

Testimony to the Joint Health Committee

2018-2019 Health and Medicaid Executive Budget Proposal

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New York State Nurses Association

My name is Jill Furillo and I am the Executive Director of the New York State Nurses Association. NYSNA is the largest union representing registered nurses in New York State, with nearly 40,000 members. As a union representing registered nurses, we are strong advocates for universal, high quality health care for all New Yorkers regardless of ability to pay. We also believe that nurses and other direct care health workers should be able to provide care for our patients and communities in accordance with professional standards, with proper nurse staffing levels, and under safe and fair working conditions.

Threats to New York Health Care from the Federal Government

For the second year in a row, New York is forced to confront fiscal threats and uncertainties emanating from Washington DC.

The majority leadership in Congress and the executive branch remain determined to repeal the ACA directly or to undermine it by reducing Medicaid funding, repealing the individual and employer mandates, undermining enrollment in the insurance exchanges, and eliminating or reducing necessary financial subsidies such as premium support and cost sharing reduction (CSR) payments. The individual mandate to purchase health coverage was repealed in the December “tax reform” bill, which will increase premiums for people buying coverage on the ACA exchanges and uninsured rates in New York and nationally by pricing middle income people who do not qualify for premium support out of the market. Proposals are circulating in the Republican controlled House to also scrap the ACA employer mandate. CMS regulations are being implemented that will allow states to impose restrictions on Medicaid eligibility, allow small business associations to introduce bare bones health plans for their “members,” and impose other similar measures to undermine current health care funding and further reduce the number of people with full health insurance. The net effect of these efforts to sabotage our health care system will reduce funding for NY hospitals while simultaneously increasing the unreimbursed costs of treatment for rising numbers of uninsured patients. These effects would be most intensely felt in rural and urban safety net hospitals that already provide high levels of care to uninsured patients.

The temporary Federal budget measure passed on a bi-partisan basis last week thankfully included funding for several key programs that will avert looming catastrophic effects on our hospitals and the broader health care system in New York. The budget agreement thus extended funding for the CHIP program for 10 years, restored two years of funding for community health clinics (FQHCs) in the amount of \$7.8 billion, and also delayed the scheduled cuts in Disproportionate Share Hospital (DSH) Medicaid funding for two years to FY 2020 (restoring approximately \$400 million in funding for New York in this fiscal year).

The failure of Congress to take action to restore funding for ACA cost sharing reductions, however, threatens the viability of the NY Essential Plan, costing New York approximately \$870 million in funding and endangering the health coverage of almost 700,000 New Yorkers who rely on this program.

The “tax reform” bill that was rammed through Congress in December permanently slashes taxes for big corporations and wealthy real estate and private equity fund investors. The temporary reductions in personal tax rates (with most of the tax cuts skewed to higher income filers) will be of little value in New York because Congress imposed a new \$10,000 cap on the deductibility of local income and property taxes. This means, in effect that the budgetary and deficit effects of the corporate tax cuts were partially funded by plundering the budgets of high income and high cost states like New York and New Jersey. This has the effect of shifting even more money from “blue” donor states like NY and NJ (states that pay in more in federal taxes than they get back in federal spending) to “red” taker states like Alabama and Montana. Thus, New York will face reduced federal funding for health care, education, and other state priorities, while many New Yorkers will now be paying more in federal taxes. And, even with the “theft” of tax revenues from New York, the new federal tax law will still increase the Federal deficit by about \$1 trillion over the next five years and by \$1.5 to \$2 trillion over the next 10 years.

These huge increases in the Federal deficit will inevitably be used as a political pretext to push for further reductions in Federal spending, and if military and debt expenses are left off the table, we can expect to see major attempts to cut “entitlement” spending – Medicare, Medicaid, Social Security and programs that assist low-income Americans will all be on the chopping block. This in turn will reduce Federal funds available for the New York state budget and simultaneously give our state less flexibility to offset lost federal revenue by finding alternative sources of state revenue.

The current political dynamic in Washington thus poses an acute threat to New York’s health care system, to vulnerable rural and urban safety net and public hospitals, and to the health care coverage of millions of our patients.

