed that they transitioned to other health settings.

Indeed, many of the oncology fellows I work with have specifically referenced their experience with undocumented immigrant patients as one of the reasons why they are leaving the public hospital system. As one fellow told me, " I love that at Bellevue I can truly practice medicine but what's the point if I can't even treat some of my patients." While Bellevue may be the largest safety net hospital in NYC, we have seen similar frustrations and feelings of helplessness across all medical disciplines in both public and private hospitals.

Ultimately, a transplant for Luis , and those like him, would have been far more cost effective than continuing with chemotherapy and end of life (EOL) care. Cost benefit studies comparing ,for example, stem cell transplants versus chemotherapy for certain cancers[4], or kidney transplants vs dialysis[5] consistently show major direct medical savings as well as adjusted life years.

While EOL care is costly, it is especially so for cancer patients. According to a study published in the Journal of Oncology Practice, in the last six months before death, oncology inpatient costs increase and are at their peak. Patients with leukemia like Luis "had the highest mean total EOL cancer-related costs" at a staggering $197,676. [6]

[4] Preussler, Jaime M et al. "Costs and cost-effectiveness of hematopoietic cell transplantation." Biology of blood and marrow transplantation : journal of the American Society for Blood and Marrow Transplantation vol. 18,11 (2012): 1620-8. doi:10.1016/j.bbmt.2012.04.001

[5] Laupacis, Andreas, Paul Keown, Nancy Pus, Hans Krueger, Beryl Ferguson, Cindy Wong, and Norman Muirhead. "A study of the quality of life and cost-utility of renal transplantation." Kidney international 50, no. 1 (1996): 235-242.

[6] Chastek, Benjamin, Carolyn Harley, Joel Kallich, Lee Newcomer, Carly J. Paoli, and April H. Teitelbaum. "Health Care Costs for Patients With Cancer at the End of Life." Journal of Oncology Practice. Web. 22 Mar. 2017. This is true whether the patient opts for hospice or not. When the patient does not opt to be in hospice, those costs are incurred in the form of visits to the emergency room and time spent in the intensive care unit. Furthermore, the patient then usually dies in the hospital.

Many of our clients unfortunately die, not necessarily because of initial poor prognosis, but because we could not navigate the bureaucratic immigration and health financing systems in time. Not only are these patients, their families and their providers directly harmed by these premature and expensive deaths but the inability for undocumented immigrants to participate in most clinical trials directly impacts health innovation and quality care for the rest of the population.

Clinical trials are essential for evaluating new treatment modalities, establishing new standards of care and, ultimately, improving and prolonging the lives of patients with serious illnesses. Nevertheless, rare disease clinical trials consistently have low rates of participation, especially when regarding patients from particular ethnic or racial, geographic, age, and other underserved demographic subgroups. The issue of clinical trial enrollment is viewed as foundational, lying at the heart of the clinical trial endeavor[7]. One-third of publicly funded trials require a time extension because they fail to meet initial recruitment goals[8]. Per a report from the Institute of Medicine, 40% of National Cancer Institute sponsored oncology trials failed to achieve minimum patient enrollment. [9]

A 2014, a research study on the Examination of Clinical Trial Costs and Barriers for Drug Development conducted on behalf of the Department of Health and Human Services cited difficulties in recruitment and patient diversity as major obstacles to conducting clinical trials in the United States ."[10] According to the American Society for Clinical Oncology, a clinical trial

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[7] Murthy, V. H., Krumholz, H. M., & Gross, C. P. (2004). Participation in cancer clinical trials race-, sex-, and age-based disparities. Jama, 291(22), 2720-2726.
[8] Campbell M.K., Snowdon C., Francis D., Elbourne D., McDonald A.M., Knight R., Grant A. Recruitment torandomised trials: strategies for trial enrollment and participation study: the STEPS study. Health Technol. Assess. 2007;11:105. iii-ix.
[9] Institute of Medicine . National Academic Press; Washington D.C: 2010. Committee on Cancer Clinical Trials.
[10] Examination of Clinical Trial Costs and Barriers for Drug Development . Available at: https://aspe.hhs.gov/report/examination-clinical-trial-costs-and-barriers-drug-development

system that enrolls patients at a higher rate produces treatment advances at a faster rate, and concurrent survival increases and mortality reductions in the cancer population.

In some of the cases where LegalHealth was able to help patients access insurance, the patients were able to participate in clinical studies which dramatically altered their lives as well as contributed to medical research. For example, Miguel, a 38-year-old with stage 4 melanoma, had an existing immigration history that we discovered deemed him eligible for public health insurance. Through our Medicaid advocacy efforts, Miguel was able to take part in one of the first immunotherapy clinical trials which led to a breakthrough in using immunotherapy to treat certain cancers. Miguel is now in remission and working to support his family. For others, like Vivian, we identified an immigration remedy which could be filed which also led to insurance eligibility. She is one of the only minority patients participating in a highly anticipated National Institute of Health trial comparing different forms of stem cell transplants for those who cannot find donor matches. Miguel and Vivian are the exceptions. They were able to participate in the clinical trials because they were fortunate enough to have a team of doctors and lawyers working together for months. Many patients do not have that luxury or the time to wait.

This proposed resolution will help minimize the health inequalities faced by our immigrant population. As I've highlighted in my testimony, adequate insurance access will improve the lives of undocumented immigrants , their family and the community at large.

New York Lawyers For The Public Interest, Inc.
151 West 30th Street, 11th Floor
New York, NY 10001-4017
Tel 212-244-4664 Fax 212-244-4570
TTY 212-244-3692 www.nylpi.org

October 31st, 2019

Testimony of Health Justice Community Organizer Mia Soto

On Behalf of New York Lawyers for the Public Interest

Before the New York City Council's Committee on Health

Good afternoon, my name is Mia Soto and I am the Community Organizer at the Health Justice Program at the New York Lawyers for the Public Interest. Thank you to Chairperson Levine and Committee members for giving the opportunity to present testimony today.

I. New York Lawyers for the Public Interest

For the past 40 years, New York Lawyers for the Public Interest (NYLPI) has been a leading civil rights and legal services advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model, we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual legal services, impact litigation, and comprehensive organizing and policy campaigns. Guided by the priorities of our communities, we strive to create equal access to health care, achieve equality of opportunity and self-determination for people with disabilities, ensure immigrant opportunity, strengthen local nonprofits, and secure environmental justice for low-income communities of color.

NYLPI's Health Justice Program brings a racial justice and immigrant rights focus to health care advocacy in New York City and State. In partnership with community-based organizations and coalitions, we work to advance four broad goals: (1) challenge health disparities; (2) eliminate racial and ethnic

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New York, NY 10001-4017
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discrimination and systemic and institutional barriers that limit universal access to health care; (3) promote immigrant and language access to health care; and (4) address the social determinants of health so that all New Yorkers can live a healthy life.

II. We urge the Council to act towards supporting the Coverage4All's Essential Plan.

NYLPI is here as a member of Coverage 4 All, a campaign to expand coverage to all New Yorkers. Led by a coalition of community members, community organizations, health care providers, legal service providers, and advocates from labor, immigrant, and health care consumer advocates. Our objective is to create a statewide health insurance product for New Yorkers who are excluded from eligibility for coverage because of harmful, shameful disparities and inequalities based on race, ethnicity, nationality, language, gender identity and other factors. We firmly believe that all New Yorkers have the right to access the care they need in their communities and we sincerely hope that the Council will prioritize immigrant communities and particularly immigrant health by allocating the funding necessary to create a state-funded plan for all New Yorkers who are currently excluded because of their immigration status.

There are more than 400,000 New Yorkers who cannot enroll in health insurance because of health insurance discrimination, exposing them to further risk of illness and injury. NYLPI has been advocating for equity in health justice for New Yorkers marginalized by race and immigration status for decades, from advocating for language access in healthcare settings to connecting noncitizen New Yorkers to health coverage. Our interdisciplinary team works with New Yorkers who are uninsured and seriously ill, by providing immigration representation and health care advocacy to ensure that individuals who are eligible can connect to state-funded Medicaid. Even after obtaining Medicaid or other insurance coverage, a considerable number of clients continue to experience barriers to accessing benefits for which they are eligible. Similarly, by expanding coverage to uninsured New Yorkers, it will bring more financial security to New York health care providers by reducing the burden of unreimbursed care for

New York Lawyers For The Public Interest, Inc.
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Tel 212-244-4664 Fax 212-244-4570
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uninsured patients. To this end, we urge the Council and the City of New York to take action to support access to care for immigrant New Yorkers.

III. Conclusion

Lastly, I want to personally thank the members of the Council and the efforts made by the City of New York for the actions you have taken to support access to care for immigrant New Yorkers, while others have failed to act for our most vulnerable population.

We look forward to continuing to work with the Council and the Committee on Health to improve immigrant New Yorkers' access to health care.

New York City Council – October 31, 2019

Health Committee and Hospital Committee Joint Hearing

Health Access in New York City, and the Roll Out of NYC Care
Testimony from Anthony Feliciano, Director of the Commission on the Public's Health System

Good Morning,

My name is Anthony Feliciano. I am the Director of a citywide health advocacy organization called the Commission on the Public's Health System. Thank you for this opportunity to testify today on a very critical topic

CPHS is a voice for the public health and hospital system, a voice for the allocation of public funding in the state and city budgets; a strong supporter of community organizing, and supporter of the health care safety net and access to health care services for everyone, particularly in low-income, medically underserved, immigrant and communities of color.

CPHS has a great deal of experience in working with Medicaid beneficiaries and with people who are uninsured. We have provided training sessions for community-based organizations on "How to Help the Uninsured," to being one of the leads from Access Health NYC Initiative and from this experience, in particular, we know how difficult it is to reach people who are otherwise eligible, but do not apply for public health insurance programs. There is a myriad of barriers that are placed in the way for people who: work long hours, have limited tolerance for dealing with bureaucracies, are immigrants in fear of the current anti-immigrant and racist climate in Washington, and speak a primary language other-than-English.

We support the NY CARES program because:

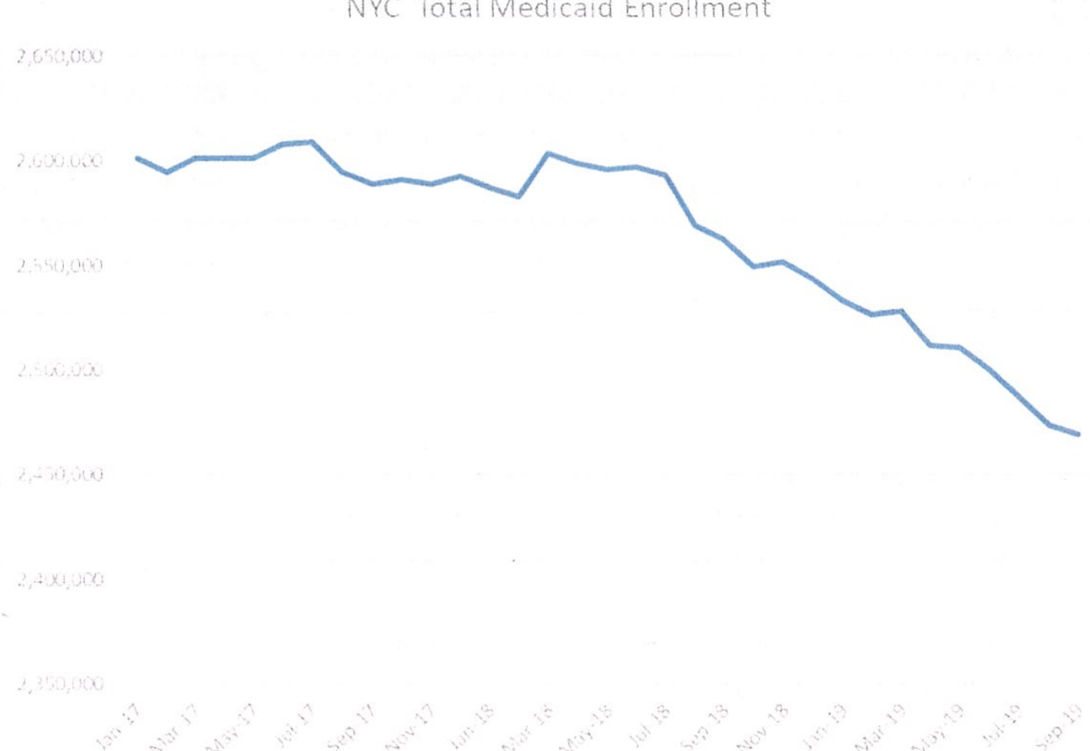
1. It enhances and takes the next steps necessary from the existing HHC Options, which is the sliding fee scale program for the New York City Health Hospitals.
2. It strengthens the links needed between reducing the burden and fears for paying for care and primary care access
3. City's has 300,000 or more uninsured immigrant residents
4. More people have health insurance now, but disparities persist among low-income communities

5. More than 400,000 New Yorkers are adversely impacted by health insurance discrimination
6. Insurance and programs that assist in paying for care and treatment are critically important, particularly if a catastrophic health issue were to hit.
7. The City Council is once again stepping up where the Governor and State Legislature has failed to do so around Access to care for immigrant New Yorkers.

We do believe strongly there are some current factors that need to be addressed and we have recommendations to ensure roll-out of NYC Cares as it becomes citywide for all the boroughs.

Factors that impact success

1. The state's health care providers already spend nearly $130 million/year in uncompensated care for uninsured people, most prominently NYC H+H. However, money and politics play unfortunate roles in determining where money under the ICP (Indigent Care Pool) funding is directed. This has created an unfair and unequal allocation of ICP to hospitals who do not play a real safety-net health care role for underserved communities. Due to the vulnerable population's safety-net hospitals serve, these hospitals are at a greater risk of reducing services and/or closing from the accumulation and unequal distribution of uncompensated care costs.
2. 132,000 fewer New Yorkers are enrolled in Medicaid than were on the day Donald Trump took office. [See graph on next page] Explanations for the decline in enrollment include the following: fewer are eligible because the $15/hour wage pushed people out of poverty status and many eligible people are reluctant to enroll because of the Trump administration's proposed changes to the definition of 'public charge.'



Source: Medicaid Managed Care Enrollment Reports by County
https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

3. Fear of drastic redefining "public charge" while not yet into law has already done what the President's administration wanted, which is causing many eligible immigrants to abandon Medicaid. New York is not alone in this situation. Kaiser reported that half of US health centers noted that immigrant patients refused to enroll themselves in Medicaid, adding that a third said that some patients dropped coverage. A month earlier, Kaiser analysts argued that" the rule may also deter new enrollment among some of the nearly 1.8 million uninsured individuals who are eligible for Medicaid and CHIP but not enrolled and are noncitizens themselves or live in a household with a noncitizen."

What we recommend:

1. Supporting stakeholder engagement

- Currently the roll-out of NYC CARES has utilize the expertise of trusted and culturally competent community-based organizations (CBOs) by offering funding through an RFP process to assist in the outreach and enrollment into NYC CARES. Part of investing in CBO's must also include them in the planning and evaluation of the roll-out, sustainment of the program, and retention of the people who get enrolled. Also, we think more CBO's would have taken opportunity of the RFP, if the amount of the funds was higher. We have heard from many, especially smaller CBO's that it was too little to cover all the resources, including staff and time needed to roll it out and complete the deliverables. Even those who were currently funded have expressed the compensation did not adequately represent the amount of work it took in the Bronx for them to make the pilot successful. However, this does not retract from the efforts and attempts that NY H+H has placed on ensuring CBO's are vital partners and the wiliness of CBO to want NYC CARES to succeed, especially since we both share same goal of ensuring access to health care for the uninsured and immigrant communities.
- The roll-out is strengthen by including the Federally Qualified Health Centers ~~are included~~ in a meaningful way as partners and vital to overall safety-net and primary care access for the uninsured and documented and undocumented immigrants. However, the current budget for NYC CARES is not enough to share with the FQHC's. If the Mayor is truly committed to this program, which he amplified is his run for President, then he revisits investing more than what has been currently budgeted for.

2. Ensuring a thorough evaluation of the program

- Review the program for any messaging that will discourage enrollment. As suggested on the NYC Care website (https://www.nyccare.nyc/), applicants are subject to a financial aid interview and the production of documents. The implied connection between participating in the interview and receiving care could have opposite effect in

encouraging New Yorkers to enroll. That link needs to be disconnected in way that the mission of providing care regardless of the ability to pay remains true.

- Request to see results from the NYC H+H evaluation of the processes, IT, the call-in number/hotline and communication of NYC CARES.
- Review what other city agencies are doing to promote and educate New Yorkers about NYC CARES, especially if there are providing services to similar communities served by NYC H+H.
- Review the workforce levels needed for this program to be sustainable and the impact to the existing access to services for current patients that go to NYC H+H.

3. **Support efforts that have added value to NYC CARES and for the uninsured and most vulnerable communities**
   - Ensure another year of funding for ACCESS HEALTH NYC (AHNYC) Initiative for FY21. AHNYC is a city-wide initiative that funds community-based organizations (CBOs) to provide education, outreach, and assistance to all New Yorkers about their rights to health care & how to access health care and coverage. Access Health NYC builds capacity, amplifies existing community-based efforts, and supports community-based organizations with the goal of targeting individuals and families, who are uninsured, speak English as a second language, people with disabilities, LGBTQ+, formerly incarcerated, experiencing homeless, and other New Yorkers experiencing barriers to healthcare access/information about
     health coverage and options. By working with CBOs, Access Health informs and connects hard-to-reach and marginalized New Yorkers to their healthcare coverage and payment options.
   - Support the aims of Coverage4All would help alleviate the costs associated with the commitment to improve access to health care for the uninsured and immigrants. Those aims include advocating that your state colleagues and the Governor allocate $532 million to create a state-funded Essential Plan for ALL New Yorkers up to 200% of the federal poverty level who are currently excluded because of their immigration status. And the state should offer state-funded Medicaid coverage to immigrants who are losing their Temporary Protected Status (TPS) by enacting A3316/S1809.

Protecting the Safety-Net

- We need a financially stable safety-net health care system, that includes in a vital way our public hospitals. Support A.6677-A/S.5546 so that we can accomplish some equity in hospital funding for ICP/charity care. Please see attached one-pager.

We support NYC CARES and our Public Hospitals.

JOIN THE FIGHT FOR EQUITY IN HOSPITAL FUNDING!

Money and politics play unfortunate roles in determining where money under the ICP (Indigent Care Pool) funding is directed. This is federal and state money that is meant to be sent to hospitals that provide care for the uninsured and have high numbers of Medicaid patients. New York State has moved very, very slowly to accomplish this goal, but there is still more needed after eight years the state is far from doing this.

There are hospitals, many that are Academic Medical Centers or part of the network around those hospitals that actually have a profit rather than losing money. Yet these hospitals are still getting ICP funds, even if they don't serve the uninsured or have that many Medicaid patients. At the same time, there are public and private hospitals that are doing the right thing by caring for their community and serving people without health insurance and Medicaid. There are also critical access and sole community hospitals around the state that need this funding to keep their doors open.

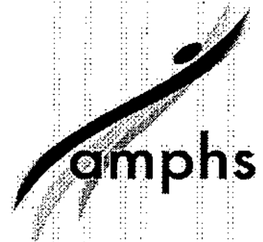
It's been many years that advocates, some unions, and elected officials have fought to change this inequity in funding. This is the year when this MUST Happen. There is an important change in the formula that has been developed and is written into Assembly and Senate bills. **YOUR support is needed NOW to make this happen.**

We ask that you join us and at the same time that you voice your support for **A.6677-A/S.5546.**

The Governor, who doesn't always do the right thing on this issue, and all of your state elected officials need to hear from you often We also need you and your organization to ensure that this information is available to residents in your community, and community-based organizations so that they too can voice their support.

- Let the Governor, your State Senator and Assemblymember, and the Chairs of the Assembly and Senate Health committees, Assemblymember Richard Gottfried and Senator Gustavo Rivera, know that you support A.6677-A/S.5546. *Message: I/We support A.6677-A/S.5546 so that we can accomplish some equity in hospital funding for charity care. Our communities need these services*
- Talk to other people and organizations and urge them to express their support.
- Invite us to talk with your group.
- Join our coalition effort to address the inequities in health care funding.

Let us know your interest by emailing ladyhealth@aol.com or calling Anthony Feliciano from the Commission on the Public's Health System at 646-325-5317



Academy of Medical and Public Health Services

5306 Third Avenue, Second Floor, Brooklyn, NY 11220
Tel: (212) 256-9036 | Email: info@amphsonline.org |
Website: www.amphsonline.org

THE RECORD

Testimony on Coverage 4 All
October 31, 2019

Mon Yuck Yu

Good Morning. My name is Mon Yuck Yu, Executive Vice President & Chief of Staff at the Academy of Medical & Public Health Services (AMPHS). I would first like to thank the New York City Council Committee on Health for your consideration in the support of the Coverage 4 All campaign.