Contingency Measures in the State Executive Budget

Given the balance of forces in the current composition of Congress and the political dynamic playing out in Washington, the proposed Executive Budget blueprint includes the following proposals to deal with the possible budget fall-out from federal actions or failure to act:

- Continuing and updating last year’s budget provision allowing the Governor to modify the enacted budget in the event that any federal action impacts the state budget by \$850 million or

more; in this case, the Governor would be authorized to issue an amended budget; the legislature would then have 90 days to return in a special session and pass its own modifications to address the issue; if the legislature is unable to pass its own amended budget, the Governor's proposal would automatically become law;¹

- Creating a new \$1 billion "Health Care Contingency Fund" to be used if Congress repeals the ACA, slashes funding for Medicaid, or takes other abrupt and destabilizing action to harm New York state patients and providers; this contingency fund would allow the Governor to temporarily plug holes in the state health care budget if any destructive action is taken by Congress; the fund is to be "seeded" with a special surcharge that the state expects to impose on the profits that are generated by the conversion of non-profit health insurers to for-profit status; it is expected that these surcharges will amount \$750 million per year over the next four years, with \$500 million per year to be used to offset Medicaid and General Fund spending and \$250 million per year to be deposited in the Health Care Contingency Fund.

NYSNA supports the concept of preparing for possible catastrophic actions by the President or the current majority in Congress, but has concerns that these contingency funds will end up reducing available funding for vital health care services. If health care funding is being put in reserve, this means there is less available to support existing health care programs and provider funding streams.

NYSNA supports the imposition of fees or taxes on any health insurer conversions, but would demand that the entire proceeds of any such conversions be used for health care purposes. We would particularly urge that at least \$500 million be specifically be dedicated to supporting rural and urban safety net hospitals that are already operating under extremely precarious financial conditions. Accordingly, we would support that this funding stream be targeted to the approximately 60 "Enhanced Safety Net Hospitals" as defined in the legislation vetoed by the Governor in 2017 (A7763/S5661-B).

The Essential Plan

The Essential Plan provides coverage to people making between 138% and 200% of Federal Poverty Level and certain documented immigrants making less than 200% of FPL. Enrollment is projected to reach almost 700,000 in 2018-2019, making it a key source of health coverage for low income New Yorkers. Total spending on the program is projected at \$3.89 billion, of which \$3.79 billion is federal funding and \$102 million is New York State share. The program relies heavily on ACA cost sharing reduction payment (CSR) funding that was unilaterally suspended by the President last year and which has not yet been renewed (despite promises made to key US Senators in exchange for their support of the "tax reform" bill). The Executive Budget uses various accounting maneuvers to keep the Essential Plan solvent in 2018-2019, but the program is under threat. NYSNA fully supports the efforts to maintain the program, but believes that we must focus on forcing Federal action to restore the underlying funding.

¹ A similar contingency process was proposed by the Governor in the budget to address the Children's Health Insurance Program (CHIP). With the passage of the 10 year CHIP extension, this proposal is now moot.

Increase the Health Insurance Windfall Profit Fee and support Safety Net Hospitals

The Executive Budget includes a proposal to impose a 14% surcharge on net underwriting gains earned by private insurance companies selling plans in New York State. The fee would not tax final net profits of insurers (which can be masked by employing tax evasion mechanisms). Instead, the surcharge would be applied to the difference between insurers' premium revenues and the actual health costs paid out to enrollees. The state estimates that this will generate \$140 million per year in added revenues. These funds would be applied to HCRA pools and some would be available for distribution to hospitals and other health care providers.

NYSNA supports increased taxation of health insurer profits, but believes that (a) the surcharge should be increased to 28% and (b) that the approximately \$280 million in added revenues should be dedicated entirely to support hospitals that qualify as Enhanced Safety Net Hospitals under the definitions that were provided in the 2017 legislation vetoed by the Governor (A7763/S5661-B).

Vital Access Provider Assurance Program (VAPAP) and Value Based Payment-Quality Incentive Program (VBP-QIP) (formerly Interim Access Assurance Fund)

This ongoing program provides assistance to financially distressed hospitals as they seek to become "sustainable" and has been used to provide assistance to about 28 hospitals since 2014. The program, however, unfairly excludes public hospitals from participation. The Executive Budget appropriates an increase of \$68.6 million in FY2018-2019 (of which \$45.4 million is state funded) for this program.

NYSNA supports this program, but would demand the inclusion of public hospital systems in the program.

Capital Financing for Essential Health Care Providers

The state appropriates \$425 million in capital funding for FY2018-2019 (down from \$500 million in 2017-2018); \$300 million will come from bond sales and \$125 million from state funds; the legislation defines "capital projects" loosely to include not only physical plant, but also debt retirement and other projects to restructure services; of the \$425 million, \$60 million is directed to community-based providers and \$45 million to residential health care facilities.

NYSNA supports this ongoing program, but believes that the amounts appropriated are inadequate and should be more clearly targeted to urban and rural hospitals that meet the definition of Enhanced Safety Net Hospitals.

NYSNA also believes that the formula for distribution of the funds should be clearly defined to include criteria that track the numbers of low income and uninsured patients served and the financial status of providers seeking these funds. Money should be targeted to those institutions with the highest proportions of Medicaid and uninsured patients and should not be granted to providers that are profitable and thus do not need support.

NYSNA Opposes the Inclusion of Budget Legislation that threatens Nursing Scope of Practice

Last year's Executive Budget included a very dangerous proposal to create a "Health Care Regulation Modernization Team" to make recommendations to "streamline" existing scope of practice

regulations, certificate of need processes, and other similar regulations. Although that particular was not enacted last year, there are several new proposals in this year's Executive Budget that will affect nursing scope of practice.

NYSNA opposes efforts to undermine nursing practice, particularly through the budget process where such measures cannot be fully analyzed and discussed because they are one small component of a universal budget bill. Any legislation that affects nursing scope of practice should be hashed out in stand-alone legislation that is fully debated as part of the regular legislative process. The proposed Executive Budget includes two proposals that target nursing scope of practice – Community Paramedicine Collaboratives and CRNA Licensing. NYSNA opposes both of these proposals.

NYSNA Opposes Authorization of Community Paramedicine Collaboratives

The Executive Budget includes a proposal (Part S, Sub-Part A, Health and Mental Hygiene Article VII Legislation) that would allow “community paramedicine collaborative” programs to employ paramedics and EMTs to engage in what effectively amounts to community nursing programs.

NYSNA has previously noted that proposals to authorize “paramedicine” are driven largely by a desire to reduce health care providers’ labor costs by substituting lower paid (and trained) EMTs for public health, home care and post-acute care nurses.

We have also noted that the EMT/paramedic “scope” of practice is not clearly defined and thus very broad, but is currently limited to the narrow context of the site of the emergency and the transportation of the emergency patient to the appropriate place for appropriate care. The paramedicine budget proposal would allow EMTs to work in non-emergency settings and would overlap with nursing scope of practice in such areas as patient assessment, development and implementation of patient care plans, patient education and other core nursing practice functions.

We have also noted that paramedicine programs, which have been allowed in some other states, are largely driven by the interests of private, for-profit EMS operators, many of whom are directly or indirectly profit generating investment vehicles used by private equity and corporate investors in EMS companies whose primary interest is to maximize their and profits (or reduce their losses) by opening new revenue streams beyond the payments received for traditional emergency response services and reducing the “down time” per EMS “rig” that is owned.

This Executive Budget proposal would “effectuate recommendations made as part of the Regulatory Modernization Initiative made by the Department of Health” and is intended to “facilitate an environment where providers, payers, and patients are best positioned to ensure access, promote patient safety, and lower costs.”

The proposed legislation would allow health care providers to form collaboratives and use emergency medical personnel to provide care “within their certification, training and experience in residential settings.”

The legislation partially addresses some of the concerns previously raised by NYSNA, but still leaves unaddressed key issues relating proper patient care and the undermining of nursing scope of practice.