AMPHS is a not-for-profit healthcare organization in Sunset Park that provides free clinical screenings integrated with individualized health education and social services to the immigrant populations of New York City. Our mission is to deinstitutionalize healthcare and make it a basic human right for all New Yorkers. We provide free health access services to uninsured immigrant populations in Sunset Park, Brooklyn without discrimination of documentation status, socioeconomic status, and any other demographic factor.

Sunset Park houses nearly 130,000 residents, of which 44% are Latino and 33% are Chinese. Among these groups, 47% are uninsured, 47% lack English proficiency, and 29% live in poverty.[1] Sunset Park is also home to one of NYC's highest concentration of undocumented immigrants and unaccompanied minors -- a group that suffers high risks of chronic, infectious, and behavioral health issues due to its lack of health insurance access.

Over and over again, we hear stories about how our immigrant populations avoid seeking care for fear of deportation. I want to share two stories.

About a month ago, Joyce, a mother of two from China, came to our office. She has lived in this country, undocumented, for over two years. Her daughter, who has had difficulty assimilating, has been skipping school and not returning home. Ms. Chen has had several interactions with ACS now and worries every night about her daughter. She has thought about killing herself for hopes that her daughter will change for the better. When she went to seek health from a mental health counselor, she was told that she would have to pay $200 per visit without insurance, a cost which she cannot bear. Thus, she remains complacent and is now on a waitlist to seek counseling services from other community-based organizations.

[1] NYC Health, "Community Board Health Profiles 2015: Brooklyn Community District 7," (2015). Retrieved from https://www1.nyc.gov/assets/doh/downloads/pdf/data/2015chp-bk7.pdf

We also have the story of Isabela, who came from Mexico fleeing violence in her home country. She suffers a long history of trauma -- her boyfriend was murdered by a gang, she was detained twice at border where she almost died, she was hit by a car that broke her jaw, and coming here, she has had her wages withheld by an abusive employer. Yet, when she went to the hospital, she was still told to pay hefty fees, leaving her with no choice, but to avoid care.

Without health insurance, undocumented immigrants are unable to access critically-needed healthcare services, including dental and mental healthcare. Emergency care does not affect chronic medical needs; neither does our sliding scale fee system nor the city's newest NYC Care program support the most needy families that still cannot afford the healthcare costs.

Furthermore, New York State Child Health Plus offers health insurance to youth age 18 and under, regardless of immigration status; youth exceeding this upper age limit are left without healthcare access unless they apply for health insurance through the marketplace, their employer, parent's employer or college. Undocumented youth and families without work authorization fall through the healthcare gaps. While recipients of Deferred Action for Childhood Arrival (DACA) and Temporary Protected Status (TPS) are eligible for work authorization and Medicaid, threats to rescind DACA and terminate TPS programs will disenfranchise more members of this community from accessing healthcare, increasing the pool of uninsured individuals, leading to an unprecedented increase of immigrants seeking healthcare services through AMPHS.

This is not the time to ignore this vulnerable population, but to support them. Here at AMPHS, we never ask about documentation, insurance or ability to pay because we believe that healthcare should not be based on a name, an ID number, or a status. Healthcare is not a privilege but a basic human right; we strongly urge the Mayor and City Council to consider supporting the Coverage 4 All campaign in solidarity with our immigrant neighbors and to promote a city that is committed to equal opportunity, social justice and health equity.

Thank you for this opportunity to testify.

New York City Council Committee On Health
Testimony of CPC (Chinese-American Planning Council, Inc.)
Presented by Carlyn Cowen, Chief Policy and Public Affairs Officer

Thank you to Chair Levine and the members of the Health Committee for convening this important hearing and the opportunity to testify today. The mission of the Chinese-American Planning Council, Inc. (CPC) is to promote social and economic empowerment of Chinese American, immigrant, and low-income communities. CPC was founded in 1965 as a grassroots, community-based organization in response to the end of the Chinese Exclusion years and the passing of the Immigration Reform Act of 1965. Our services have expanded since our founding to include three key program areas: education, family support, and community and economic empowerment.

CPC is the largest Asian American social service organization in the U.S., providing vital resources to more than 60,000 people per year across all five boroughs. We accomplish this through more than 50 programs at over 30 sites, ranging from early childhood services to senior services, workforce and legal services and everything in between. CPC employs over 700 staff whose comprehensive services are linguistically accessible, culturally sensitive, and highly effective in reaching low-income and immigrant individuals and families. We serve community members from 40 different countries, speaking 25 different languages. Two-thirds of our community members are Asian American and Pacific Islander (AAPI), and the remainder represent the diversity of communities of color and immigrant communities. With the firm belief that social service can incite social change, CPC strives to empower our constituents as agents of social justice, with the overarching goal of advancing and transforming communities.

To that end, we are grateful to testify about issues that impact the individuals and families we serve, and we are grateful to the City Council for their leadership on these issues. Today, we are here to urge the New York City Council to pass a resolution in support of expanding the essential plan and expanding NYC Cares.

In New York City, AAPIs are the fastest growing racial group, and one in five AAPIs do not have access to health insurance. 1.7 million New Yorkers are currently uninsured, over a million of whom live in New York City. The inequities of access get even more stark when disaggregating data among AAPI subgroups- for example Japanese American have 5.3% uninsurance rate whereas Tongan Americans have a 27% uninsurance rate. At CPC, fully one in four community members that walks through our doors does not have health insurance. These are community members that rely on the emergency room for primary care, if they ever seek care at all. These are the community members that are not currently eligible for any of the public options.

48% of Asian American New Yorkers lack the income to meet their basic needs, and so many of those who do have health insurance still cannot afford needed medical care. Asian Americans have the highest rate of underinsurance of any racial/ethnic group, at 28%. In human terms, what this means is that our community members are making the regular choice between rent, groceries, and going to the doctor or paying for their prescriptions.

In today's political climate, insurance is even more of a fraught issue for those who do not have secure immigration status, or those who have family members that are non-citizens. We recently had a victory in the form of an injunction blocking the Department of Homeland Security's proposed rule on "public charge," which would threaten immigrants' ability to enter the U.S. or obtain a green card because of their lawful enrollment in benefits like Medicaid and SNAP. While as of now the rule cannot go into effect, in many ways, the damage has already been done. According to the Urban Institute, one in seven immigrants is already forgoing public benefits out of fear of how the rule will impact them or their families. At CPC, we have seen this on a daily basis since the rule was proposed, and community members began lining up to de-enroll from government subsidized health insurance because they fear that they or one of their family members may get deported. Many of these community members are on costly, necessary, life-saving prescriptions. Many of them will likely stop their medical care regimens out of fear of having their family separated. The most recent attack on immigrants came in the form of a proclamation which stated that someone can be denied a visa if they cannot prove that they can obtain health insurance, which means that we are literally separating families over insurance.

People without coverage are more likely to delay seeking preventive care for serious and chronic health conditions, avoid seeking care, and are at higher risk of incurring medical debt or bankruptcy. This leads to higher emergency room utilization, prevalence of acute or avoidable conditions, and cost-inefficiency and waste. The human cost of the anxiety of not knowing whether one's immigration status, which already hangs in the balance, will also lead to lack of healthcare, cannot be underestimated. At a time when immigrants are being driven into the shadows and invisibilized, it is imperative that New York City and New York State do everything in its power to take a strong stand that the State will protect its residents regardless of immigration status.

For all of these reasons, we urge the Council to support the expansion of the Essential Plan and expand NYC Cares. CPC appreciates the opportunity to testify on these issues that so greatly impact the communities we serve, and look forward to working with you on them.

If you have any questions, please contact Carlyn Cowen, Chief Policy and Public Affairs Officer, at ccowen@cpc-nyc.org.

Taking Hispanic causes to heart

Testimony to the NYC Council on behalf of the Hispanic Federation

Presented by Michael Pereira, Health Outreach Coordinator, Hispanic Federation
October 31, 2019

Joint Committee on Health and Hospitals

*Public Hearing on the resolution in support of **S. 3900 / A. 5974** relating to coverage for health care services under the basic health program for individuals whose immigration status renders him or her ineligible for federal financial participation*

Good morning, my name is Michael Pereira and I am the Health Outreach Coordinator for the Hispanic Federation, the nation's premier Latino membership organization founded to address the many inequities confronting Latinos and the non-profit organizations that work directly with them.

For more than 25 years the Hispanic Federation has provided grants, administered human services, and coordinated advocacy efforts for our broad network of agencies. Collectively, the Federation serves more than 2 million Latinos in areas of health, immigration, economic empowerment, civic engagement, and education. Today, we are testifying on behalf of HF's health service providers and the Latinos Unidos Contra El SIDA (LUCES) coalition - Hispanic Federation's AIDS Leadership group - comprised of 30 New York City agencies with long histories of services to diverse groups of Latinos.

First and foremost, I would like to thank the New York City Council for welcoming us today and listening to our testimony in support of the council's resolution focusing on the Coverage4All's Essential Plan bill in the New York State Legislature. We applaud the New York City Council for calling on our assembly members, state senators, and on the Governor to pass and enact S. 3900/A. 5974, which would expand eligibility for the Essential Plan to individuals who currently face barriers to health care coverage due to their immigration status.

New York is often defined as being a beacon for immigrants and should be leading the way in ensuring that every New Yorker has access to healthcare, regardless of immigration status. Barriers to accessing health insurance is a public health concern that affects more than 400,000 New Yorkers. Those without health insurance often wait until they are in excruciating pain or at risk of dying to go to an emergency room just to receive care. Not only is this dangerous for the individual in need of services, but also comes at a monetary and societal cost to the larger community.

Hispanic Federation believes that regardless of one's immigration status; weather you are a DACA recipient like 42,000 other New Yorkers or a TPS holder like some 33,600 New Yorkers— everyone should be able to see a primary physician on a regular basis for health care needs. Health is not a luxury; it is a basic human right and necessity.

Being insured has life-saving implications. Not only is Coverage4All a sound public health policy but having health insurance means that our community will have access to a primary care physician and preventive care. It means our neighbors will have access to annual physicals and regular cheek-ups. It means symptoms will be reported when they are first noticed without the fear of going into debt or worse – waiting until the pain is unbearable, visiting the emergency room, and finding out that it's too late for anything to be done.

Coverage4All is a mechanism for New York State to invest in healthier communities and better our entire society.

TESTIMONY IN SUPPORT OF INT 1668-2019
New York City Council Health Committee and Hospitals Committee
Joint Hearing
October 31, 2019

Thank you to the City Council and committee chairs, Council Member Mark Levine and Council Member Carlina Rivera, for today's hearing on expanding access to primary care and for the opportunity to share our recommendations. I am Patrick Kwan, Senior Director for Advocacy and Communications for the Primary Care Development Corporation (PCDC).

Founded in 1993 by Mayor David Dinkins and a visionary group of health and civic leaders, PCDC is a nonprofit organization and a U.S. Treasury-certified community development financial institution that has partnered with the City of New York for over 25 years to build equity and excellence in primary care for millions of New Yorkers. PCDC has worked with over 400 health care sites to increase and improve the delivery of primary care and other vital health services across all five boroughs. We have financed and enhanced health care facilities and practices in 50 out of 51 City Council districts, including financing half of all Federally Qualified Health Centers (FQHCs) – from the smallest to the largest - in New York City.

Through our capacity building programs, PCDC has trained and coached more than 9,000 health workers to deliver superior patient-centered care, including at NYC Health + Hospitals, where we have provided technical assistance for ambulatory care redesign for more than 15 years. We have also assisted more than 500 primary care practices in New York and beyond to achieve Patient-Centered Medical Home (PCMH) recognition, improving care for more than 5 million patients nationwide. In partnership with the Montefiore School Health Program and New York School-Based Health Alliance, PCDC helped developed the first and only nationwide recognition program approved by the National Committee for Quality Assurance (NCQA) for school-based health centers.

Our mission is to create healthier and more equitable communities by providing the capital, advocacy, research, and expertise needed to build, expand, and strengthen our primary care infrastructure. We believe every New Yorker in every neighborhood should have access to high quality primary care.

Support Int 1668-2019 to Expand Access to Primary Care

PCDC is dedicated to financing, enhancing, and advocating for primary care because primary care makes the difference between a life-threatening chronic condition and a manageable or treatable condition. Primary care is essential to better health outcomes, lower costs, and healthier families and communities by preventing and treating illnesses before they become more serious, costly, and difficult to treat.

New Yorkers need hospital beds for when we are seriously sick and emergency rooms for emergencies — and we need primary care services to stay healthy, maintain our health from infancy to old age, and avoid costly hospital stays and emergency room visits.

Primary care is not the solution to every health issue but there are few chronic health conditions that can be managed better without primary care.

That is why PCDC strongly supports the investments and commitments made in recent years by the City Council, NYC Health + Hospitals (H+H), the Department of Health and Mental Hygiene (DOHMH), and the de Blasio administration to enhance and expand access to primary care, including through funding for DOHMH's Prevention and Primary Care program's Bureau of Primary Care Access and Planning (PCAP) and Bureau of Primary Care Information Project (PCIP) as well as through initiatives such as Caring Neighborhoods, *One New York: Health Care for Our Neighborhoods* transformation plan for H+H, and most recently, NYC Care.

We are pleased to support Int 1668-2019 as another major effort to expand primary care access by amending the administrative code to establish a citywide primary care program to help connect New Yorkers to coordinated, personalized care at H+H facilities as well as Federally Qualified Health Centers (FQHCs), and other not-for-profit and private medical service providers.

New York City's nonprofit community-based FQHCs provide quality primary care and other vital health services to 1.2 million patients, regardless of their ability to pay or their health insurance or immigration status. The City Council's continued support and investment with discretionary funding for FQHCs will ensure their ability to sustain programs and services to serve all New Yorkers in need of high-quality, comprehensive care.

Maximize City Council Grant Funds for Additional Primary Care Expansion

About 25 years ago when PCDC was founded, New York City's primary care landscape was bleak. A front page *New York Times* story reported on a "severe deficit of doctors in poor urban neighborhoods" and a devastating study that found "only 28 properly qualified doctors to serve a population of 1.7 million in nine low-income neighborhoods in Harlem, north central Brooklyn and the South Bronx." The 1993 story also highlighted PCDC's founding to finance health facilities to bring high quality and culturally competent care to underserved communities through a $17 million investment by the City. At the same time, then-Mayor Dinkins also provided the Health and Hospitals Corporation with $48 million in capital and operating funds to build 20 family health care centers in 13 of New York City's most medically underserved communities in what was then called CommuniCare, and which is now known as Gotham Health.

While New York City's primary care infrastructure has improved dramatically over the last 25 years – as demonstrated in PCDC's *Primary Access Profiles* examining all 51 Council Districts, federal actions are creating a bleak outlook for the city's health care safety net, directly undermining health care access, coverage, and service delivery for millions of New Yorkers. Now is a critical time to examine and work to accelerate access to quality health care for all New Yorkers.

New York's underserved communities need primary care services most, relying on the care and services provided by community-based providers. These same providers lack resources to expand and improve services. While the City Council has made important and generous investments in community providers, these investments have and will not meet the substantial capital needs of providers throughout the city.

For example, there is a substantial need for supporting primary care and behavioral health integration. Patients with serious mental illness are often affected by chronic conditions. Just as it is important to integrate

behavioral health into primary care settings, we must also integrate primary care into behavioral health settings to help prevent and reduce chronic conditions and promote wellness of New Yorkers.

PCDC has been a strong and willing partner to the City across administrations. As a U.S. Treasury-certified community development financial institution with a mission-driven expertise in financing community-based health care, PCDC has found we are most successful when we leverage our resources to partner with the City and other entities to jointly finance projects for community primary care providers without recourse to bank capital. The strategy is to finance the construction, expansion, and renovation of facilities and programs by utilizing a variety of capital instruments, including public and private loans, debt, and grants. This enables the financing of key projects and ensures that scarce public resources are matched with private dollars to finance more and larger projects to meet the immediate and substantial needs in our communities. In addition to our technical assistance capacity, we have a variety of financing mechanisms and technical assistance available to support new or renovated primary care facilities.

Our recent financing in New York City for projects such as the Apicha Community Health Center in Lower Manhattan, Callen-Lorde Community Health Center in Downtown Brooklyn, the Institute for Community Living and Community Healthcare Network's East New York Health Hub, and the Joseph P. Addabbo Family Health Center in the Rockaways have included federal New Markets Tax Credits, New York State Community Health Care Revolving Capital Fund, and private investments in addition to City Council grants. We look forward to working with the City Council on a comprehensive strategy to maximize grant funds for financing primary care infrastructure expansion and improvement needs in our communities.

With overwhelming evidence of its positive impact on improving health care quality and outcomes while lowering health care costs, primary care is the most reliable means of ensuring patient and community health. To meet its responsibility, primary care must be reinforced with sound policies and adequate resources. We look forward to working with the City Council to support these goals.

Thank you for your consideration of our recommendations to help build and strengthen New York City's primary care infrastructure.

Contact:

Patrick Kwan, Senior Director of Advocacy and Communications
Primary Care Development Corporation
45 Broadway, 5th Floor, New York, NY 10006
(212) 437-3927 | pkwan@pcdc.org

PRIMARY CARE ACCESS IN NEW YORK CITY

2019 REPORT

pcdc.org

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NEW YORK CITY COUNCIL DISTRICTS & PRIMARY CARE ACCESS

1.1 INTRODUCTION

Primary care is the foundation of the health care system and a cornerstone of healthy, thriving communities. Increasing primary care access across New York City, as in other major cities, creates healthy communities, ensures health equity, and reduces health care costs.

Primary care is often the first point of contact with the health care system and can prevent, identify, and treat illnesses as well as promote wellness. Effective primary care means that providers and services are accessible, affordable, comprehensive, ongoing, and coordinated.

Inequalities in primary care access and delivery alike are largely driven by economics, including insurance coverage, reimbursement, and social determinants of health. Geographic, demographic, and socioeconomic characteristics impact where primary care providers (PCPs) are located, and even in communities where providers are available, disparities in access may remain.

1.2 NEW YORK CITY COUNCIL DISTRICTS & PRIMARY CARE

FIG 1.
Map of New York City Council Districts

The **Primary Care Development Corporation (PCDC)** has identified key measures of primary care access. This report utilizes existing data to identify primary care facilities and services in NYC to contrast measurable elements of access to quality primary care across Council Districts (CDs). By examining multiple dimensions of primary care access at the District-level, we hope to further our understanding of primary care access for constituents while presenting content to help identify gaps in access, support advocacy for additional primary care services, and inform siting of new primary care facilities.

PRIMARY CARE ACCESS MEASURES

SECTION 2.0

2.1 ACCESS OVERVIEW

Primary care access is when a person is able to receive the needed primary care services that are timely, affordable, and in a geographically proximate location. Such qualities are largely dependent on factors including the availability of health care practitioners and facilities that provide primary care, the quality of these services, and whether providers accept a patient's health insurance or provide care without regard to ability to pay.

2.2 PRIMARY CARE PROVIDER AVAILABILITY

FIG 2a.
Primary Care Providers (PCPs) per 10,000 adult residents (18+ years) by New York City Council District, 2016-2017

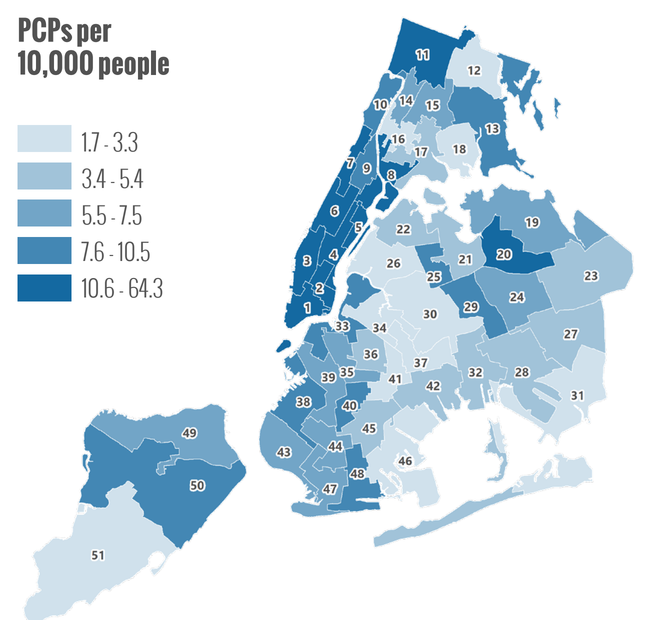


FIG 2b.
PCP Availability Ranking

Districts with the most PCPs per 10,000 people

	District	PCPs
1.	District 2	64.3
2.	District 1	42.6
3.	District 4	41.5
4.	District 11	37.7
5.	District 6	28.7

Districts with the fewest PCPs per 10,000 people

	District	PCPs
1.	District 34	1.7
2.	District 37	2.2
3.	District 51	2.4
4.	District 41	2.6
5.	District 30	2.7

Availability of primary care providers (PCPs) within communities has been associated with positive health outcomes and increases in health care service utilization.[1,2] People who live in areas with fewer primary care providers may have to travel farther or wait longer to be able to access primary care services.[3]

2.3 HEALTH INSURANCE COVERAGE

FIG 3a.
Percent of Insured adult residents (18+ years) by New York City Council District, 2012-2016

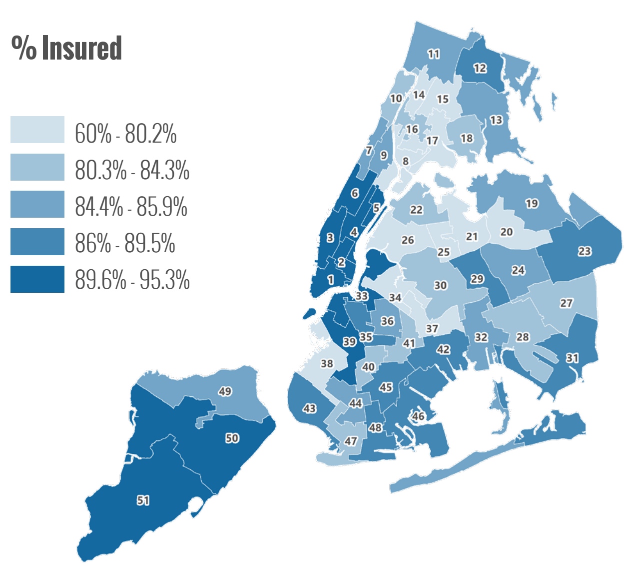


FIG 3b.
Health Coverage Ranking

Districts with the highest insured rates*			Districts with the lowest insured rates*		
1.	District 4	95.3%	1.	District 21	60.0%
2.	District 51	94.2%	2.	District 20	69.2%
3.	District 5	94.0%	3.	District 25	73.0%
4.	District 6	94.0%	4.	District 38	75.3%
5.	District 3	93.6%	5.	District 34	76.9%

**Rates reflect the percent of persons with health insurance coverage*

Health insurance coverage is essential to the ability to access primary care. Persons who are uninsured are often sicker,[4] spend a greater proportion of their income on out-of-pocket health care costs, have greater difficulty accessing services,[5,6] and are more likely to lack a usual source of care than their insured counterparts.[7]

2.4 PUBLIC INSURANCE ACCEPTANCE

FIG 4a.
Percent of PCPs Accepting Medicaid by New York City Council District, 2016-2017

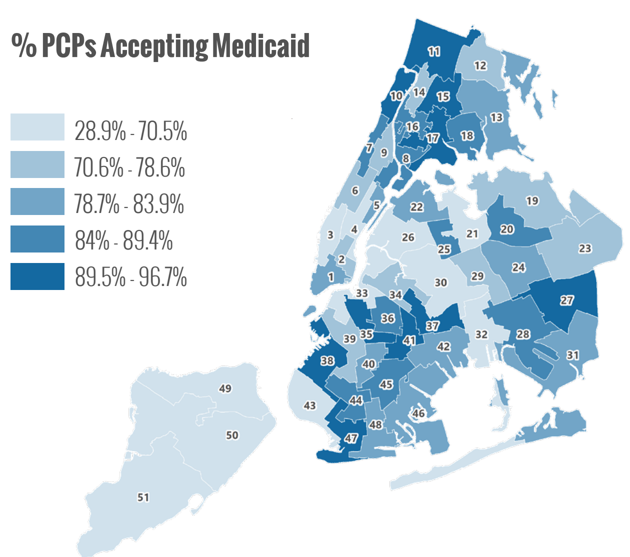
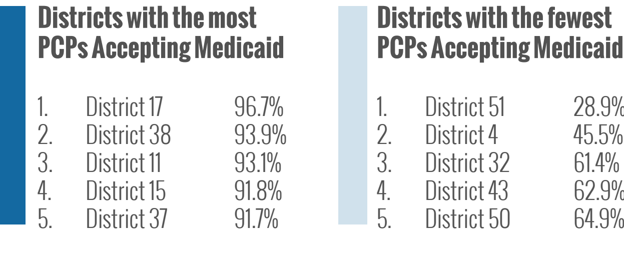


FIG 4b.
Medicaid Acceptance Ranking



Districts with the most PCPs Accepting Medicaid			Districts with the fewest PCPs Accepting Medicaid		
1.	District 17	96.7%	1.	District 51	28.9%
2.	District 38	93.9%	2.	District 4	45.5%
3.	District 11	93.1%	3.	District 32	61.4%
4.	District 15	91.8%	4.	District 43	62.9%
5.	District 37	91.7%	5.	District 50	64.9%

Medicaid acceptance measures the proportion of primary care providers that accept patients on Medicaid, a public insurance program for low-income people. For low-income communities with large Medicaid-insured populations, an insufficient supply of neighborhood-based providers accepting Medicaid presents a barrier to care, and may result in poorer health outcomes.

FIG 5a.
Percent of PCPs Accepting Medicare by New York City Council District, 2016-2017

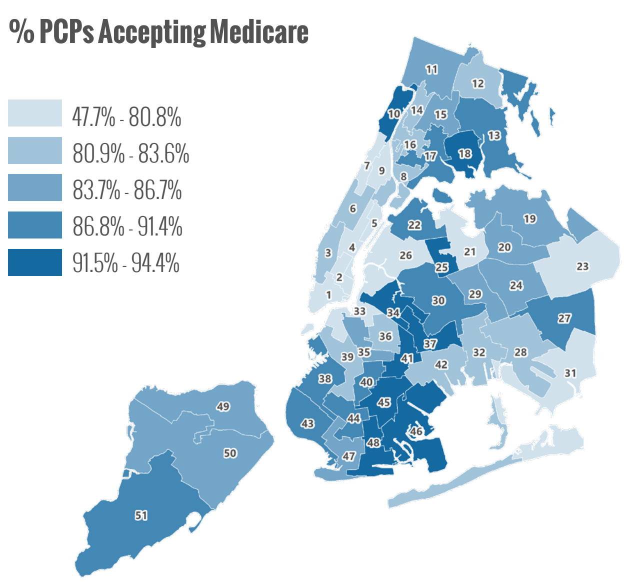


FIG 5b.
Medicare Acceptance Ranking

Districts with the most PCPs Accepting Medicare

	District	%
1.	District 37	94.4%
2.	District 46	94.2%
3.	District 48	94.0%
4.	District 18	93.3%
5.	District 34	92.9%

Districts with the fewest PCPs Accepting Medicare

	District	%
1.	District 5	47.7%
2.	District 4	69.4%
3.	District 21	72.9%
4.	District 9	73.0%
5.	District 33	74.8%

Medicare acceptance measures the proportion of primary care providers that accept patients on Medicare, which includes people who are ages 65+ and certain younger persons with disabilities. This population is growing annually, particularly with the aging of the Baby Boomer generation. Primary care is particularly important for Medicare beneficiaries, as older adults are more likely to be living with and managing multiple chronic conditions.[8] Neighborhood-based primary care services are essential for older adults, as greater mobility issues are experienced by the Medicare population.

2.5 PATIENT-CENTERED CARE

FIG 6a.
Percent of PCP Access Points with PCMH Recognition by New York City Council District, 2016-2017

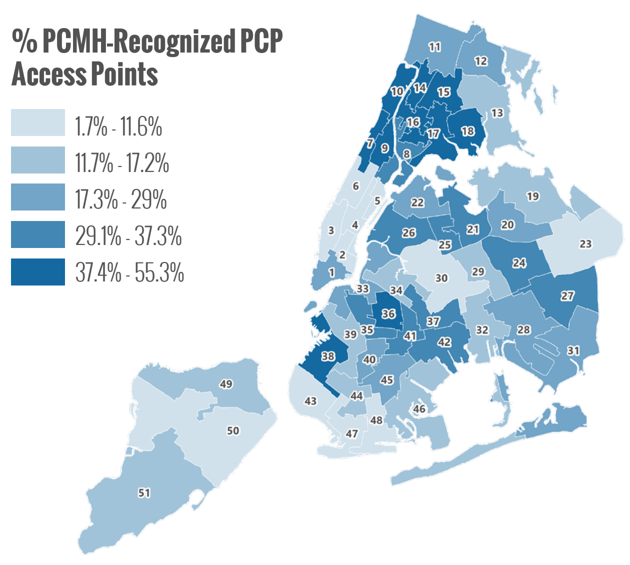
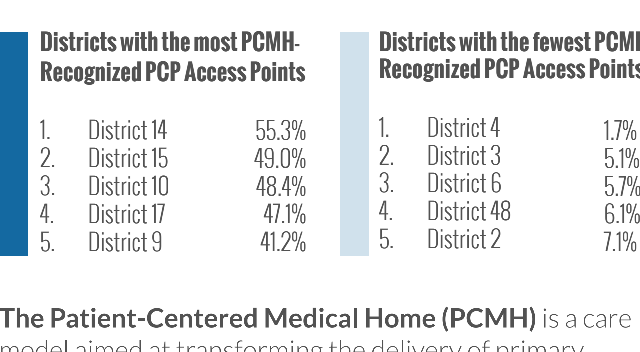


FIG 6b.
PCMH-Recognition Ranking



Districts with the most PCMH-Recognized PCP Access Points

	District	%
1.	District 14	55.3%
2.	District 15	49.0%
3.	District 10	48.4%
4.	District 17	47.1%
5.	District 9	41.2%

Districts with the fewest PCMH-Recognized PCP Access Points

	District	%
1.	District 4	1.7%
2.	District 3	5.1%
3.	District 6	5.7%
4.	District 48	6.1%
5.	District 2	7.1%

The Patient-Centered Medical Home (PCMH) is a care model aimed at transforming the delivery of primary care through a commitment to quality improvement and a patient-centered care approach.[9] In New York State's Medicaid program, PCMH-enabled primary care practices receive additional reimbursement.

HEALTH STATUS MEASURES

SECTION 3.0

3.1 HEALTH STATUS OVERVIEW

The health status of a district indicates health care needs of the population and factors that impact the district population's health. Examining multiple measures of population health provides insight into the need experienced by residents as well as burdens placed on primary care providers and facilities. The health status of a population should inform the primary care services required to address the health care needs of residents.

3.2 DIABETES PREVALENCE

FIG 7a.
Percent of adult residents (18+ years) that report having been diagnosed with Diabetes by New York City Council District, 2015

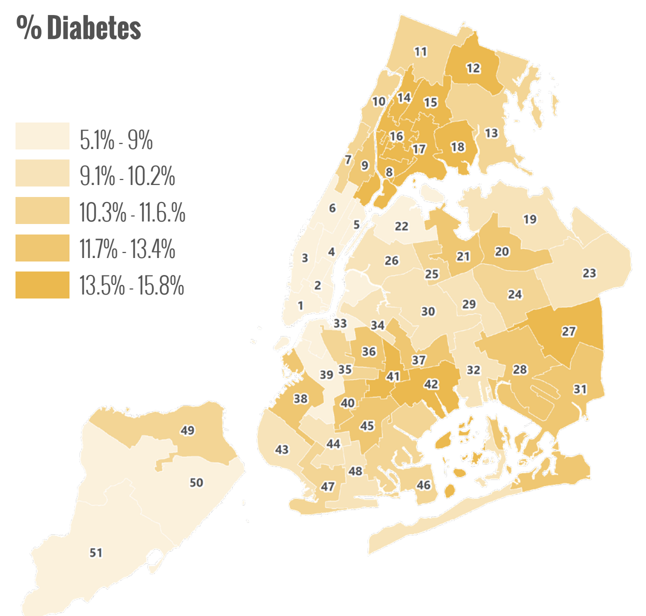


FIG7b.
Diabetes Prevalence Ranking

Districts with the highest prevalence of Diabetes

	District	%
1.	District 16	15.8%
2.	District 17	15.7%
3.	District 41	15.2%
4.	District 42	15.2%
5.	District 8	14.8%

Districts with the lowest prevalence of Diabetes

	District	%
1.	District 5	5.1%
2.	District 3	5.4%
3.	District 4	5.7%
4.	District 2	6.0%
5.	District 6	6.3%

Diabetes serves as a measure of chronic disease burden, reflecting the percent of residents that report ever being told by a doctor, nurse, or health professional that they have diabetes. Primary care plays an important role in mitigating the chronic disease burden within populations, and helps reduce unnecessary hospitalizations and mortality due to poorly managed chronic conditions.[10] Furthermore, diabetes disproportionately affects individuals with lower socioeconomic status, and is indicative of overlapping factors related to increased primary care need.

3.3 IMMUNIZATION COVERAGE

FIG 8a.
Percent of adult residents (18+) without a flu immunization by New York City Council District, 2009-2013

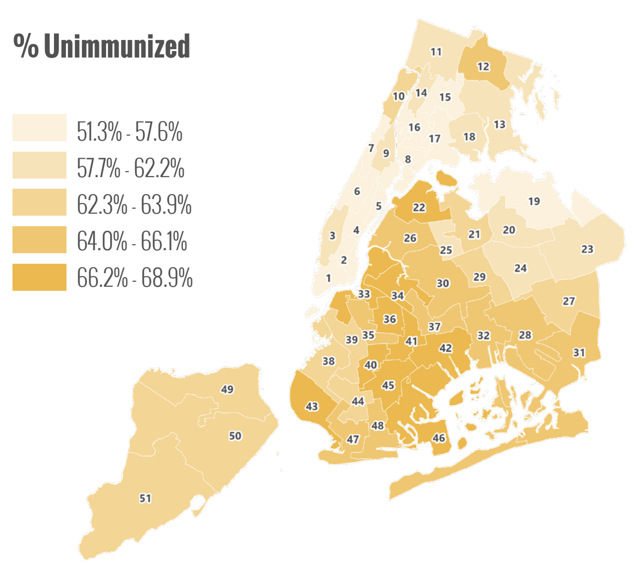


FIG 8b.
Immunization Ranking

Districts with the highest percent of unimmunized people

	District	%
1.	District 45	68.9%
2.	District 40	68.8%
3.	District 34	68.5%
4.	District 46	67.9%
5.	District 36	67.8%

Districts with the lowest percent of unimmunized people

	District	%
1.	District 6	51.3%
2.	District 5	51.7%
3.	District 1	52.1%
4.	District 4	55.6%
5.	District 15	56.8%

The estimated percentage of residents without a flu **immunization** serves as a proxy for preventive health care utilization. Preventive care is foundational to primary care, and in the case of influenza vaccinations in New York City, is associated with reduced preventable hospital visits[11] and therefore better overall health outcomes and reduced health care costs.

3.4 HEART DISEASE MORTALITY

FIG 9a.
Heart Disease Mortality Rate per 100,000 residents by New York City Council District, 2011-2013

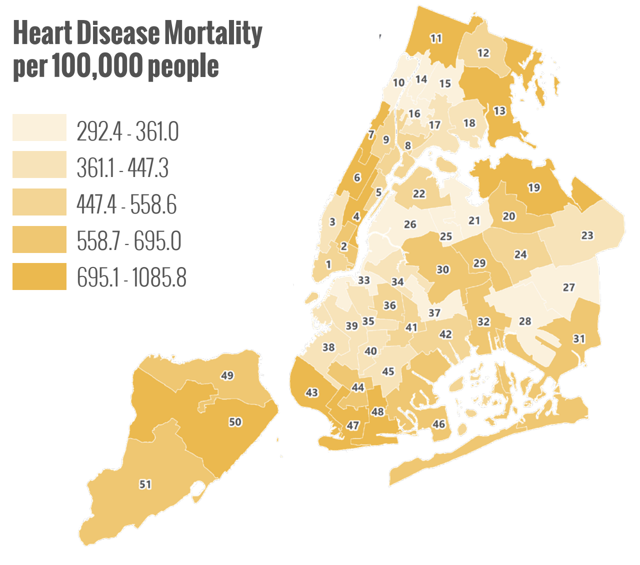


FIG 9b.
Heart Disease Mortality Ranking

Districts with the highest heart disease mortality rate per 100,000 people

	District	Rate
1.	District 50	1085.8
2.	District 11	1031.1
3.	District 48	1008.0
4.	District 47	898.9
5.	District 13	866.1

Districts with the lowest heart disease mortality rate per 100,000 people

	District	Rate
1.	District 21	292.4
2.	District 10	304.4
3.	District 16	315.6
4.	District 33	317.5
5.	District 37	318.2

Heart disease is the leading cause of death nationwide.[12] Heart disease mortality rates are a measure of chronic-disease related, potentially preventable mortality. Key components of high-quality primary care, including team-based and patient-centered approaches, can help to reduce the risk of cardiovascular disease or slow its progress when detected early.[13,14]

3.5 POTENTIALLY PREVENTABLE ED VISITS

FIG 10a.
Potentially Preventable Emergency Department (ED) Visits per 100 persons by New York City Council District, 2016

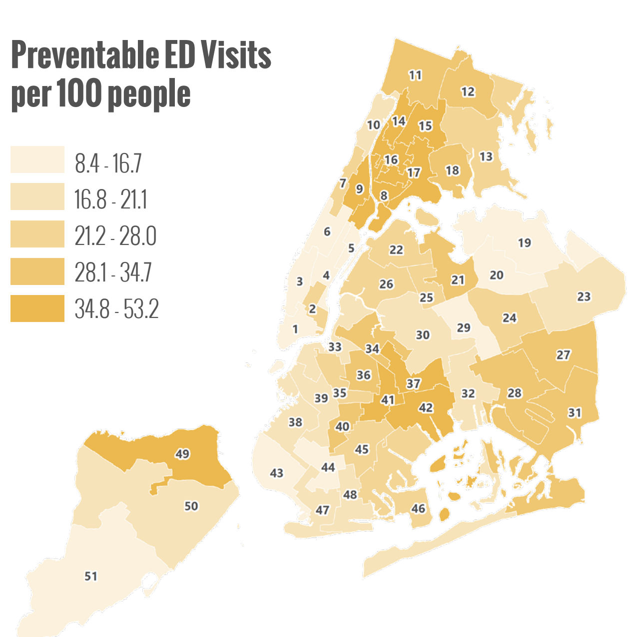


FIG 10b.
Potentially Preventable ED Visit Rate Ranking

Districts with the highest preventable ED visit rates*

	District	Rate
1.	District 8	53.2
2.	District 16	48.1
3.	District 17	47.3
4.	District 9	41.4
5.	District 42	40.8

Districts with the lowest preventable ED visit rates*

	District	Rate
1.	District 6	8.4
2.	District 5	10.6
3.	District 19	12.3
4.	District 3	13.9
5.	District 51	14.2

**The rate of potentially preventable emergency department visits per 100 people*

Preventable emergency department (ED) visit rates are widely used to measure need for additional primary care access, or higher quality and more comprehensive care that appropriately addresses the health needs of local residents. High rates of preventable ED visits may indicate a strain on health care system costs and resources.[15]

SOCIOECONOMIC POSITION MEASURES

SECTION 4.0

4.1 SOCIOECONOMIC POSITION OVERVIEW

Understanding the relationship between socioeconomic position (SEP) and primary care is essential in evaluating factors that determine access to primary care. SEP refers to the social and economic factors that influence a person's position within a larger, socially stratified population and significantly contribute to existing disparities in the quality of available primary care and level of care continuity provided.[16,17] By evaluating the specific vulnerabilities each population experiences, PCDC has created a multidimensional lens to evaluate access to primary care.