The legislation includes the following specific provisions:

- Paramedicine programs would have to be formed and operated by a “community paramedicine collaborative” that includes at least one hospital, at least one physician (who may be affiliated with or employed by the collaborating hospital), at least one emergency services (ambulance) provider, and if the services are to be provided in a private residence, at least one home care services agency.
- The definition of “paramedicine programs” clearly makes this an EMT-based program, rather than a more broadly integrated health care initiative that includes EMTs working with RNs and other health care workers to provide integrated community care.
- An authorized “Community Paramedicine Program” is defined as a program carried out by a paramedicine collaborative “pursuant to which individuals who are certified...[as EMTs/paramedics]...shall perform community paramedicine services in residential settings other than the initial emergency medical care and transportation of sick and injured persons, provided that such individuals are (i) certified pursuant to article thirty of this chapter; (ii) employees or volunteers of an emergency medical services provider that participates in the collaborative; (iii) providing services that are within their education or training; and (iv) working under medical control as defined by [applicable law].” Because EMT scope of practice is vaguely defined, however, this provision would seem to allow a very wide scope for paramedics and EMTs to practice in non-emergency, home visits with patients.
- The proposal also authorizes paramedicine collaboratives to provide psychiatric and mental health care to patients in their homes, without any provision for special training or collaboration with mental health nurses and other appropriate providers.
- The proposal does not clearly define the allowed purposes of the collaborative, other than the broad concept of providing services to people in residential settings “for the purpose of achieving objectives identified by the collaborative such as: preventing emergencies, avoidable emergency room visits, avoidable medical transport, and potentially avoidable hospital admissions and readmissions; improving outcomes following discharge from a general hospital or other inpatient admission; and/or promoting self-management of health or behavioral health care conditions.” These goals seem to overlap with home health, post-discharge sub-acute, psychiatric and mental health, and community health nursing roles and functions and would require patient assessment and care plan implementation.
- The proposed legislation makes no provision for prior review or approval of such programs by the DOH. The collaboratives could begin operating paramedicine programs simply by sending a letter to the DOH identifying the participating entities and the point person to contact, describing the goals of the collaborative, describing the population and geographic area to be served, the services to be provided, describing “to the extent

possible” the plan for coordinating care with other care providers, and the date on which the services will begin to be provided.

- There are no definitions or limitations on the provision of services or standards of training and education for EMTs. Indeed, the existing EMS standards of medical control of EMTs in the emergency setting require direct medical control/instruction or indirect control through the use of existing policies/protocols developed by the state Emergency Medical Advisory Committee, approved by the state Emergency Medical Services Council and the Commissioner, and implemented by regional a Medical Advisory Committee.
- For community paramedicine, by way of contrast, the definition of “medical control” is limited to “advice and direction provided and policies, procedures, and protocols issued by a physician who is responsible for the overall clinical supervision of the community paramedicine program.” This amounts to a substantially lower standard of care and practice for EMTs than is currently the case for emergency services. There would effectively be almost no regulatory oversight by the DOH or existing EMS bodies of these paramedicine programs.
- The proposed statute does not include provisions to ensure that emergency responders will be available to emergency situations. It provides only that an EMS service participating in a paramedicine collaborative “make reasonable efforts to ensure that it has sufficiently staffed the provision of initial emergency medical care and transportation of sick and injured persons before making staff available to provide community and paramedicine services.” There is no mechanism to prevent actual reductions in emergency response capacity or to ensure that there are sufficient staff available for emergency duties. There are also no mechanisms for enforcing emergency response readiness or penalizing providers that cause patient harm by diverting emergency resources to paramedicine programs.

This legislation is a direct attack on nursing scope of practice and gives clear economic incentives for EMS providers to maximize their revenues at the expense of response times for patients needing life and death emergency assistance. NYSNA opposes the community paramedicine proposal in Part S, Sub-Part A, Health and Mental Hygiene Article VII Legislation.

CRNA Scope of Practice and Licensing Should Not Be Addressed in the Budget

The Executive Budget also proposes legislation (Part H, Health and Mental Hygiene Article VII Legislation) that would expand and codify the scope of practice of Certified Registered Nurse Anesthetists (CRNAs). The proposed legislation would amend Section 6902 of the Nurse Practice Act by adding new Section (4) permitting RNs who are certified as CRNAs to practice “nurse anesthesia.” Anesthesia services are defined to include anesthesia and anesthesia-related care, pre-anesthesia evaluation and preparation, anesthetic induction, post-anesthesia care, peri-anesthesia nursing, clinical support functions, and pain management. CRNAs would also have the authority to prescribe drugs, devices, anesthetic agents and pain management agents.