4.2 RACE AND ETHNICITY

FIG 11a.
Percent of Black, non-Hispanic (NH) residents (all ages) by New York City Council District, 2012-2016

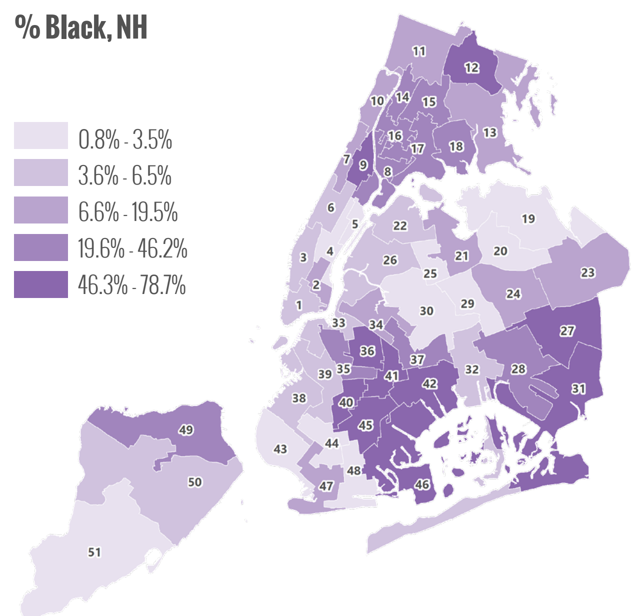


FIG 11b.
% Black, NH Population Ranking

Districts with the highest percent of Black, NH residents

Rank	District	%
1.	District 41	78.7%
2.	District 42	73.9%
3.	District 27	70.5%
4.	District 31	68.3%
5.	District 12	67.3%

Districts with the lowest percent of Black, NH residents

Rank	District	%
1.	District 51	0.8%
2.	District 19	1.1%
3.	District 44	1.3%
4.	District 30	1.3%
5.	District 43	1.4%

The proportion of **Black, non-Hispanic residents** is one measure of the racial and ethnic composition of a community. While challenging to measure and describe the dynamic racial and ethnic composition of each district in NYC, primary care practices are well-position to respond to the unique cultural needs of their patient populations[18] and thereby reduce inequities in health outcomes.[19]

4.3 UNEMPLOYMENT

FIG 12a.
Percent of unemployed adult residents (20-64 years) by New York City Council District, 2012-2016

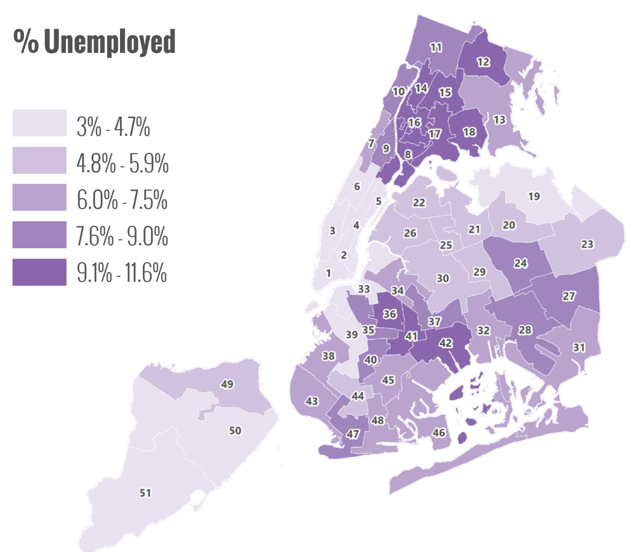


FIG 12b.
Unemployment Ranking

Districts with the highest unemployment

	District	%
1.	District 15	11.6%
2.	District 18	10.1%
3.	District 42	10.0%
4.	District 8	9.8%
5.	District 36	9.8%

Districts with the lowest unemployment

	District	%
1.	District 4	3.0%
2.	District 5	3.4%
3.	District 6	3.7%
4.	District 50	4.2%
5.	District 1	4.3%

Unemployment, measured by the percent of unemployed residents ages 20-64, often is a barrier to necessary health care, income stability, and social support, and can also be detrimental to an individual's physical and mental well-being.[20-22] This measure provides insight as to the economic strain experienced by a population.

4.4 POVERTY

FIG 13a.
Percent of adult residents (18+ years) living at or below 100% of the Federal Poverty Level (FPL) by New York City Council District, 2012-2016

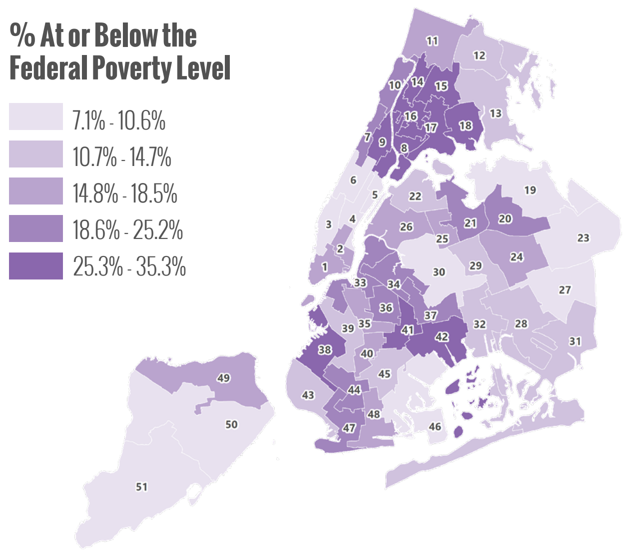


FIG 13b.
Poverty Rate Ranking

Districts with the highest poverty rates

	District	%
1.	District 16	35.3%
2.	District 8	35.0%
3.	District 17	34.7%
4.	District 15	33.1%
5.	District 14	32.2%

Districts with the lowest poverty rates

	District	%
1.	District 5	7.1%
2.	District 51	7.3%
3.	District 4	7.7%
4.	District 19	8.2%
5.	District 23	8.3%

Poverty is measured by the percent of residents at or below the Federal Poverty Line, and is a key component of access. Beyond the correlation between poverty and many health and quality of life measures, poverty is indicative of the level of need for affordable primary care services, especially for low-income, uninsured, or under-insured residents.[23,24]

4.5 OLDER ADULTS

FIG 14a.
Percent of population over 64 years of age by New York City Council District, 2012-2016

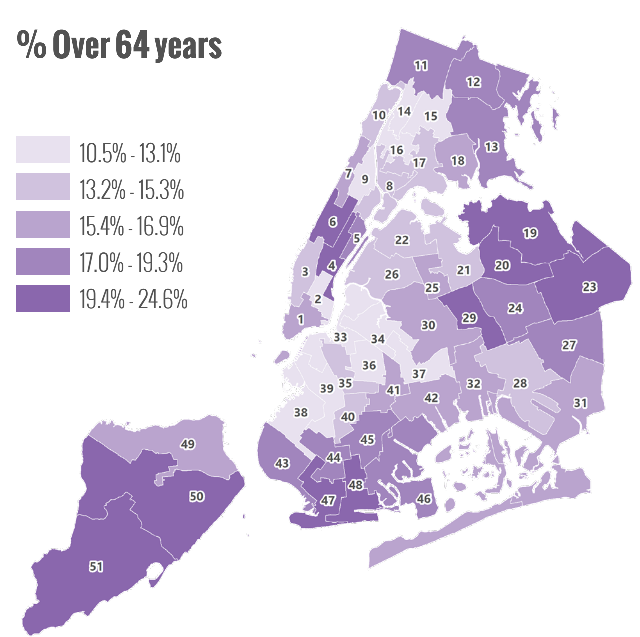


FIG 14b.
Older Adult Population Ranking

Districts with the highest percent of adults over 64 years

	District	Percent
1.	District 5	24.6%
2.	District 48	24.4%
3.	District 19	23.8%
4.	District 47	21.6%
5.	District 50	21.3%

Districts with the lowest percent of adults over 64 years

	District	Percent
1.	District 37	10.5%
2.	District 34	11.0%
3.	District 33	11.0%
4.	District 14	11.1%
5.	District 16	12.0%

Older residents and those with disabilities represent vulnerable populations that often benefit most from continuous primary care. These same populations experience more challenges to accessing needed care, most notably for city-dwelling older adults with chronic conditions or mobility challenges, and those living in public housing.[25-27] Improved access for this population can reduce the burden of chronic diseases and related complications, and reduce rates of preventable emergency department visits.[25]

PRIMARY CARE POLICY IN NEW YORK CITY

SECTION 5.0

Recommendations for Primary Care Advocates and Policymakers in New York City:

+ Ensure adequate supply of PCPs in every district.
+ Take measures such as PCP-to-population ratio into account when siting and providing capital for primary care facilities.
+ Work toward primary care access parity for districts with relatively low socioeconomic position.
+ Encourage high-quality primary care provision and access through reimbursement models that reward proven quality programs (such as Patient-Centered medical Home) and targeted capital grants and loans.

ACKNOWLEDGEMENTS

SECTION 6.0

Thank you to the New York City Council for supporting our efforts to improve primary care and health equity for City residents.

The New York City Council in New York City Hall

TECHNICAL NOTES & METHODS

SECTION 7.0

Primary Care Provider Definition :

In this profile, Primary Care Provider (PCP) is defined as a physician (MD or DO) with a primary specialty of Internal Medicine, General Medicine, or Family Medicine.

Methods

The Primary Care Profiles are comprised of primary care access, health status, and sociodemographic position data, aggregated and presented at the Council District level. The concept of access to care is multidimensional in nature and is determined by factors such as provider availability, proximity to providers and characteristics of primary care practices.

Access to care is also influenced by the health status, demographic, and socioeconomic position (SEP) characteristics of a community.

Primary care access measures included in the Profiles represent provider availability (PCPs per 10,000 persons), affordability of services (uninsured rates and percentages of PCPs accepting Medicaid and Medicare), and quality of care (proportion of PCP access points with PCMH recognition). Together, these measures help evaluate how primary care access varies across NYC and can help identify Districts and areas with poor access to care.

In addition to primary care access measures, we included health status and SEP measures to provide information on the potential need for primary care access, by District. Health status measures, such as diabetes prevalence and heart disease-related mortality, are indicators for the chronic disease burden of a community. The potentially preventable emergency department (PPED) visit rate is indicative of both poor health status and health conditions that could be managed in a primary care setting. Immunization rates serve as a proxy for preventive health care usage. The set of SEP measures were selected through careful review of literature to identify social and demographic factors closely linked to both health care access, status, and equity. SEP measures included the percent of Black, Non-Hispanic residents, percent of residents below 100% of the Federal Poverty Level (FPL), percent of unemployed residents ages 20-64, and the percent of residents 65 years or older.

Given that none of the data presented in the Profiles was available at the Council District level, we collected data at either the ZIP Code or census tract level and calculated District-level estimates. To do this, data available at the ZIP Code level were first cross-walked to modified ZIP Code Tabulation Areas (ZCTA) in NYC. For all data, a spatial overlay was used to calculate proportion of data in each ZCTA or CT that was within a Council District, and the proportion (or count) of data was then assigned to the District and summed to create totals for each District. Descriptive statistics, graphs, and choropleth maps were produced for all measures by NYC Council District, borough, and citywide.

Ratio of primary care providers per 10,000 persons ages 18 years and older

- Number of PCPs with a practice location in the Council District multiplied by 10,000, and then divided by the population of persons 18 years of age and older residing in a District
    - NOTE: This measure is intended to allow for comparison between Districts, and does not establish a threshold for adequate PCP availability among adults
- PCPs with multiple practice locations in one District were counted once within the District

Percent of persons ages 18–64 who are uninsured, 2012–2016

- Number of persons ages 18-64 in the District with no insurance divided by the total number of persons ages 18-64 residing in the District

Percent of primary care providers that accept Medicaid

- Number of PCPs in the District that accept Medicaid divided by the total number of PCPs in the District

Percent of primary care providers that accept Medicare

- Number of PCPs in the District that accept Medicare divided by the total number of PCPs in the District

Percent of primary care sites that are recognized as Patient-Centered Medical Homes

- Number of PCP sites identified as PCMH-recognized divided by the total number of PCP sites in each District

Note on Primary Care Access Measures:

Each measure presented in the profile serves to compare access between Council Districts in New York City. These comparisons do not establish a threshold for adequate access for the measures.

DATA SOURCES

Figure 1. Map of New York City Council Districts

New York State Civil Boundaries, New York State GIS Data, 2018.
New York State Streets, New York State GIS Data, 2019.

Figure 2. Primary Care Provider (PCP) Availability

Specialized Knowledge & Applications (SKA), 2016-2017.
Provider Network Data System (PNDS), 2017.
National Plan and Provider Enumeration System (NPPES), 2017.

Figure 3. % Insured

United States Census via the American Community Survey, 2016 Five-Year estimate, ID: S2701

Figure 4-5. % PCPs Accepting Medicaid, Medicare

Specialized Knowledge & Applications (SKA), 2016-2017.
Provider Network Data System (PNDS), 2017.
National Plan and Provider Enumeration System (NPPES), 2017.

Figure 6. % PCMH-Recognized PCP Access Points

Specialized Knowledge & Applications (SKA), 2016-2017.
Provider Network Data System (PNDS), 2017.
National Plan and Provider Enumeration System (NPPES), 2017.
National Committee for Quality Assurance (NCQA), 2017.

Figure 7. % Diabetes Prevalence

Behavioral Risk Factors Surveillance System (BRFSS) via Centers for Disease Control and Prevention (CDC) 500 Cities estimates, 2015

Figure 8. % Unimmunized

NYC Community Health Survey, 2009-2013

Figure 9. Heart Disease Mortality

NYC Department of Health and Mental Hygiene's Vital Statistics, 2011-2013

Figure 10. Potentially Preventable ED Visits

Statewide Planning and Research Cooperative System (SPARCS), 2016.

Figure 11. % Black, NH

United States Census via the American Community Survey, 2016 Five-Year Estimate, ID: DP05

Figure 12. % Unemployed

United States Census via the American Community Survey, 2016 Five-Year Estimate, ID: S2301

Figure 13. % At or Below the Federal Poverty Level

United States Census via the American Community Survey, 2016 Five-Year Estimate, ID: S1701

Figure 14 . % Over 64 years

United States Census via the American Community Survey, 2016 Five-Year Estimate, ID: B01003

CITATIONS

SECTION 8.0

CITATIONS

Primary Care Access Measures

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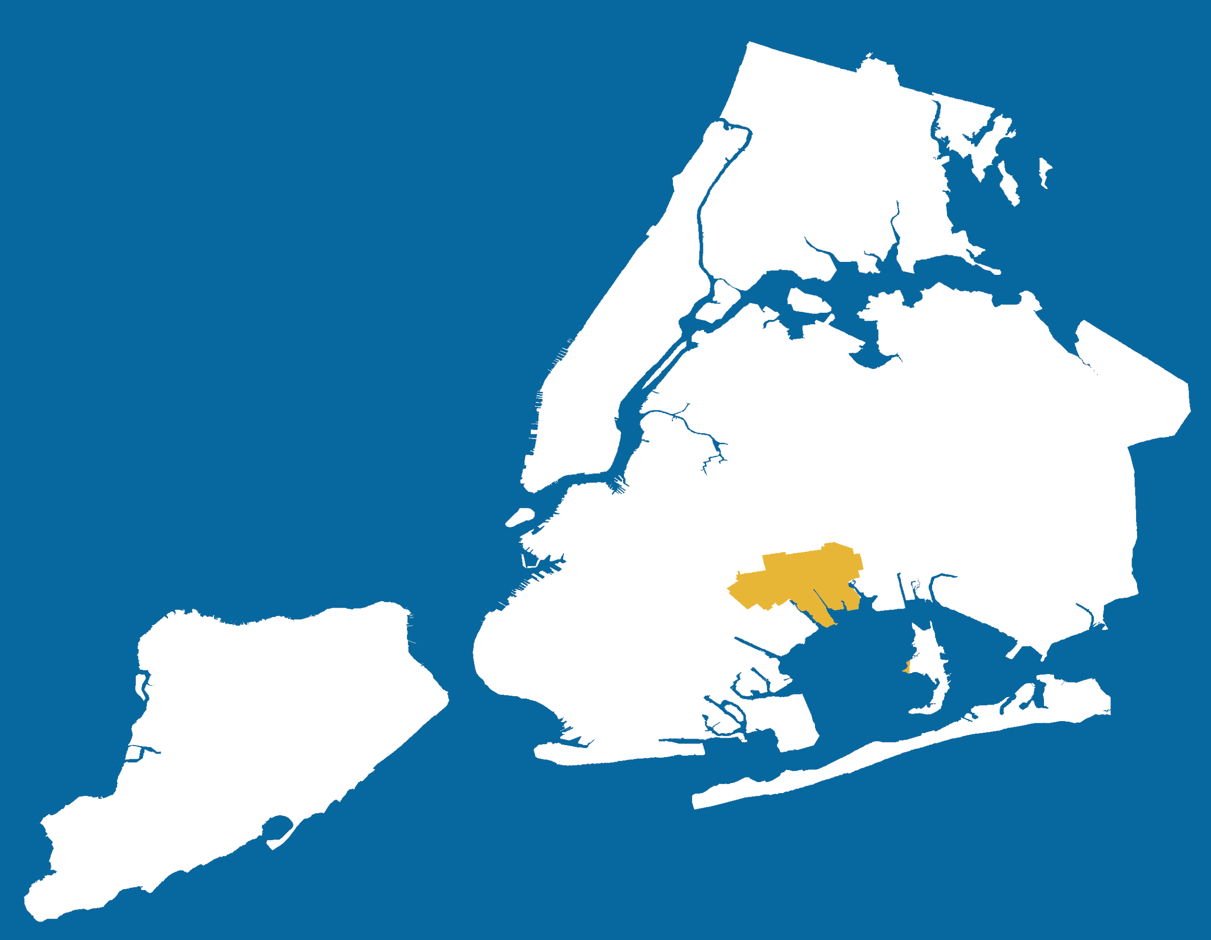
Primary Care Development Corporation
45 Broadway
Fifth Floor
New York, NY 10006

pcdc.org | (212) 437-3900 | info@pcdc.org



COUNCIL DISTRICT 42

2019 PRIMARY CARE PROFILES

A look at adult primary care access in New York City

COUNCIL DISTRICT 42

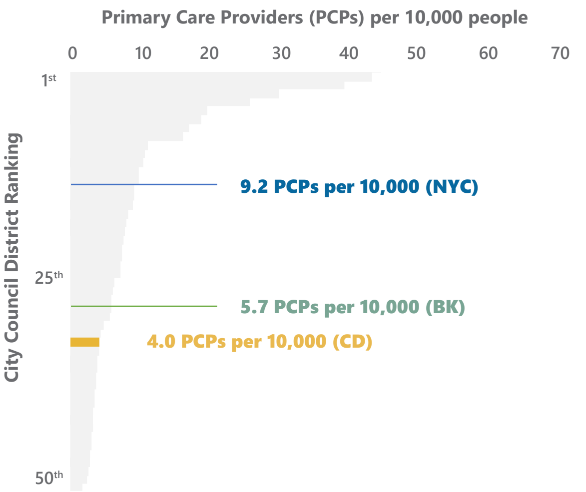
Includes the East New York, New Lots, Remsen Village, Spring Creek, and Starrett City neighborhoods.

CD | BK | NYC

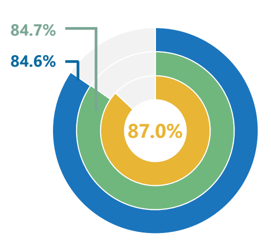
For comparison purposes, each metric is displayed at the city (NYC), borough (BK), and Council District (CD) level

PRIMARY CARE ACCESS

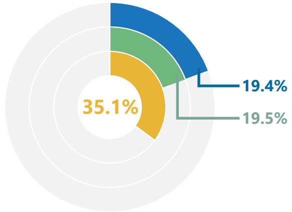
Primary care access is when a person is able to receive the primary care services needed that are timely, affordable, and in a geographically proximate location.



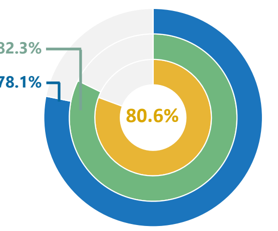
Primary Care Provider Availability
Number of PCPs per 10,000 people. This District has an estimated **4.0 PCPs per 10,000 residents**.



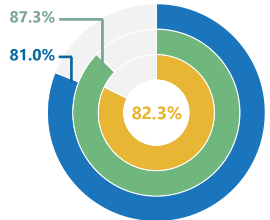
Health Insurance
87.0% of District residents have health insurance coverage



PCMH-Recognition
35.1% of the District's Primary Care Access Points are Patient-Centered Medical Home (PCMH)-Recognized



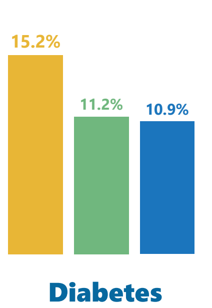
Medicaid Acceptance
80.6% of PCPs in the District accept patients with Medicaid



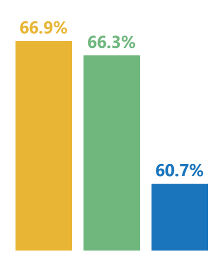
Medicare Acceptance
82.3% of PCPs in the District accept patients with Medicare

HEALTH STATUS

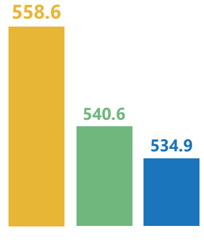
Health status indicates factors that impact a population's overall health, and the level of primary care services needed to address the health needs of a population.



Diabetes Prevalence
15.2% of District residents report having diabetes

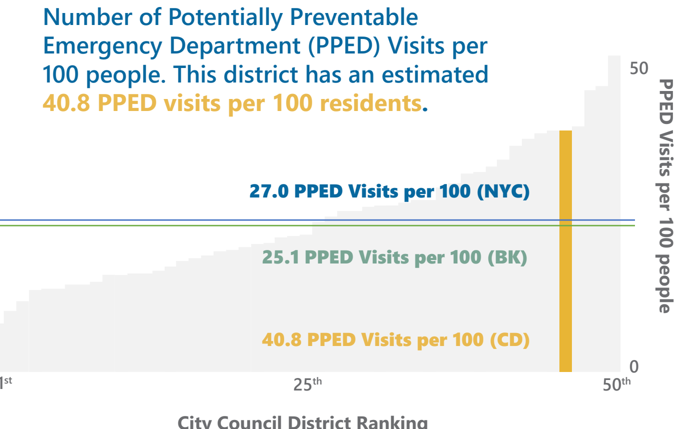


Lack of Immunization
66.9% of District residents have not received the influenza vaccine



Heart Disease Mortality
558.0 deaths per 100,000 District residents result from heart disease

Preventable ED Visits
Number of Potentially Preventable Emergency Department (PPED) Visits per 100 people. This district has an estimated **40.8 PPED visits per 100 residents**.

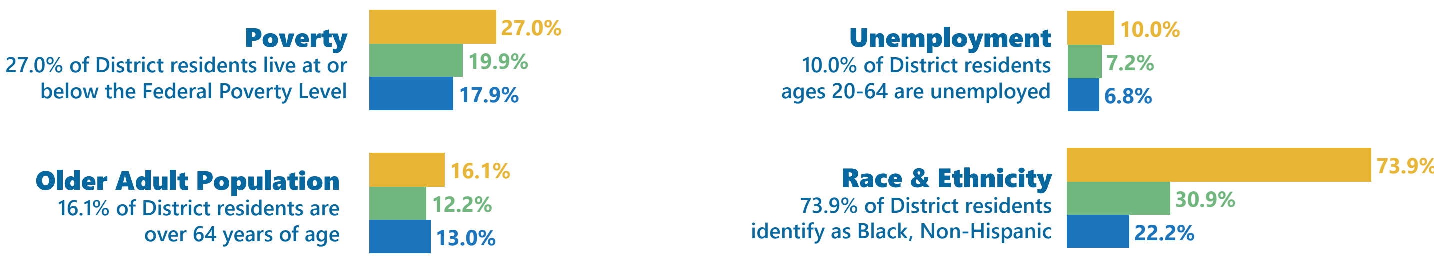


PRIMARY CARE DEVELOPMENT CORPORATION

CD | BK | NYC

SOCIOECONOMIC POSITION

Socioeconomic position refers to the social and economic factors that significantly contribute to existing health disparities, and is interdependent with the quality of available primary care and level of care continuity provided.



FACILITIES

The locations of key health care facilities within the District, including those for specific populations, are mapped to display the distribution of sites that deliver primary care and related services.

COUNCIL DISTRICT FACILITY COUNT	FACILITY TYPE	ALL DISTRICTS AVERAGE
25	Article 28	19
6	Federally Qualified Health Centers (FQHCs)	3
1	Title X Family Planning Program	1
5	Mental Health Treatment Centers	5
8	Drug and Alcohol Treatment Centers	6
1	School-Based Health Center	2
13	Patient-Centered Medical Home (PCMH) Access Point	12

Article 28
FQHC
Title X
SBHC
Drug and Alcohol Treatment
Mental Health Treatment
PCMH

APPROACHES & ACTIVITIES TO IMPROVE PRIMARY CARE ACCESS

Promoting quality primary care access among all individuals across NYC is critical to ensuring health equity, creating healthy communities, and reducing health care costs. This profile may serve to inform health care planning and future siting of health care facilities. The findings also support advocacy for additional services to encourage equitable access to primary care.

- Ensure sufficient amount of PCPs in every district.
- Take measures such as PCP-to-population ratio into account when siting and providing capital for primary care facilities.
- Work towards primary care access parity for districts with relatively low socioeconomic position.
- Encourage high-quality primary care provision and access through reimbursement models that reward proven quality programs, such as Patient-Centered Medical Home, and targeted capital grants and loans.

Primary Care Development Corporation

Founded in 1993 in New York City, PCDC is a nationally recognized nonprofit that catalyzes excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity. In New York State, PCDC has worked with hundreds of primary care organizations to expand access to high-quality primary care.

As a Community Development Financial Institution (CDFI), PCDC provides low-interest capital and expertise to build, renovate, and expand community-based health care facilities, supporting providers in delivering quality care to their patients in settings that promote dignity, respect, and wellness. PCDC also provides expert consulting, training, and coaching to help primary care practices adopt patient-centered models, care coordination, and integrated services; improve operations; incorporate coordinated care; leverage health information technology; and boost patient health outcomes.

PCDC works with key policy makers, trade associations, and industry leaders to advance policy initiatives that strengthen, sustain, and expand access to quality primary care. In a rapidly evolving health policy environment, PCDC brings both policy expertise and nearly a quarter century's experience investing in and strengthening primary care practices in NYS.

Technical Notes

For more information about data, measures, and methodology, please refer to the New York City Council District Profiles on our website: **pcdc.org**

Contact Information

Primary Care Development Corporation
45 Broadway, Suite 530
New York, NY 10006
Mary M. Ford, MS
mford@pcdc.org
212-437-3900
pcdc.org

Testimony for Health and Hospitals Committees
Joint Hearing on In.1668 and Resolution 0918
Thursday, October 31, 2019
Nathalie Interiano, Policy and Advocacy Manager

Thank you for the opportunity to provide testimony in favor of Intro 1668 and resolution 918 calling on the City and the State to expand health coverage for New Yorkers that do not qualify for federal programs.

My name is Nathalie Interiano and I am from Care For the Homeless. CFH has 35 years of experience providing medical and mental health services exclusively to people experiencing homelessness in New York City. We operate 24 federally qualified and state licensed community health centers in Manhattan, Brooklyn, Queens and the Bronx. Our service sites are co-located at facilities operated by other non-profits that include shelters for single adults and families, assessment centers, soup kitchens and drop-in centers. Additionally, our community-based health center model brings services directly to neighborhoods where the need is most significant. Both models reduce barriers homeless New Yorkers regularly face in navigating a complex health care system by increasing access to high quality care. All services are always provided, regardless of an individual's ability to pay. We serve 7,100 patients in 46,000 visits annually. 85% of our clients are at, or below, 100% of the federal poverty limit, 63% receive Medicaid, and 27% are uninsured.

We have often testified about the need to provide appropriate medical and mental health care to New Yorkers experiencing homelessness. Appropriate medical care includes preventative medicine, ongoing treatment, and specialty services such as podiatry, optometry and dentistry which are vital to vulnerable and often underserved populations. But people don't often have easy or convenient access to these essential services hindering opportunities to work, the ability to maintain healthy lives and to obtain and keep permanent housing.

We consider what we do a specialty because of how long it takes to gain the trust of our clients. Trust is something that we take very seriously, and, in this climate, it is imperative to not only increase access to medical services, but to provide access to the same high-quality services afforded to all New Yorkers. We applaud the City in its effort to introduce NYC Care to communities most in need and we are extra supportive of the initiative to include the vast network of community health centers located in the very communities where uninsured residents live. Community health centers, like CFH, have worked hard to gain the trust of the communities that we serve and are well equipped to carry out the NYC Care mandate.

Last year we had a mother and daughter come to our health center who had been using our services for many years. At the end of the visit we tried making a referral to an outside facility and the mother absolutely refused to go because she feared accessing any service outside of our facility would jeopardize her status in the United States. This was a necessary referral that she decided to forgo

because she did not trust another health care provider. Stories like these are not uncommon, and really speaks to the power that community health centers hold in providing the necessary services to address the health needs of a community.

Even as medical care is legally more accessible, the fact is we must work harder to provide access to vulnerable populations that often fall, or are excluded from, the safety net.

We want to thank both the Health and Hospitals Committees and City Council for your outstanding commitment to increasing access to health care for uninsured NYers. We look forward to partnering with you while continuing our mandate to provide high quality, comprehensive primary care services to anyone seeking care regardless of insurance coverage, income or immigration status. Thank you.

633 Third Avenue 10th Floor
New York, NY 10017
PH 212.254.8900
FAX 212.260.6218
www.cssny.org

David R. Jones
President & Chief Executive Officer

Steven L. Krause
Executive Vice President &
Chief Operating Officer

Testimony of the Community Service Society of New York in Support of Resolution 0918-2019 Coverage for health care services under the basic health program for individuals whose immigration status renders him or her ineligible for federal financial participation (S.3900/A.5974) before the New York City Council Committee on Health

October 31, 2019

The Community Service Society of New York (CSS) is grateful for the opportunity to provide comments on the proposed resolution in support of legislature pending before the New York State Legislature (A.5974/S.3900) that would allow all New Yorkers to enroll in the New York's Basic Health Plan, known as the Essential Plan, based on income and regardless of their immigration status. For the reasons outlined below, CSS strongly supports the resolution.

For 175 years, CSS has been an unwavering voice for low- and moderate-income New Yorkers. Our health programs help New Yorkers enroll into health insurance coverage, find healthcare if they are ineligible or cannot afford coverage, and help them use their coverage or otherwise access the healthcare system. We do this through a live-answer helpline and through our partnerships with over 50 community-based linguistically and culturally competent organizations throughout New York State. Annually, CSS and its partners serve approximately 130,000 New Yorkers. CSS also conducts high-level policy research that supports the needs of our constituents. Specifically relevant to this resolution, CSS authored a report, *How Can new York Provide Health Insurance Coverage to its Uninsured Immigrant Residents,* that outlined the costs and feasibility of offering the Essential Plan to New York's immigrant population.[1]

Since the implementation of the Affordable Care Act (ACA), New York has successfully cut its uinsurance rate in half—from 10% to 5% of the population. In fact, New York was one of just three states in the country that continued to see a decrease in its rate of uninsurance according to the most recent census data released last month.[2] Our success is attributed to a number of factors, including its state-of-the-art state-based Marketplace and its robust community-based Navigator program. But perhaps the single most important component of our

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[1] Elisabeth Benjamin, "How Can New York Provide Health Insurance Coverage to Its Uninsured Immigrant Residents? An Analysis of Three Coverage Options," January 2016, https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/Immigrant%20Health%20Report%20Web%202.pdf.

[2] Health Insurance Coverage in the United States: 2018, Current Population Reports, US Census Bureau, September 2019 Slide deck at slide 10, available at, https://www.census.gov/content/dam/Census/newsroom/press-kits/2019/iphi/presentation-health-insurance.pdf.

success is New York's implementation of the Basic Health Plan (Essential Plan) option under the ACA. The wildly popular Essential Plan offers free or $20 a month care, with no deductibles, for people earning up to 200 percent of the federal poverty level. To date, 780,000 New Yorkers have enrolled—nearly the entire eligible population.

Unfortunately, both federal and state immigration restrictions limit coverage options for the roughly 200,000 uninsured unauthorized adult immigrants who reside in our state—leaving them with no affordable options for comprehensive coverage. The proposed legislation (S.3900/A.5974) would remedy this situation because it would offer a state-funded version of the Essential Plan for everyone who meets the income requirements regardless of immigration status. There are several reasons why New York should take this landmark step.

First, New York should enact this bill because it has been a historic leader in offering coverage to its immigrant residents without federal assistance. For example, it was the first state to offer comprehensive Child Health Plus coverage to children no matter what their immigration status is up to age 19. And, most recently, New York City has expanded access to health care for all uninsured New Yorkers, including all immigrants, through the NYC Care Program.

Second, evidence from the implementation of the Affordable Care Act is pouring in and proving that health insurance improves health and financial well-being of individuals and communities.[3] At the individual level, numerous studies indicate that people without coverage are more likely than their insured counterparts to delay seeking preventive care and services for serious and chronic health conditions.[4] Surveys indicate that people without coverage report that they avoid accessing medical care for fear of costs associated with receiving treatment.[5] When they do seek treatment, it is of lower quality[6] and they are at higher risk of incurring medical debt and/or bankruptcy.[7] Recent research now shows that access to coverage is associated with

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[3] Center on Budget and Policy Priorities, "Chart Book: Accomplishments of Affordable Care Act," March 19, 2019, https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act.

[4] A. Wilper et al., "Health Insurance and Mortality in US Adults," *Am. J. of Pub. Health,* 99(12) 2289-2295 (2009); S. Collins et al., "Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief," The Commonwealth Fund, (2011), available at: http://www.commonwealthfund.org/Surveys/2011/Mar/2010-Biennial-Health-Insurance-Survey.aspx; J. Hadley, "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," *J. of the Am. Med. Ass'n.,* 297(10):1073-84 (2007); S. Rhodes et al., "Cancer Screening—United States, 2010," Centers for Disease Control, (2012), available at: http://www.cdc.gov/mmwr/pdf/wk/mm6103.pdf

[5] *See, e.g.,* R. Riffkin, "Cost Still a Barrier Between Americans and Medical Care, Gallup, (Nov. 2014) available at: http://www.gallup.com/poll/179774/cost-barrier-americans-medical-care.aspx; Community Service Society of N.Y., "Findings from a Statewide Poll on Health Reform in New York," (Feb. 2008).

[6] J. Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Med. Care Res. and Rev.* 60: 3S-75S (June 2003); D. Baker et al., "Lack Of Health Insurance And Decline In Overall Health In Late Middle Age," *New Eng. J. of Med.,* 345:1106-112 (Oct. 2001).

[7] A. Finkelstein et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," *The Q. J. of Econ.*, Oxford University Press, vol. 127(3), at 1057-1106 (2012); D. Himmelstein et al., "Medical bankruptcy in the

significant reductions in mortality[8] and improvements in mental health,[9] at least in part due to higher continuity of care.[10]

Finally, lack of coverage for a significant portion of New York's population also causes problems for the broader health care system because it causes payers and providers to charge more to the insured population in order to offset the losses in providing care to the uninsured.[11] In 2015, economists at the National Bureau of Economic Research attributed uncompensated care costs associated with the uninsured to be approximately $900 per person per year.[12] Presumably, these costs have risen in the ensuing four years.

For all these reasons, CSS enthusiastically encourages the New York City Council to pass this important resolution. Thank you again for considering our comments. Should you have any questions or seek further elaboration, please do hesitate to contact me at: jpinzon@cssny.org or 212-614-5353 or Elisabeth Benjamin at: ebenjamin@cssny.org or 212-614-5461.

United States, 2007: Results of a National Study." *Am. J. of Med.* 122(8):741-6 (2009), available at: http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.

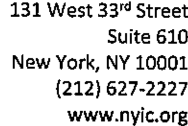
[8] B. Sommers et al., "Changes in Mortality After Massachusetts Health Care Reform: A Quasi-experimental Study," *Annals of Internal Med.*, vol. 160(9) at 585 (2014); Institute of Medicine, *America's Uninsured Crisis: Consequences for Health and Health Care,* National Academies Press, at 60-63 (2009).

[9] K. Baicker et al., "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes," *New Eng. J. of Med.*, 368: 1713-1722 (2013).

[10] J. Hadley, *supra* n. 12.

[11] Estimates of cost shifting vary from 1.7% of private health insurance costs, or $14 billion (Hadley) to 4.6%, or $3.9 billion (Kaiser Commission on Medicaid and the Uninsured). *See* J. Hadley et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, And Incremental Costs," *Health Aff.*, vol. 27(5):406 (2008); T. Coughlin et al, "Uncompensated Care for Uninsured in 2013: A Detailed Examination," Kaiser Commission on Medicaid and the Uninsured, at 23-24 (May 2014).

[12] C. Garthwaite et al, "Hospitals as the Insurers of Last Resort, Working Paper 21290, National Bureau of Economic Research," June 2015.


131 West 33rd Street
Suite 610
New York, NY 10001
(212) 627-2227
www.nyic.org

The New York Immigration Coalition
Testimony on NYC Care Oversight, Int. 1668 and Res. 0918
Committees on Hospitals and Health

Max W. Hadler, MPH, MA

October 31, 2019

Good Afternoon. My name is Max Hadler and I am the Director of Health Policy at the New York Immigration Coalition (NYIC). The NYIC is an advocacy and policy umbrella organization for more than 200 multi-ethnic, multi-racial, and multi-sector groups across the state working with immigrants and refugees.

Thank you to Committee Chairs Carlina Rivera and Mark Levine for calling this hearing and for the opportunity to testify before the committee. I'd like to address three issues today:

1) The NYIC's view of progress on the NYC Care program;
2) Introduction 1668 to broaden the scope of the city's existing access-to-care program; and
3) Resolution 0918 in support of bills in the New York State Legislature that would create a state-funded Essential Plan insurance program for undocumented adults.

NYC Care

There are an estimated 600,000 New Yorkers without health insurance, about half of whom are undocumented immigrants. NYC Care launched in August with the goal of improving access to care for those individuals. While New York City already has a strong network of providers who care for our city's residents regardless of immigration status, insurance coverage, or income, lack of health insurance has a profound effect on the ability to access care in a continuous and timely manner. NYC Care was created to direct many of these individuals to care earlier and in a way that promotes their wellbeing.

At the NYIC we appreciate Mayor de Blasio for standing by immigrant communities with a powerful message of inclusion and taking this important step to create a program that is gradually meeting some of the health needs of uninsured New Yorkers. From the outset we have said that the methodical 17-month rollout of the program and the $100 million investment are insufficient. We stand by that view, but we are also encouraged by the progress that has been made to date in achieving initial enrollment goals in the Bronx and the upcoming expansion to Brooklyn and Staten Island. The expanded pharmacy hours have also proven helpful with higher-than-expected utilization in the first few months.

The NYC Care team at Health + Hospitals has done an admirable job getting the word out about the program and connecting with community-based organizations citywide, including but not limited to the CBOs that have been funded to do NYC Care-specific outreach. We strongly encourage the City to continue funding CBOs to do outreach on a longer-term basis than the initial six-month contracts in the Bronx. We also look forward to seeing to fruition the effort to allow community-based health insurance navigators to enroll community members directly into NYC Care once screened for coverage rather than forcing patients through additional financial counseling hurdles at H+H.

Given the slow rollout of NYC Care, we urge H+H, and the Council in its oversight role, to ensure that data are regularly made public on important program progress parameters, including but not exclusive to:

- total enrollment by age, gender, preferred language, geography;
- clients deciding not to enroll because of public charge or other immigration-related concerns;
- indications that the collaborative care model is leading to increased access to mental health services;
- volume and types of calls to the customer service line; and
- program spending.

Introduction 1668

Similar to our concern about the slow rollout of NYC Care, we have from the beginning expressed reservations about limiting a new citywide access-to-care program to H+H sites. The ActionHealthNYC pilot clearly demonstrated the integral role that community health centers play in health access and continuity of care. Improving linkages between community health centers and H+H must continue to be a priority in working to improve access to care for uninsured New Yorkers. Introduction 1668 provides a framework for doing so, and we thank Councilmember Levine for launching this important effort.

While the NYIC supports Introduction 1668, we would like to see it build upon the existing structure of NYC Care now that the city has launched the program. We also believe that any funding necessary to implement Introduction 1668 must be an addition to the "at least" $100 million in annual funds already committed to the existing NYC Care program. The expansions described in Introduction 1668 cannot be achieved with the existing funding. Given the need to identify payment mechanisms for other participating providers, this additional funding would represent a significant investment. We urge the Administration and Council to work together to identify ways to make this a financial reality.

We also believe that the navigator and telemedicine provisions of Introduction 1668 merit further definition and investigation, and if adopted, that they be fully funded to meaningfully improve access to care for all uninsured New Yorkers.

Again, we believe the effort to include community health centers, which already provide high-quality care to so many uninsured New Yorkers in areas beyond H+H's reach, is a critical one. It is hard to imagine a truly successful effort to guarantee comprehensive health access in New York City that does not include providers beyond H+H.

Resolution 0918

Finally, we would like to enthusiastically endorse Resolution 0918 and thank Councilmember Adrienne Adams as prime sponsor, as well as members of the Women's Caucus for cosponsoring the resolution and Committee Chair Levine for bringing it up for consideration. The resolution calls on the State of New York to pass, and the Governor to sign, S.3900/A.5974, which would create a state-funded Essential Plan insurance program for New Yorkers whose immigration status makes them ineligible for the current Essential Plan or for any other type of affordable health insurance coverage. This discriminatory exclusion currently affects more than 400,000 New Yorkers, yet the state refuses to act on this injustice and move toward universal coverage. In doing so, it continues to threaten the lives of people who have limited access to coverage. It also does a disservice to the state's health care providers, most prominently H+H. In total, the state's providers would stand to save about $130 million annually in uncompensated care costs if this coverage expansion were approved.

The NYIC is one of the co-leads of the Coverage4All campaign, which worked for these bills to be introduced and has been advocating for several years for the state to take action on them. We greatly appreciate the Council's consideration of this resolution and strongly urge its passage as a public and official declaration of the Council's willingness to stand behind all of the state's undocumented and mixed-status families and their right to affordable health care.