CRNAs would have to maintain a collaborative agreement with and receive medical direction from a qualified physician. CRNAs with less than 3600 hours of practice would be subject to more physician

oversight, those with more than 3600 hours would be permitted to maintain a looser collaborative agreement. CRNAs would be allowed to practice in hospitals and other Article 28 settings, office-based practices and dentist/periodontist offices.

A new Section 6912 of the Nurse Practice Act would set the parameters for certification of CRNAs. These would include RN licensure, completion of an educational program registered by the department or accredited by a national body recognized by the department and payment of a \$50 fee. CRNAs who have been practicing for 2 of the last 5 years prior to enactment could be certified without meeting additional requirements if they submit an application that includes a physician's attestation of the applicant's competence and experience within 2 years of enactment. While the application is pending, they may continue to practice and use the title of CRNA.

NYSNA supports legislation to codify the scope of practice of CRNAs, but has concerns that existing CRNAs may be prejudiced or adversely impacted if they are not able to meet the criteria for "grandfathered" status.

NYSNA, accordingly, opposes inclusion of this legislation in the budget. Any legislation to codify CRNA practice standards and licensing criteria should be introduced as a stand-alone bill to allow full analysis and review, and to ensure that existing CRNAs are not prejudiced by the new criteria.

NYSNA Opposes Corporate For-Profit Ownership and Operation of Retail Health Clinics

NYSNA strongly believes that it is imperative to protect nurses and patients from ongoing efforts to expand the ability of for-profit corporations to own and operate "retail clinics" in commercial settings and strongly opposes the "Walmartization" of health care in New York. For-profit corporate ownership and private equity investment in and control of hospitals and other health care providers, including retail health clinics, is a threat to patient care and to the practice of nursing.

The proposed Executive Budget legislation to authorize corporate ownership and operation of health clinics includes the following provisions:

- Retail clinics can be owned and operated by "retail practice sponsors" who are defined to include (a) for-profit corporations, (b) general hospitals (which in NY state are now solely non-profit); (c) nursing homes (which can be both for-profit and non-profit), and (d) any other Article 28 facilities.
- Retail clinics can be operated in any commercial establishment.
- Services provided must be episodic and/or emergent in nature.
- Services cannot be provided to children under the age of 2, with minor exceptions.
- Retail clinics must have the same hours of operation as the commercial establishment and open to the general public without appointment.
- Retail clinics must be staffed at all time by at least one physician, PA or NP.
- No more than four PAs may be supervised by a single physician.
- Retail clinics will not be directly overseen by the DOH, and will instead require only accreditation by "a nationally recognized accrediting entity" approved by the department. They

will be allowed to begin operation upon providing a letter to DOH with minimal basic information as to the operator and services to be provided, without prior PHHPC review or approval, and with no opportunity for public comment or input.

- The Board and officers of business entities that operate retail clinics will be allowed to consider not only the interests of the business and the shareholders, but also the interests of patients of the retail clinic and “community and societal considerations, including those of the communities in which retail practices are located.” Though these “social factors” are included in the factors to be weighed by the corporate owners, they are permissive and not mandatory. Thus, the corporate operators of retail clinics would still be permitted to give priority to profits and corporate interests over patient care or the various “social” considerations.
- Operators would be required to accept payment without “discrimination as to source,” meaning that Medicaid, Medicare or other payment sources would presumably have to be accepted, but the application of this principle in practice is not clearly spelled out. Would Medicaid patients, for example, be required to make up the difference between Medicaid payment rate and the list price for a given service?
- Clinics would have to post their prices for each service.
- Clinics would be required to offer a “sliding scale” of payment for those without insurance or otherwise unable to afford to pay. This provision is also unclear as to its effects on the availability of services to people who cannot afford to pay for services. What are the criteria for determining a sliding payment scale? Would a patient with no money or ability to pay be turned away?
- Retail clinic operators would also be required to maintain a “collaborative relationship” with a hospital, physician practice, ACO, or DSRIP PPS within its geographic area to “facilitate development and implementation of strategies that support the provision of coordinated care within the population served by the parties to such relationship.” This provision is ambiguous and would seem to allow for “collaborative relationships” that take on the effective form of kick-back schemes or other revenue enhancing mechanisms. It would also seem to provide incentive for hospital systems and physician-groups to use retail clinics to seize market share from other competing hospitals or providers. This would be particularly problematic if used as a competitive technique to strip patients with insurance away from safety net providers (hospitals and FQHCs).
- A sponsor operating 3 or more clinics is also required to post on its public website a statement of how its operations will “improve access to services in communities where they are located,” support a “commitment to offer assistance to individuals who do not have health care coverage,” and describe “an overall commitment by the retail practice sponsor to operate some of its retail practices in medically underserved areas of the state...” These provisions sound good, but they are not very meaningful upon closer examination. For example, a fast food company’s PR department can produce similar descriptions of its commitment to providing nutritious foods in low income neighborhoods, but still generate most of its profit margins from the sale of sugary sodas (this is where fast food’s real margin lies). The statute does not actually require corporate owners of retail clinics to actually provide services to low income or medically underserved populations and has no mechanism to monitor or enforce any such policy preference.