While Governor Cuomo and the state Legislature sit on their collective hands as hundreds of thousands of city and state residents go without health insurance, it is gratifying to see the City – both the Administration and the Council – take action to improve access to care for immigrant New Yorkers. We appreciate your efforts and look forward to continuing to work with you until all New Yorkers have access to timely, affordable, high-quality health care. Thank you for the opportunity to testify today.

New York City Council Committees on Health and Hospitals

Joint Hearing on Int. 1668

October 31, 2019

Thank you for the opportunity to provide testimony today in favor of Intro. 1668. My name is Rose Duhan and I am the President and CEO of the Community Health Care Association of New York State (CHCANYS), the Primary Care Association for federally qualified health centers (FQHCs).

Health Centers are New York City's Primary Care Safety Net

CHCANYS is the voice of community health centers that serve as leading providers of primary care in New York State. We work closely with more than 70 FQHCs, also known as community health centers, that operate over 800 sites statewide. FQHCs are non-profit, community run clinics located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking it, regardless of their insurance status or ability to pay. All health centers are required to have a sliding fee scale for patients under 200% of the federal poverty limit. Federal law also mandates that a majority of health center board members be patients of that health center, ensuring that the center is reflective of and responsive to their community.

The 500 community health center sites in New York City, scattered throughout all five boroughs and in nearly every community district, create an expansive primary care safety net. 1.4 million, or one in seven, New Yorkers receive care at a community health center. Health centers are experts at providing care to those most in need- more than 90% of health center patients in New York are below 200% of the federal poverty limit, 62% receive Medicaid, and 16% are uninsured. Last year, New York health centers served 220,000 uninsured New Yorkers, approximately one-third of all uninsured residents.

Community health centers are more than just a doctor's office- they provide a full range of

culturally appropriate, comprehensive health and support services, including physical health, behavioral health and dental services and enabling services like transportation, case management, insurance enrollment assistance, and health education. While all health centers are required to provide care to anyone seeking it, some health centers have special expertise in serving certain populations-- like people experiencing homelessness, migrant farm workers, refugees and people from the LGBTQI community. Community health centers also operate approximately 125 school-based health centers in New York City.

CHCANYS Support for Intro. 1668

CHCANYS is pleased to support Intro. 1668, which would create a health access program in New York City aimed at bringing the over 600,000 uninsured New Yorkers into care. Under the program, enrollees would be offered a medical home providing comprehensive primary care in their community district and a patient navigator to assist them in accessing services. CHCANYS has also been supportive of the recently implemented NYC Care, which seeks to connect uninsured patients with providers at one of the more than 30 Gotham Health sites. Gotham Health, a federally qualified health center and member of CHCANYS, is a critical component of the expansive network of New York City health centers, providing comprehensive primary care services to hundreds of thousands of New Yorkers every year. We work closely with Health and Hospitals and Gotham leadership and have appreciated their transparency and open communication with CHCANYS and the other New York City health centers as NYC Care has gotten underway.

CHCANYS urges the City Council to work with the Administration to build on the early successes of the NYC Care program by leveraging the breadth and expertise of the 500 community health centers sites throughout the City. Of the 43 Council Districts with health center sites in them, approximately one third have Gotham Health sites. The remaining 27 Districts have health centers operated by another community health center organization. All health centers share a common mandate, however- to provide high quality, comprehensive primary care services to anyone seeking care, regardless of insurance coverage, income, or immigration status. CHCANYS is appreciative of Intro. 1688's effort to design a health access

program that incorporates all of New York's community health centers.

A coordinated health access program, such as the kind envisioned by Intro. 1668, would facilitate access to primary and preventive care, as well as care for chronic conditions. People who are both poor and uninsured are more likely to delay needed medical care for chronic diseases, less likely to fill a prescription, and more likely to be hospitalized for a condition that could have been otherwise avoided with timely health care. Uninsured persons receive less preventive care, are diagnosed at a more advanced stage of illness and, once diagnosed, tend to receive less therapeutic care and have a higher mortality rate. Lack of insurance leads to higher rates of emergency room use, especially for conditions that could have been mitigated early or treated more efficiently in a primary care setting. Studies have shown that access to coordinated health care services through a health access program reduces reliance on more costly forms of care, such as emergency departments, and increases the number of uninsured patients who report having a usual source of care.[1]

CHCANYS looks forward to working with the Council and the Administration to ensure that Intro. 1668 utilizes and enhances the City's strong primary care safety net. We wholeheartedly support enhancing access to care throughout New York City by leveraging the full complement of community health centers in all five boroughs. CHCANYS supports Intro. 1668 and urges the Council and the Administration to design a health access program that supplements existing state and federal community health center funding, such as the Health Center Program Funding and New York Safety Net Funding, aligns with federal sliding fee scale requirements at community health centers, and supports the health center mandate to provide care to anyone who seeks it, regardless of insurance status or income.

Thank you for the opportunity to speak to you today. I am happy to answer any questions.

[1] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0003

FOR THE RECORD

Official Testimony for City Council Committee on Health and Committee on Hospitals
Joint Hearing on Intro. 1668
Thursday, October 31, 2019

Community Healthcare Network (CHN) is pleased to submit testimony in favor of Intro. 1668, which would expand access to healthcare for over 600,000 uninsured New Yorkers by incorporating community health centers and patient navigation into the City's Health Access program.

CHN is a non-profit network of 14 Federally Qualified Health Centers (FQHCs), including two school-based health centers and a fleet of medical mobile vans. We provide affordable, integrated primary care, behavioral health, dental, and social services to over 85,000 New Yorkers annually in Manhattan, Queens, Brooklyn, and the Bronx. We turn no one away.

Since 1981, CHN has provided a range of healthcare services to historically underserved communities. Over time, we have expanded our scope of services and identified unique ways to meet our patients where they are. In doing so, we have established an invaluable connection with our communities built on trust and respect. This is the hallmark of community health centers.

Any program aimed at increasing access to and engagement in care among underserved populations would be remiss to not draw upon the strength of community-based institutions. FQHCs offer a valuable source of primary care for un- and underinsured patients and retain strong ties with medically-underserved populations.

Critically, FQHCs are a trusted source of care for immigrant communities. In the wake of federal attacks on immigrants – and health and social services more broadly – FQHCs play an integral role in providing services to increasingly vulnerable and often uninsured populations.

While the Mayor's NYC Care initiative has been a promising first step towards increasing access to care for uninsured patients, it does not leverage the influence of long-standing community-based institutions. Intro. 1668 helps build upon this effort by leveraging the work that FQHCs are already doing, further increasing access to primary care and social services.

CHN proudly supports Intro. 1668 and urges the Council to ensure that the Health Access program (1) does not add burdensome administrative requirements for clinical providers and (2) supports greater coordination between Health + Hospitals and FQHCs.

We thank Speaker Johnson, Chairperson Levine, Chairperson Rivera, and the Committees for their ongoing support of community health centers and look forward to continuing our work alongside the City Council to better serve populations throughout New York City.

Testimony of Andrea Bowen
before the New York City Council

Committee on Health
Mark Levine, Chair

Committee on Hospitals
Carlina Rivera, Chair

October 31, 2019

My name is Andrea Bowen, Principal of Bowen Public Affairs Consulting. I'm a transgender woman, and a coordinator of the transgender, gender non-conforming, and non-binary, or TGNCNB, Solutions Coalition, which advocates for community-based economic justice and anti-violence strategies to support TGNCNB New Yorkers. Thank you Chairs Levine and Rivera, bill sponsors, Council Members, and staff of the Committees on Health and Hospitals, for giving me the opportunity to speak today. Thank you, also, for your stalwart support of health care efforts for the TGNCNB community, including your amazing advocacy for the creation and baselining of the LGBTQ Community Outreach Workers program within H+H.

I am testifying today to emphasize a few points of deep importance to the TGNCNB Solutions Coalition, relating to NYC Care, Int. No. 1668, and Res. No. 918-A:

- **Regarding NYC Care:** It is of paramount importance to our coalition that NYC Care cover transition-related care, being care that is specific to the needs of the TGNCNB community. We intend to work with H+H to outline which transition-

related care treatments are covered by NYC Care—a project that has not begun in earnest yet—but today want to highlight, for Council, this path of advocacy.

- **Regarding Intro 1668:** We support Intro 1668's effort to ensure a widespread and localized system of primary care provision throughout the five boroughs. Our major request is that § 17-1902(b) be amended to ensure that patients of medical homes are provided information about other health resources that may be population specific, e.g., LGBTQ Community Outreach Workers, and that the reporting provided to the Speaker in this section note the frequency of referrals from medical homes to the aforementioned type of population-specific health resources, and the extent to which population-specific health resources were provided by medical homes. This will allow the city to track the extent to which these medical homes are providing resources on population-specific medical needs. Below is recommended amended language to Intro 1668, § 17-1902(b), in underline, that aims to effectuate the intent mentioned in this testimony.

  1. The health access program shall offer individuals a medical home and shall assign each participant a patient navigator. Patient navigators are required to provide patients a directory with names, titles, recent contact information, and position descriptions of other staff within New York City's health care system that serve a navigator role, or similar, for specific populations, including but not limited to the Health and Hospitals Corporation's LGBTQ Community Outreach Workers.

  [...]

3. The department shall ensure that a medical home is provided in each community district and that at least one participating acute care hospital providing specialty services is provided in each borough. The department, one year after the effective date of the local law that added this section, shall issue a report to the Speaker of the City Council and post on the department website listing any community districts in which the department failed to establish a medical home as well as any borough in which the department failed to provide an acute care hospital and the reasons for such failure. The department shall also, within the same report, provide data on which medical home patient navigators have made referrals to other population-specific patient navigators or similar position as mentioned in § 17-1902(b)(1), with specific data reported on which medical homes have made referrals to particular population-specific resources, and which population-specific resources have been utilized via referral from medical homes.

- **Regarding Res. No. 918-A:** We support this resolution, as we believe it vital that immigrants, regardless of immigration status, be eligible for coverage of health care services. Following New York State's requirements for private insurance (Forty Ninth Amendment to 11 NYCRR 52[1]) this plan should allow for coverage

[1] New York State Department of Financial Services (2018). Forty-Ninth Amendment to 11 NYCRR 52 (Insurance Regulation 62), "Minimum Standards for Form, Content and Sale of Health Insurance, Including Standars for Full and Fair Disclosure," available at https://www.dfs.ny.gov/docs/insurance/r_finala/2018/rf62a49txt.pdf (accessed 30 October 2019)

of transition-related care.[2] New York is home to TGNCNB people of varying immigration statuses, and transition-related care should not be denied to anyone, regardless of status. We support City Council adding a clause to the resolution: Whereas, people regardless of immigration status have a right to transition-related care, or health care that is specific to transgender, gender non-conforming, and non-binary (TGNCNB) people, and that an Essential Plan for all New Yorkers should cover transition-related care for people of all immigration statuses.

Thank you, Chairs Levine and Rivera, bill sponsors, committee members, and Council staff for your time and consideration. If you have any questions about my testimony, you can contact me at andy@bowenpublicaffairs.com.

[2] For a clear articulation of NYS law relating to insurance coverage of transition-related care, see Health Care for All New York LGBT Task Force (2017) "Factsheet: Coverage for Transgender New Yorkers: Navigating Private Insurance to Get the Care You Need," available at http://hcfany.org/wp/wp-content/uploads/2017/07/HCFANY-TransCareFactSheet-FINAL.pdf (accessed 30 October 2019)

ALLIANCE FOR HEALTHY COMMUNITIES NORTH AND CENTRAL BROOKLYN (AHC-NCB)

Bedford Stuyvesant Family Health Center
Patricia Fernandez, *Chief Executive Officer*

Brooklyn Plaza Medical Center
LaZetta Duncan-Moore, *Chief Executive Officer*

Brownsville Multi-Service Family Health & Wellness Centers
Harvey Lawrence, *Chief Executive Officer*

October 31, 2019 – 10:00 am

Good morning, Chairman Mark Levine and Members of the NYC Council Committee on Health and the Committee on Hospitals.

My name is ADELE FLATEAU and I am here to testify on behalf of the **Alliance for Healthy Communities-North and Central Brooklyn** ("The Alliance"). The Alliance is a partnership of three (3) Federally Qualified Health Centers (FQHCs) in Brooklyn which are also members of the Community Health Care Association of NYS (CHCANYS). The three centers and their respective Chief Executive Officers are: Bedford Stuyvesant Family Health Center (Patricia Fernandez, Chief Executive Officer); Brooklyn Plaza Medical Center (LaZetta Duncan-Moore, Chief Executive Officer); and Brownsville Multi-Service Family Health & Wellness Centers (Harvey Lawrence, Chief Executive Officer).

I am here as the Project Consultant for the Alliance because they are not able to attend this important hearing and have asked me to testify on their behalf regarding **Intro. 1668 - Health Access Program.** By way of background, I have 30 years of experience working directly in health care as an executive as well as being a community advocate. I've held senior-level positions in the private sector as well as the public sector for NYC Health + Hospitals, from which I am now retired.

The Alliance would like to first express its complete endorsement of the testimony presented by CHCANYS and the crucial issues they have raised about the need for improved access to care throughout New York City. As they pointed out, the 500 sites operated by FQHCs in New York City provide a vital role in serving the medically under-served. More than 90% of our patients are below 200% of the federal poverty limit and many of them are uninsured. Like CHCANYS, we believe that it is wise public health policy to provide access to care for those who are most vulnerable and face difficult socio-economic conditions. As they pointed out in their testimony, *"Uninsured persons receive less preventive care, are diagnosed at a more advanced stage of illness and, once diagnosed, tend to receive less therapeutic care and have a higher mortality rate. Lack of insurance leads to higher rates of emergency room use, especially for conditions that could have been mitigated early or treated more efficiently in a primary care setting."*

The Alliance health centers serve the communities of North and Central Brooklyn, with the majority of patients living in **Community Districts 2 (**Fort Greene), **CD-3** (Bedford-Stuyvesant), **CD-5** (East New York) and **CD-16** (Brownsville). Our communities, predominantly Black and Latino, face excessive rates of Late or No Prenatal Care; Childhood Asthma ER visits; Child and Adult Obesity; New HIV Diagnoses; Psychiatric Hospitalizations; and Premature Death Rates before age 65.

According to data provided by the NYC Department of Health and Mental Hygiene, 2018 Community Health Profiles, the Alliance Health Centers are facing some of the most drastic health outcomes, mortality rates and disparities in New York City:

- In Brownsville (Community District 16)), 13.3% of women have **Late or NO Prenatal Care** – double the 6.7% rate for NYC overall.
- In all of our Districts, **Childhood Asthma Emergency Room visits** (ages 5-17) exceed NYC overall; with extremely high rates for Bedford-Stuyvesant (CD-3) and Brownsville (CD-16).
- **Childhood Obesity** rates in Bedford-Stuyvesant (22%), Brownsville (23%) and East New York (25%) exceed NYC overall, which is 20%. This means more than one out of every 5 children in grades K-8 are considered obese.
- **New HIV Diagnoses** rates have reached alarming rates in Bedford-Stuyvesant (55.1 per 100,000 population), Brownsville (67.4) and East New York (38.1) – compared with NYC (24 new HIV diagnoses per 100,000 population).
- **Premature Death Rates before age 65** "summarize" the health inequities facing our communities. The rate of premature death per 100,000 population is 169.5 for NYC overall, while it is 178.7 for CD-2; 283.8 for CD-3; 264.8 for CD-5 and an astounding rate of 365.1 for CD-16, more than double NYC's rate.

All of this data underscores the critical need for the proposed **Intro. 1668, Health Access Program,** and for improving prevention services. It is not simply a good idea but will enhance both the quality of life and the length of life for thousands of New Yorkers -- while also reducing health care costs and unnecessary utilization of Hospitals and Emergency Rooms. Historically, this has been our mission and we have developed

many innovative, community-based services to improve health and mental health outcomes. We have extensive partnerships with other institutions such as educational; vocational/employment; faith-based; artistic/therapeutic programs; food and nutrition services. However, the proposed program would be a much-needed complement to our existing services.

We urge the NYC Council and the Administration to develop and implement a health access program which will be integrated with the vital safety net services of FQHCs. Thank you for the opportunity to speak with you today on behalf of the **Alliance for Healthy Communities – North and Central Brooklyn.**

# # #

CONTACTS:

HARVEY LAWRENCE
President & CEO
Brownsville Multi-Service Family Health & Wellness Centers
Email: hlawrence@bmsfhc.org
Tel: 718-345-5000

ADELE FLATEAU
Project Consultant
The Alliance for Healthy Communities
Email: amflateau@gmail.com
Tel: 917-702-5112

Amf: ALLIANCE-NCB_NYC-Council-TESTIMONY-2_103019

26 Bleecker Street
New York, NY 10012
p: 212.274.7200 · f: 212.274.7276
www.ppnyc.org

Testimony of Planned Parenthood of New York City
Before The New York City Council Committees on Health and Hospitals Regarding the Health Access Program and Expansion of the New York State Essential Plan
October 31st, 2019

Good afternoon, my name is Carmina Bernardo and I am the Senior Director of Public Policy and Regulatory Affairs at Planned Parenthood of New York City. I would like to thank Committee Chairs Council Members Mark Levine and Carlina Rivera for holding this important oversight hearing on health access in New York City.

Planned Parenthood of New York City (PPNYC) has been a leading provider of sexual and reproductive health services in New York City for more than 100 years, conducting over 90,000 patient visits per year. . PPNYC provides a wide range of health services including access to birth control; emergency contraception; gynecological care; cervical and breast cancer screenings; colposcopies; male sexual health exams; testing, counseling, and treatment for sexually transmitted infections; the HPV vaccine; HIV testing and counseling; and pregnancy testing, options counseling and abortion. We also provide PrEP and PEP, transgender hormone therapy, vasectomies, and, recently, menopausal hormonal therapy. We are a trusted name in health care because of our commitment to comprehensive, inclusive care.

In addition to our clinical services, PPNYC has a robust education department, reaching more than 26,000 youth, adults and professionals across New York City annually. Our programs provide tools to help our participants make informed decisions and lead healthy and safe lives. Our education programs are committed to reaching young people and caring adults in the communities they live.

Resolution 918

PPNYC proudly supports Res. No. 918 which calls on the New York State Legislature to pass and the Governor to sign A.5974/S.3900. Thise bill would establish a state- funded Essential Plan and allow more individuals to enroll in a public health insurance plan, regardless of their immigration status. The enactment of the Affordable Care Act led to an unprecedented rise in individuals eligible for health care. However, many New Yorkers are barred from obtaining public coverage through the New York State of Health Marketplace because of their immigration status, leaving over 400,000 individuals in the state with limited access to care[1]. Currently, the federally funded Essential Plan that exists in New York allows for individuals whose household incomes are below two hundred percent of the federal poverty line[2]. A New York State funded

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[1] Legislative Priorities. (n.d.). Retrieved October 23, 2019, from https://www.coverage4all.info/legislative-priorities.

[2] Essential Plan Information. (2019, August 12). Retrieved October 21, 2019, from https://info.nystateofhealth.ny.gov/essentialplan.

Essential Plan could allow for an additional 100,000 individuals to enroll in affordable health care coverage.

As a trusted health care provider, we see firsthand the challenges and barriers immigrant New Yorkers face when accessing care. Immigrant New Yorkers make up 37% of our city's population, yet are less likely to be insured and receive routine preventive care than other New Yorkers[3]. Due to gains made by the Affordable Care Act, the percentage of foreign-born adults without insurance in New York has markedly decreased, however, nearly half a million uninsured unauthorized immigrants in the state continue to face severely limited coverage options[4]. The expansion of the Essential Plan allows for all New Yorkers, regardless of their immigration status, to enjoy the benefits of the existing Essential Plan to which only citizens or lawful residents have access.

Studies show that when individuals have access to quality health care, they are less likely to be sick, develop a disability, visit the emergency room, or die prematurely[5]. Additionally, limited access to health care can lead to lost wages, lower levels of productivity, force individuals to be increasingly absent from work, and generally raise the price of providing health care in the long run[6]. It also forces health care systems to provide uncompensated care, which can ultimately destabilize health care access in communities most in need.

Introduction 1668

PPNYC believes that high quality healthcare is a human right and we support Intro. 1668 and the creation of a Health Access Program that would expand access to health care services at Health + Hospital facilities, non-for-profit and private medical providers, regardless of immigration status, employment status or preexisting conditions. As an organization that is committed to meeting patients where they are, we are thrilled to see the City of New York commit to a Medical Home model that encourages providers and care teams to meet patients where they are, addressing all conditions, regardless of severity.[7] By implementing a program using the Medical Home model, the City of New York is reiterating their commitment to providing quality care that is medically-based, patient-centered, comprehensive, accessible, and culturally competent.

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[3] The Newest New Yorkers - 2013 Edition." (2013). NYC Department of City Planning. Retrieved from https://www1.nyc.gov/site/planning/data-maps/nyc-population/newest-new-yorkers-2013.page
[4] NYC DOHMH. "Immigrant Health—Insurance Status and Access to Preventive and Primary Care in New York City." (July 2016). NYC Vital Signs, Vol. 15, No. 3. Retrieved from https://www1.nyc.gov/assets/doh/downloads/pdf/survey/survey-2016-immigrant-health.pdf.
[5] Access to Health Services. (n.d.). Retrieved October 23, 2019, from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services.
[6] Porter, E. (2017, June 27). When Cutting Access to Health Care, There's a Price to Pay. Retrieved October 23, 2019, from https://www.nytimes.com/2017/06/27/business/economy/health-care-senate-mortality.html.
[7] American Academy of Family Physicians (2007). "Joint Principles of the Patient-Centered Medical Home." Retrieved from https://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf

26 Bleecker Street
New York, NY 10012
p: 212.274.7200 · f: 212.274.7276
www.ppnyc.org

Additionally, we strongly support the implementation of patient navigation services in addition to the Medical Home through the Health Access Program. Studies show that navigation programs and linkage to care and service programs eliminate disparities that arise as a result of employment status, housing type and marital status[8]. Implementing patient navigation services throughout New York City will provide a means to receive the support, referrals and the connections necessary to access care for our most disenfranchised individuals.

Planned Parenthood is committed to ensuring that all individuals have access to high quality care and we strongly support the implementation of a Health Access Program that--if implemented correctly-- will help secure access to primary health care services. However, we do have outstanding questions about the implementation of the program, specifically about the structure of the medical home, the range of services that will be covered and the requirements for participation in the Health Access Program.

Patient navigation has proven to be extremely effective at addressing systemic barriers that affect healthcare. Given this, we believe that it is important for the City of New York to consider the following:

- What patient navigation principles will the Health Access Program follow?
- How will Patient Navigators be assigned to patients? What factors will be evaluated to determine the need patient navigation services?

Additionally, we would like more information about the structure of the medical home, particularly:

- What structure will be used to establish a "medical home"?
- What is the criteria for the medical home?
- What is the criteria to be the primary provider acting as the lead agency in coordinating care?
- How will social and environmental concerns be implemented into the medical home model? How will they be addressed? How will referrals be made?

At PPNYC we are committed to increasing access to healthcare on all fronts, and removing barriers that restrict access. Given this priority, we would like to know who will be eligible for the Health Access Program and what services will be provided, specifically:

- Is there a New York City Residency Requirement to participate in the Health Access Program?

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[8] Rodday, A. M., Parsons, S. K., Snyder, F. , Simon, M. A., Llanos, A. A., Warren-Mears, V. , Dudley, D. , Lee, J. , Patierno, S. R., Markossian, T. W., Sanders, M. , Whitley, E. M. and Freund, K. M. (2015), Impact of patient navigation in eliminating economic disparities in cancer care. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1002/cncr.29612.

Planned Parenthood of New York City

26 Bleecker Street
New York, NY 10012
p: 212.274.7200 · f: 212.274.7276
www.ppnyc.org

- What services will be included under the Health Access Program? Will the full range of sexual and reproductive health care services be covered?
- What is the criteria for the sliding-fee scale?

Conclusion

Especially with constant attacks from the federal government on immigrants, we must stand up to ensure all New Yorkers have access to quality care. Earlier this year, the Trump-Pence Administration made changes to the Public Charge rule. These changes dramatically expanded the scope of government benefits considered when determining who is a public charge, which would barr millions of individuals from adjusting their immigration status. Fortunately, this is tied up in the courts and not in effect. Additionally, the Administration implemented changes to the Title X Family Planning program, the nation's only federal funded grant program dedicated to providing sexual and reproductive health services to low-income and uninsured individuals. Title X serves 4 million people each year, regardless of immigration status and has been a vital resource to immigrants seeking quality health care but ineligible for coverage through the Affordable Care Act.

Given our current political climate, it is important that New York City ensure that all people have access to the best health care for themselves and their families. We applaud the New York City Council for making an effort to protect the rights of marginalized groups and safeguarding their access to health care. The implementation of Coverage for All and the Health Expansion Program would ensure that all individuals, including those who are presently uninsured or undocumented, have access to health care and a range of options for where they can seek care. PPNYC enthusiastically supports Resolution No. 918 and Introduction No. 1668.

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Since 1916, Planned Parenthood of New York City (PPNYC) has been an advocate for and provider of sexual and reproductive health services and education for New Yorkers. Through a clinical services, education, and advocacy, PPNYC is bringing better health and more fulfilling lives to each new generation of New Yorkers. As a voice for sexual and reproductive health equity, PPNYC supports legislation and policies to ensure that all New Yorkers will have access to the full range of sexual and reproductive health care services and information

October 31, 2019

Good morning. My name is Arline Cruz and I am the Health Programs Manager at Make the Road New York (MRNY). Thank you for giving us the opportunity to provide testimony today on the Essential Plan Expansion through Coverage 4 All and the NYC care bills.

Make the Road New York is a non-profit community-based membership organization with over 24,000 low-income members dedicated to building the power of immigrant and working class communities to achieve dignity and justice through organizing, policy innovation, transformative education, and survival services. We operate five community centers in Brooklyn, Queens, Staten Island, Long Island, and Westchester County.

MRNY's services teams, which includes legal, health, and adult education, serves thousands of immigrants each year to assist their ability to thrive in their communities. We provide direct legal representation, case management, and facilitated enrollment into public health insurance programs, training, and strategic support for members and organizing campaigns.

Essential Plan Expansion:

MRNY fully supports the City Council's resolution in support of Coverage 4 All's bills (A5974/S3900) to create a state-funded Essential Plan for ALL New Yorkers up to 200% of the federal poverty level, regardless of immigration status. Make the Road New York co-founded and co-leads the Coverage for All Campaign, along with the New York Immigration Coalition.

Every year MRNY serve hundreds of uninsured New Yorkers who are anxiously awaiting to be able to enroll in health insurance, since they are currently not eligible because of their immigration status. Even without access to health insurance, they understand the cost saving and life-saving implications for access to care. Yet, health insurance discrimination based on immigration status affects more than 400,000 New Yorkers and it needs to end NOW.

BROOKLYN
301 GROVE STREET
BROOKLYN, NY 11237
718 418 7690

QUEENS
92-10 ROOSEVELT AVENUE
JACKSON HEIGHTS, NY 11372
718 565 8500

STATEN ISLAND
161 PORT RICHMOND AVENUE
STATEN ISLAND, NY 10302
718 727 1222

LONG ISLAND
1090 SUFFOLK AVENUE
BRENTWOOD, NY 11717
631 231 2220

WESTCHESTER
46 WALLER AVENUE
WHITE PLAINS, NY 10605
914 948 8466

WWW.MAKETHEROADNY.ORG

URBAN HEALTH PLAN, INC.
1065 SOUTHERN BOULEVARD BRONX, NEW YORK 10459
718 991-4833

New York City Council Committees on Health and Hospitals

Joint Hearing on Int. 1668

October 31, 2019

On behalf of our health center, I want to thank you for the opportunity to speak before you today in favor of Intro. 1668. My name is Paloma Hernandez and I am the President and Chief Executive Officer of Urban Health Plan, a federally qualified community health center that as a system of care currently serves 90,000 individual patients in the South Bronx, Corona, and Central Harlem. Over the past 45 years, our organization has grown from one site to a total of 29 practice sites including 10 health centers, one mental health center, 12 school based health centers, 4 centers located within tier 2 homeless shelters, an assisted living facility and a boys and girls club, and three WIC sites.

At Urban Health Plan, we take great pride in providing true community based care in a culturally and linguistically proficient manner. Since the inception of the NCQA Patient Centered Medical Home program, we were among the very first providers to have achieved recognition. We serve as that medical home for patients by assuring that care is comprehensive and coordinated. Having been grown from the community, we understand the needs of our patients and how to best address them. We not only provide primary care, but we also provide over 18 medical subspecialties, diagnostic testing services including a state of the art breast imaging center, and an extraordinary amount of enabling services that assure that our most at risk patients are supported in between their medical visits. Clinical pharmacists, social workers, nutritionists, community health workers, care managers, and health educators are all part of our interdisciplinary teams; all working to ensure the best health outcomes for our patients while controlling costs and maximizing resources.

In 2016-2017, Urban Health Plan participated, as did several other FQHCs and NYC Health and Hospitals sites, in a City led effort called Action Health NYC. This program was a multiagency yearlong demonstration project led by the New York City (NYC) Department of Health and Mental Hygiene (DOHMH), that aimed to increase access to healthcare for low-income uninsured

NYC residents who were ineligible for either public health insurance or insurance offered through the New York State of Health program, the State's Affordable Care Act Marketplace. The program was conducted as an evaluation project with a member and a study group. Among its findings, the Program improved healthcare access for members compared with the study group during the study period (May 1, 2016, through June 30, 2017) with significantly more members reporting having a primary care provider and using primary and specialty care, than did the study group. There was also a favorable impact on receipt of many preventive services including hypertension, diabetes, weight, cholesterol, tobacco use, depression, colorectal cancer, and HIV screenings as well as influenza vaccinations than did those in the study group. Our patients were linked to a case manager that helped the patients navigate the system, by assisting with appointments and assuring adequate follow up. We implemented this program in Corona where close to 85% of our adult patients are uninsured.

This firsthand experience and because of the medical home care management model that we employ, Urban Health Plan fully supports Intro. 1668, as this would continue for us the work that we began under ActionHealthNYC.

Currently collaborating with the NYC Health and Hospitals Corporation around the NYC Care Program, we envision this being a way of supplementing their work and assuring that all NYC residents who are uninsured will be able to be served through a medical home model as proposed in this bill. Access to quality primary health care is the only way to effectively and systematically reduce preventable hospitalizations, reduce emergency room utilization, and reduce the number of readmissions that all lead to extraordinarily unnecessary health care costs. Through the proposed health care access program not only will uninsured patients receive coordinated care in a team based medical home model but they will be afforded a patient navigator that will assist in identifying and addressing all of the social drivers of health that are out of the purview of the exam room but critically important is reducing health inequities. Lack of money will no longer serve as one of the most prevalent barriers for patients to access care. On the contrary this program levels the playing field for those that enroll. Having served large numbers of uninsured patients, federally qualified health centers are acutely aware of the differences in how these

patients access care compared to the insured patient.

Urban Health Plan and all of the communities that we serve, thank you for including federally qualified health centers as part of the Health Access Program. We look forward to working with you as an integral part of the City's primary care safety net and continuing to drive the message that health care is a right not a privilege as we work to create a healthier City of New York.

Thank you again for the opportunity to share my thoughts with you today.

Testimony of Helen Schaub
1199SEIU United Healthcare Workers East

New York City Joint Legislative Hearing
Committee on Health and Committee Hospitals
October 31st, 2019

Thank you for inviting us to testify here today. 1199SEIU United Healthcare Workers East represents hundreds of thousands of dedicated caregivers here in New York City. We are strongly supportive of Intro 1668, which would expand the providers eligible to participate in the New York City Care health access program to nonprofit Federally Qualified Health Centers (FQHCs) in addition to the Health and Hospitals Corporation. As a labor union that represents workers in both H+H clinics and in FQHCs around the city, we clearly see the value both of the original program and of the proposed expansion.

The Mayor's New York City Care program, while not health insurance, does aim to provide the estimated 615,000 uninsured New York City residents with an affordable primary care medical home to access primary care. While some of those residents are eligible for subsidized insurance but unenrolled, a significant percentage do not qualify for any insurance programs. H+H is a logical home base for NYC Care as it already serves the emergency and acute care needs many uninsured New Yorkers. Increasing access to primary care will not only help New Yorkers stay healthier and benefit from early detection and treatment, it will help H+H conserve precious resources by avoiding unnecessary hospitalizations and admissions.

The program will also benefit from expansion to trusted community providers like Federally Qualified Health Centers. As the Independent Budget Office showed[1], several community districts with high rates of uninsured residents do not have access to nearby public hospital facilities. These include Queens CD 7 in Flushing, which had the highest uninsured rate in the City in 2017, of 15.5%. Brooklyn Community District 7, in Sunset Park, also has a high rate of uninsured residents but no nearby public facilities. Many of those neighborhoods are served by FQHCs, who are trusted providers in the community, including to the uninsured, and have invested in culturally competent and multilingual staff.

An additional potential benefit of including nonprofit FQHCs in NYC Cares is to strengthen their relationship with H+H when it comes to referrals for specialty and acute care. The lack of streamlined connections between these providers can put unnecessary and potentially dangerous obstacles in the path of those seeking care.

The Council is also considering Resolution 918, in support of a bill in the State Legislature which would extend the State's Essential Plan to individuals who are ineligible for Federal financial participation. Our union has fought for many years for universal health coverage, and we support this bill and other efforts to ensure that everyone has access to affordable health insurance and high-quality health care.

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[1] https://ibo.nyc.ny.us/iboreports/h+h-facilities-uninsured.pdf

GREATER NEW YORK HOSPITAL ASSOCIATION

STATEMENT OF SUPPORT

555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

October
Thirty-One
2 0 1 9

TO: Members of the New York City Council

FROM: Greater New York Hospital Association (GNYHA)

RE: Resolution 0918-2019: In Support of Expanding Essential Plan Eligibility

GNYHA supports Resolution 0918-2019, which lends the City Council's support to legislation in Albany (A.5974/S.3900) that would extend health coverage through the State Essential Plan to individuals currently ineligible due to their immigration status. **GNYHA and our member hospitals believe health care is a human right and have long and strongly supported expanding access to quality care for all.**

Since the enactment of the Affordable Care Act in 2010, the number of uninsured individuals in New York State has dropped significantly to around one million people. Undocumented immigrants, who are currently ineligible for any form of subsidized coverage other than emergency Medicaid, represent around one-third of this number. Allowing these New Yorkers to access health coverage will enable them and their families to seek care when needed. This legislation would build upon the success of the Child Health Plus program, which already covers children up to age 19 regardless of their immigration status. Currently, many of these individuals lose coverage after turning 19 years old.

Expanding coverage to adults regardless of their immigration status will also help New York's financially struggling safety net providers—30 of which are on a State "watch list" for having less than 15 days of cash on hand—reduce the amount of uncompensated care they provide. These hospitals struggle to maintain services for their communities, and this legislation would provide a much-needed lifeline.

For these reasons, GNYHA supports Resolution 0918-2019 and urges the City Council to adopt it.

MORRIS HEIGHTS HEALTH CENTER
85 West Burnside Avenue, Bronx, NY 10453
Tel: (718) 483-1270 ▪ Fax: (718) 294-6912 ▪ www.mhhc.org

New York City Council Committee on Health

New York City Council Committee on Hospitals

Joint Hearing on Int. 1668

October 31, 2019

Thank you, Chairman Levine, Chairwoman Rivera, and members of the committees, for the opportunity to provide testimony today in favor of Intro. 1668. My name is Crystal Jordan, and I am the Chief Operating Officer of Morris Heights Health Center ("MHHC"). MHHC, a federally qualified health center in the Bronx, has been providing medical, dental, specialty, and behavioral health services to the medically underserved for over 35 years. Specialty services include cardiology; ENT (ear, nose, and throat); obstetrics and gynecology; ophthalmology and optometry; dermatology; gastroenterology; podiatry; orthopedics and physical therapy as well as radiology including mammography.

With a planning grant of $25,000, MHHC with a staff of 10 began providing medical services in the country's poorest Congressional district with infant mortality rates at around 15 to 26 per 1,000 births and a physician-to-patient ratio of 1 to 15,000. Though MHHC began as a small, health center to address the needs of poor women in the Bronx who did not have access to primary care and were experiencing significant barriers to obtaining gynecology and obstetrics services, it has grown to one of the largest community health centers in New York State. In 2018, we provided services to over 57,000 men, women and children at 8 stand-alone sites as well as 20 school-based health centers. MHHC employees over 500 individuals including over 130 providers, 70 staff for enabling services like navigation and case management, as well as over 120 clinical support staff.

Though we have come a long way in the last 30 years, there is still more work to be done. Out of the 62 counties in New York State, the Bronx is number 62 in terms of poor health outcomes. For this reason, MHHC strongly supports legislation that will improve the ability of sites like MHHC to provide care to those that continue to be underserved by creating a health access program in New York City aimed at bringing the over 600,000 uninsured New Yorkers into care. Along with CHCANYS, MHHC urges the City Council to work with the Administration to build on the early successes of the NYC Care program by leveraging the breadth and expertise of community health center sites throughout the City.

As we move forward, we urge the council to take several factors into consideration.

1) Efforts to address access must address dental as well as behavioral health concerns. Successful health outcomes are closely tied to addressing the whole person. Covered health care services should include outpatient behavioral health and dental services.
2) Practices with combined internal medicine and pediatric practitioners should also receive priority consideration similar to family medicine practitioners.

Thank you for the opportunity to speak to you today. I am happy to answer any questions.

71-07 Woodside Ave.
Woodside, NY 11377
(718) 937 - 1117

Adhikaar Testimony - City Hall Hearing; Coverage4All
Thursday, October 31

Namaste and Good afternoon, my name is Sandhya Pradhan, I am the Health Navigator at Adhikaar. Adhikaar is the only women-led worker and community center serving and organizing the Nepali-speaking community on workers rights, immigrants rights, access to healthcare and language justice issues. We are one of the newer immigrant communities in New York City, where the majority of our members are low-wage workers.

Today I am speaking on behalf of the thousands of Nepali immigrants in New York with temporary protected status (TPS). The Trump Administration has already terminated TPS for Nepal and several other countries as part of an anti-immigrant agenda. While there is one federal lawsuit, *Bhattarai v Nielsen*, that is providing a temporary hold through preliminary injunction on an expiration date for these thousands of Nepalis, this is exactly only that - temporary. Thanks to TPS, so many of these TPS holders have been able to enroll for health insurance through New York State, and they have been able benefit from health care coverage with little premium or no cost out of pocket. However, this coverage is dependent on a status that is under attack.

The state of Nepali TPS holders is in a delicate situation. It is entirely dependent on the results of this federal lawsuit, and the decision is currently pending. We can not wait to see what will happen in the federal courts. So many of our members are currently benefitting from the Essential Plan, which has allowed many to get regular checkups with their doctors and dentists without having to worry about the bills. Beena, is a long-time member with TPS and a domestic worker. She was able to access life-saving eye surgery and now is able to afford her regular follow-up check-ups and medicine due to having health insurance with her TPS status.

I'd like to thank the Council and others in the city for taking action to support access to care for immigrant New Yorkers, however we have not seen the same type of support from Albany. I ask for your support to pressure those at the State level to act immediately and show their support for Coverage4All. What rests in their hands are thousands of TPS holders, at risk of losing status, and their health care coverage left vulnerable and uninsured.

I hope that you share our belief that every immigrant, regardless of status, undocumented, TPS or anything else, deserves the right to live a quality and healthy life. Thank you.

New York City Council Committees on Health and Hospitals
Joint Hearing on Int. 1668
Testimony of Brian P. McIndoe, MPH, President and CEO of Ryan Health
October 31, 2019

On behalf of Ryan Health, I submit this written testimony in support of Int. 1668 to include Federally Qualified Health Centers (FQHC) in the NYC Care program. Ryan Health is a network of mission-driven community health centers working throughout Manhattan. We serve approximately 50,000 New Yorkers annually at 18 sites, including our six community health centers, school-based health centers, community outreach centers, and a mobile health center.

NYC Care will provide health care access to more than 600,000 uninsured New Yorkers, and FQHCs can play an integral role in reaching underserved populations. Int. 1668 would create a health access program to allow FQHCs to participate in NYC Care.

Ryan Health and our fellow FQHC's are the unsung successes of our disjointed health care system. Since our inception in the late 1960s, we have provided underserved populations critical access to primary care and specialty services. The vital link to care that we offer keeps our patients healthier and out of costly emergency rooms. Throughout New York State, costs are 24 percent lower for FQHC Medicaid patients, saving the Medicaid system $2.5 billion. We all benefit when New Yorkers have access to high-quality care and manage their health — costs are lower, and people live longer and better lives.

Ryan Health is named after Congressman and activist William F. Ryan, one of the first to articulate that "health care is a right, not a privilege." The US is the only industrialized nation in the world without universal access to health care, and that burden is weighing heavier and heavier on our people. New Yorkers contend with an outrageous cost of living and other daily challenges unique to our city. Access to health care should not be one of them.

For over fifty years, Ryan Health and other FQHCs have been welcoming individuals to our centers. We're on the frontlines of health care for tens of thousands of New Yorkers, for many their first resort and others their last. Just as envisioned in NYC Care, we do not turn away anyone, regardless of their ability to pay -- we offer a sliding fee scale based on family size and income. Our quality driven staff members work hard every day to provide unparalleled care that helps our patients get healthy and stay healthy. The result is that we improve the health and lives of entire communities.

Ryan Health offers crucial primary and pediatric care, as well as specialty services including behavioral health, women's health, dental care, chronic disease management, HIV treatment and prevention, and opioid addiction treatment.

Our holistic approach improves health and decreases costs. For example, our intensive diabetes management program starts with counseling to teach our patients how to live a healthy lifestyle, which can minimize the effects or even avoid the onset of diabetes altogether. We empower them to self-manage their diagnosis, to understand how diabetes works, monitor their own blood sugar levels, and take the proper dosage of insulin. Because diabetes affects so much of the body, we connect our patients with podiatrists, endocrinologists, ophthalmologists, and dentists. Our team acts as the patient navigator envisioned as an aspect of NYC Care.

We take the lead on emerging crises, like HIV/AIDS care in the 1980s and 90s, and now the opioid crisis, which is responsible for the deaths of nearly 1,500 New Yorkers last year and has lowered US life expectancy for the first time since World War I. Now, members of the community who may be struggling with addiction to prescription painkillers or street drugs like heroin, can come to one of our primary care centers for treatment. And they are taken care of like everyone else -- there's no separate facility, and no special door to walk through. There's no stigma and no judgment when individuals visit us for treatment.

We thank Speaker Corey Johnson, Health Committee Chair Mark Levine, and Hospital Committee Chair Carlina Rivera, all of whom have a Ryan Health center in their districts, for sponsoring this legislation. We all recognize that our health care system needs help, and FQHCs, like Ryan Health, have been providing quality, affordable care to anyone who walks through our doors for years. We look forward to expanding our reach to ensure a healthy New York through NYC Care.

# # #

SENATOR
GUSTAVO RIVERA
33RD DISTRICT

CHAIRMAN, MAJORITY MEMBER
HEALTH
COMMITTEES:
CRIME VICTIMS, CRIME AND
CORRECTION
FINANCE
HOUSING
MENTAL HEALTH AND
DEVELOPMENTAL DISABILITIES
SOCIAL SERVICES

October 31, 2019

To: New York City Council Joint Committee on Health and Hospitals

From: New York State Senator Gustavo Rivera, Chair of the Senate Health Committee

Re: Resolution 0918A - Calling on the State of New York to pass, and the Governor to sign, S.3900/A.5974, an act to amend the social services law, in relation to coverage for health care services under the basic health program for individuals whose immigration status renders him or her ineligible for federal financial participation.

Thank you for the opportunity to submit testimony at this hearing on Resolution 0918A, which calls for the Essential Plan to be expanded to undocumented people. I sponsor this legislation in the Senate with Assembly Member Gottfried, S.3900/A.5974, and I support the call for it to be passed by the State Legislature and signed by the Governor in this upcoming legislative session.

Since the enactment of the Affordable Care Act in 2010, New York has dramatically decreased the number of uninsured people. However, immigrant New Yorkers have not benefited from the new coverage or public coverage options through the New York State of Health Marketplace because of their immigration status. It has been found that many undocumented people delay or go without needed care, which results in visits to hospital emergency rooms for care that would be better addressed by primary care, urgent care, or other preventative care providers.

California is ahead of the curve in its effort to accomplish this. In July of 2019, it passed and signed into law legislation that will expand coverage for all residents under 26 years of age with income under six hundred percent of the federal poverty level to enroll in publicly funded healthcare. Their state is becoming the first in the country to expand coverage for young adults, regardless of their immigration status. New York can follow in California's footsteps and, in fact, outpace them by enacting S.3900/A.5974, allowing undocumented people with income below two hundred percent of the federal poverty level regardless of age to have publicly funded health insurance coverage.

New York State has already achieved the highest percentage of residents with health insurance coverage out of the four most populated states in the country. To understand why this is important, let's look at a few facts surrounding the undocumented population. It is estimated that:

- There are over five hundred thousand undocumented people in New York City alone
- They pay over $1 billion state and local taxes
- They contribute about $40 billion to the state's economic output.

ALBANY OFFICE: CAPITOL BUILDING, ROOM 502, ALBANY, NEW YORK 12247 (518) 455-3395 • FAX (518) 426-6858
DISTRICT OFFICE: 2432 GRAND CONCOURSE, SUITE 506, BRONX, NEW YORK 10458 (718) 933-2034 • FAX (718) 933-2825
grivera@nysenate.gov

CHAIRMAN, MAJORITY MEMBER
HEALTH
COMMITTEES:
CRIME VICTIMS, CRIME AND CORRECTION
FINANCE
HOUSING
MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
SOCIAL SERVICES

For the benefit of our City and our State, we must provide necessary benefits to every New Yorker living here regardless of their immigration status, not only because it is good for our economy and provides needed health care, but because it is a right that we owe to each other. S.3900/A.5974 is important legislation which will make a real difference In the lives of many New Yorkers.

I would be remiss if I did not state that ultimately New York needs to adopt the New York Health Act (NYHA) which will guarantee healthcare to everyone, regardless of income or immigration status, without co-pays or deductibles under a system that puts dollars currently going into insurance company profits back into paying for people's care. However, until the NYHA is adopted and implemented, passage of S.3900/A.5974 is essential.

I would like to thank the New York City Council's Health and Hospital Committees for recognizing the need to provide coverage for every New Yorker and for allowing me to submit this testimony.

Sincerely,

Gustavo Rivera

New York State Senator
33rd District

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DISTRICT OFFICE: 2432 GRAND CONCOURSE, SUITE 506, BRONX, NEW YORK 10458 (718) 933-2034 • FAX (718) 933-2825
grivera@nysenate.gov

40 Worth Street, 5th Floor
New York, NY 10013-2988
646-619-6400
healthsolutions.org

Testimony of Public Health Solutions
Before the New York City Council
Committee on Health
Oversight-Health Access in New York City, and the Roll Out of NYC Care
T2019-5177

October 31, 2019

Good afternoon Chair Levin and Council Members Ampry-Samuel, Cohen, Barron, Powers, Eugene, and Holden. I am Marla Tepper, General Counsel and Vice President of Legal Affairs at Public Health Solutions ("PHS"). Thank you for the opportunity to testify before this committee about how the Trump Administration's assault on women and reproductive rights is impacting our clients' access to drugs and contraceptive supplies at our two Brooklyn reproductive and sexual health centers. We applaud the Council's work to address health equities and to improve health outcomes in New York City.

PHS Sexual and Reproductive Health Clinics' Funding

For decades, the federal Title X family planning program has supported millions of low-income and underinsured individuals in accessing high-quality preventive reproductive and sexual health care services. This program has been fundamentally undermined by the Trump Administration - whose implementation of an unethical "gag rule" has forced longstanding providers of Title X services out of the program.

After managing a network of Title X providers for over 40 years, including two health centers of our own in Ft. Greene and Brownsville that provided critical health care services to thousands of New Yorkers, PHS made the ethical decision to reject Title X funding. We did so because of the federal government's recent gag rule which interfered with our ability to provide the care we believe in. New York State stepped up to provide us and our sub-recipients funding through April 2020 and helped keep our doors open.

Our clients

Our health centers have enabled thousands of New Yorkers access safe, affordable, comprehensive and confidential care over the past several years. Our client population for family planning services is diverse: We see people of all races and ethnic groups. In 2017, 40% of PHS's Title X clients identified as Black or African American, compared to 26% of New York City's population, while 42% identified as Hispanic or Latino/a, compared to 29% of the City's population. We serve teenagers and adults; people who have children, or plan for children, or do not want to be parents. Our patients are married and unmarried; lesbian, gay, bisexual, transgender, and queer ("LGBTQ") individuals; and a significant portion are immigrants. A total of 15% of the clients had limited English proficiency.

We serve predominantly low-income, high-risk patients who are dependent on publicly subsidized health facilities to obtain basic—but critical—medical care. Approximately 70% of PHS patients are 100% below the poverty level, 76% are 200% below the poverty level, and 26% lack health insurance. The overwhelming majority of our family planning patients reside in medically underserved areas where reproductive health services are not easily accessed.

<u>Impact on drugs and contraceptive supplies</u>

Relinquishing Title X funds impacts on our clients' ability to access low-cost drugs and pharmaceutical supplies including birth control pills, contraceptive devices and vaccinations. When funded under Title X, PHS participated in the federal 340B drug discount program administered by the Health Resources and Services Administration's ("HRSA") Office of Pharmacy Affairs. Participation in the 340B Program allowed PHS to receive outpatient drugs at significantly reduced prices. Although PHS is eligible to register for the 340B program in January based on federal funding it receives from the CDC for STD clinics at its sexual and reproductive health centers, that registration will not be effective until April 1, 2020.

Until it resumes participation in the 340B program in April, PHS will not be able to offer discounted drugs to our clients. Teens and undocumented immigrants who are uninsured will be most hard hit. Unless we receive support, more than 1,300 adolescents seeking confidential services will be charged the full cost of drugs. Over 1,100 undocumented immigrants and other uninsured individuals will also be charged the full price of essential drugs and supplies. Our clients' Inability to access drugs jeopardizes the effectiveness of our clinical services and ultimately, our clients' continued use of our clinics.

Annual Pharmaceutical Supplies Cost with 340B Access	Annual Projected Pharmaceutical Supplies Cost without 340B Access	Types of supplies purchased	Populations who would be charged full cost without support
$149,150	$208,810	• Contraceptives, including LARC • Vaccinations • STD Screening and Treatment • Plan B	• More than 1,300 adolescents seeking confidential services • More than 1,100 undocumented persons and other uninsured persons

We urge this Committee to counter the Trump's attack on family planning and reproductive rights by providing critically needed funding to address these gaps safeguard patient access to necessary drugs and supplies.

Thank you again for championing New Yorkers' access to healthcare. We are available to answer any questions you may have.

Respectfully submitted,

Marla Tepper
General Counsel and Vice President, Legal Affairs
Public Health Solutions

About PHS

Health disparities among New Yorkers are large, persistent and increasing. Public Health Solutions changes that trajectory and supports vulnerable New Yorkers in achieving optimal health and building pathways to reach their potential. We improve health outcomes and help communities thrive by providing services directly to vulnerable low-income families and supporting 200 community-based organizations through our long-standing public-private partnerships. We focus on a wide range of public health issues including food and nutrition, health insurance, maternal and child health, sexual and reproductive health, tobacco control, and HIV/AIDS.

New York City Council
Committees on Health & Hospitals
Oversight Hearing: Health Access in New York City, and the Roll Out of NYC Care
October 31st, 2019

Testimony of Tasfia Rahman,
Policy Coordinator, Coalition for Asian American Children and Families (CACF)

Good morning. My name is Tasfia Rahman, and I am a Policy Coordinator at the Coalition for Asian American Children and Families (CACF). We would like to thank Chairs Levine and Rivera and members of the committees for holding this hearing today.

Since 1986, CACF is the nation's only pan-Asian children and families' advocacy organization and leads the fight for improved and equitable policies, systems, funding, and services to support those in need. The Asian Pacific American (APA) population comprises over 15% of New York City, over 1.3 million people. Yet, the needs of the APA community are consistently overlooked, misunderstood, and uncounted. We are constantly fighting the harmful impacts of the model minority myth, which prevents our needs from being recognized and understood. Our communities, as well as the organizations that serve the community, too often lack the resources to provide critical services to the most marginalized APAs. Working with almost 50 member organizations across the City to identify and speak out on the many common challenges our community faces, CACF is building a community too powerful to ignore.

As a New York State Patient Navigator contractor that works with 8 other APA serving and led organizations, we are too aware of the challenges APA families and individuals face in accessing health coverage and care:

- Almost 15% of Asian Americans (AA) ages 18 and over remain uninsured in New York City.[1]
- A majority (89%) of AA uninsured in NYC are foreign-born.[2]
- 21% of APAs are considered underinsured, meaning the insurance coverage they have is inadequate.[3]

Disparities in health access and care are especially are compounded in our community by poverty, immigration status-related challenges, language barriers, cultural stigmas regarding public benefits, and low utilization of primary and preventive care. Consider:

- Almost a quarter of Asian Americans live in poverty in NYC.[4]
- Asian Americans are heavily immigrant with 70% foreign-born.[5]

---

[1] 2015 New York City Community Health Survey, DOHMH.
[2] Ibid.
[3] Ibid.
[4] 2019 NYC Poverty Measure Annual Report, Office of the Mayor.
[5] 2013-2017 American Community Survey 5-Year Estimates.

- Asian Americans have the highest rate of linguistic isolation of any group in the City at 42%, meaning that no one over the age of 14 in the household speaks English well.[6]

Because of the pressing need to ensure better coverage and care for the most vulnerable immigrants in our community, we support the adoption of the following:

Introduction 1668-2019 because NYC Care needs to be full resourced to support the work nececessary to ensure that everyone, especially the most marginalized and vulnerable communities have access to quality health coverage and care. We also advocate for strong partnerships with local community-based organizations (CBOs) to ensure that immigrant communities are being reached and increase their access. Therefore, it is crucial that these groups and our communities are adequetely resourced to fullfill the mission of NYC Care.

Resolution 0918-2019 calls on New York State to pass and Governor Cuomo to sign S.3900/A.5974, which will expand health insurance coverage under Essential Plan to include those who are ineligible because of their immigration status. Considering that the APA families and individuals face high rates of uninsurance and underinsurance and are heavily immigrant, this expansion is crucial to improving their health and well-being.

New York City has always led in ensuring that immigrant communities are protected. We hope New York City Council continues this leadership by passing Introduction 1668-2019 and Resolution 0918-2019. Thank you so much for giving me the opportunity to testify and I am happy to answer any questions you may have!

[6] U.S. Census Bureau, 2016 American Community Survey.

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Nicole White

Address: 490 Myrtle [illegible] Brooklyn NY 11205

I represent: myself

Address:

THE COUNCIL
THE CITY OF NEW YORK 37

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Courage 4 All

Date:

(PLEASE PRINT)

Name: Man Yuck Yu

Address: 5306 3rd Ave 2nd Fl, Brooklyn, NY 11220

I represent: Academy of Medical & Public Health Services

Address:

THE COUNCIL
THE CITY OF NEW YORK 36

Appearance Card

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☐ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Domna Antoniadis

Address:

I represent: New York Legal Assistance Group

Address: NYLAG

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Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Adele Flstesu
Address: 3408 Clarendon Road - 11203
I represent: Alliance for Healthy Communities
Address: Same

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34

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Valerie Goffe
Address: ________
I represent: 1199 Seiu
Address: ________

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Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Tasfia Rahman
Address: 50 Broad Street
I represent: Coalition for Asian American Children & Families
Address: ________

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☐ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: WINN PERIYASAMY

Address: ________

I represent: Physicians for a National Health Program / constituent

Address: 235 W 63RD ST. APT 3F

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31

Appearance Card

I intend to appear and speak on Int. No. Health & Hosp Comm. NYC Care Res. No. ________

☒ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Leon Bell

Address: ________

I represent: New York State Nurses Assoc.

Address: 131 W. 33rd St NY NY

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Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☒ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Anthony Feliciano

Address: ________

I represent: CPHS

Address: ________

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Appearance Card

I intend to appear and speak on Int. No. 1668 Res. No. 918

☒ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Helen Schaub

Address: 330 W 42nd St 7TH NY 10036

I represent: 1199 SEIU

Address: same

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Appearance Card

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☐ in favor ☐ in opposition

Date: 10/31

(PLEASE PRINT)

Name: Jessica Diamond

Address: 1317 Roosevelt Ave

I represent: Hudson River Healthcare

Address: ________

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Appearance Card

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☐ in favor ☐ in opposition

Date: 10/31

(PLEASE PRINT)

Name: Hope Glassberg

Address: 16 N Dutches St NY

I represent: Hudson River Healthcare

Address: ________

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Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ~~____~~
☑ in favor ☐ in opposition S.3900/A.5974

Date: 10.31.19

(PLEASE PRINT)

Name: Michael Pereira

Address: 55 Exchange Pl Suite 501 NY 10005

I represent: Hispanic Federation

Address: 55 Exchange Pl Suite 501 NY 10005

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NYSNA

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: SONIA LAWRENCE

Address: 3376 Fenton Ave Bx NY

I represent: Lincoln Hospital

Address: 234 E 149 Street Bx NY 10451

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25

Appearance Card

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☑ in favor ☐ in opposition

Date: 10-31-19

(PLEASE PRINT)

Name: Brian Fuss

Address: 7 Penn Plaza 14th NY NY 10001

I represent: Center for Healthcare Retail

Address: 7 Penn Plaza 14th, NY NY 10001

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☑ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Arline Cruz

Address: 301 Grove St Bk, NY 11237

I represent: Make the Road NY

Address: 301 Grove St Bk, NY 11237

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Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. 918-A

☒ in favor ☐ in opposition

Date: 10/31/2019

(PLEASE PRINT)

Name: DOMNA ANTONIADIS

Address: ________

I represent: New York Legal Assistance Group

Address: 7 Hanover Square 18 Floors NY NY 10004

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Appearance Card

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☐ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: GBENGA ANONUSI

Address: 214-51 JAMAICA AVENUE NY 11428

I represent: DSI INTERNATIONAL INC

Address: 214-51 JAMAICA AVENUE NY 11428

Please complete this card and return to the Sergeant-at-Arms

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Appearance Card

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☑ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Judith Cutchin RN
Address: 131 West 33rd St. 4th Fl.
I represent: New York State Nurses Association
Address: 131 West 33rd St 4th FL

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Appearance Card

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☐ in favor ☐ in opposition

Date: October 31, 2019

(PLEASE PRINT)

Name: Mitchell Katz, MD
Address: President + CEO
I represent: N.Y.C. Health + Hospitals
Address: ________

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Appearance Card

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☐ in favor ☐ in opposition

Date: October 31, 2019

(PLEASE PRINT)

Name: Marielle Kress
Address: Executive Director NYC Care
I represent: N.Y.C. Health + Hospitals
Address: ________

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Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: October 31 2019

(PLEASE PRINT)

Name: Ted Long M.D.
Address: Vice President, Ambulatory Care
I represent: NYC Health + Hospitals
Address:

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Appearance Card

I intend to appear and speak on Int. No. 1668 Res. No. 0918
☒ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: MAX HADLER
Address:
I represent: NY IMMIGRATION COALITION
Address:

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☐ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Rishi Sood
Address: Executive Director
I represent: NYC Department of Health and
Address: Mental Hygiene

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Appearance Card

I intend to appear and speak on Int. No. 1668 Res. No. 0918
☒ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: ANTHONY FELICIANO

Address: ______

I represent: CPHS

Address: ______

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Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☒ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Paloma Hernandez

Address: 1065 Southern Blvd.

I represent: Urban Health Plan

Address: 1065 Southern Blvd.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☒ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Juan C Pinzon

Address: ______

I represent: Community Service Society

Address: 633 3rd Ave NY, NY

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THE COUNCIL
THE CITY OF NEW YORK

PCDC panel

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Patrick Kwan

Address:

I represent: Primary Care Development Corporation

Address: 45 Broadway, NY NY

THE COUNCIL
THE CITY OF NEW YORK

PCDC panel

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Mary Ford

Address:

I represent: Primary Care Development Corporation

Address: 45 Broadway, NY NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1668 Res. No. 819
☑ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Nathalie Interiano

Address:

I represent: Care For the Homeless

Address:

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ____________

(PLEASE PRINT)

Name: Rose Duhan

Address: 111 Broadway, Suite 1402

I represent: Community Health Care

Address: Association of NYS

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ____________

(PLEASE PRINT)

Name: Mia Soto

Address: ____________

I represent: New York Lawyers for the Public

Address: Interest

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. 1668

☑ in favor ☐ in opposition

Date: ____________

(PLEASE PRINT)

Name: Dr. Juan Tapia

Address: 233 Broadway

I represent: Somos Community Care

Address: ____________

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☒ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Carlyn Cowen

Address:

I represent: Chinese American Planning Council

Address: 150 Elizabeth Street

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☒ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Andrea Bowen

Address: 147 S Oxford St Apt 1D 11217

I represent: Transgender, gender non-conforming, nonbinary Solutions Coalition

Address: 116 Nassau St. 3rd Fl

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. [illegible] Res. No. 918

☑ in favor ☐ in opposition

Date: 10/31/19

(PLEASE PRINT)

Name: Maryam Mohammed-Miller

Address: 26 Bleecker St

I represent: Planned Parenthood NYC

Address: "

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1668 Res. No. 918

☑ in favor ☐ in opposition

Date: OCT 31, 2019

(PLEASE PRINT)

Name: DR. JUAN TAPIA

Address:

I represent: SOMOS COMMUNITY CARE

Address: 519 8Th AVE

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