Though the proposed legislation attempts to address some of NYSNA's concerns about the effects of increased for-profit health care penetration of the New York market, the legislation falls short in protecting existing health care networks, preventing disruption of care for low income and uninsured patients and addressing health care disparities.

Operators of retail chains like CVS and Walmart should not be directly involved in the provision of health care in New York. Studies show that retail clinics tend to cater to higher income patients and communities, that they do not lower costs of care at the system-wide level, that they shun low income and medically underserved communities, and that their primary goal is to increase market share and profit rates of their for-profit corporate owners.

The state should maintain the existing restrictions on direct corporate ownership and operation of the health care clinics. Under current law CVS and Walmart can contract with appropriate medical providers to operate clinics within their stores if they so desire. They should not be allowed to directly own and operate these clinics. NYSNA strongly opposes this proposal.

Other Notable Health Care Proposals in the Executive Budget

State Reductions in Psychiatric and Mental Health Hospital Capacity

The Executive Budget continues the process of closing state psychiatric inpatient capacity, with ongoing bed closures and the partial shifting funding to create long-term housing and other programs. Though NYSNA supports the expansion of housing and other support services for psychiatric and mental health patients, we are concerned that state policy is creating severe unintended consequences at the local level.

The state is reducing its psychiatric bed capacity at the same time that many private sector hospital systems are also reducing their inpatient psychiatric and mental health capacity. The private sector hospitals are shedding these services because of the low reimbursement rates they receive and their pursuit of higher margin services to increase their budget surpluses (profits).

The result of this process is an increasing shifting of psychiatric and mental health patients from the State and private sector to local public health systems. This shift exacerbates the already precarious financial condition of our public hospitals (particularly the NY City Health & Hospitals system, which is facing a \$1.8 billion deficit in FY2020 and which accounts for a grossly disproportionate amount of local psychiatric services).

In addition, nurses and patients in emergency rooms and the remaining inpatient psychiatric units in both the private and the public sector are faced with increasing overcrowding, long wait times for services, lack of beds, and a deterioration of patient and worker safety in the face of increasing incidents of work place violence.

This situation is unacceptable. NYSNA supports a reassessment of the state's emphasis on psychiatric bed reductions and supports increased funding to the public and private hospital systems that are

being left to shoulder an increasing burden of providing mental health services. The State needs to address a growing crisis in the provision of necessary and vital psychiatric and mental health services in New York.

Increase Nurse Family Partnership Funding

Funding for Nurse Family Partnership programs is maintained at 2017-2018 levels. NFP programs have a demonstrated track record of improving health and life outcomes of both mothers and their infant children. Recipients show better health, lower health care costs, higher educational attainment, better future job prospects and earning, lower rates of incarceration – all of which reduce future state expenditures on related services. This program pairs a public health nurse with the family from birth to early childhood and provides high rates of savings to the State. NYSNA supports increased funding for the NFP.

Increase Nurse Scholarship Program Funding

The Executive Budget maintains funding for Nurse Scholarship programs at 2017-2018 levels. Existing nursing scholarship programs are inadequate and need to be increased in the face of the recent enactment of mandatory BS nursing educational standards for future RNs (“BSN In 10”), the need to maintain the nursing workforce in the context of an aging population and accelerating RN retirements, the increased in college education costs and debt burdens on students, and the need to maintain a pathway into nursing for working class and minority students. NYSNA supports increased funding for this vital program.

No Cuts to Public Health Programs

The Executive Budget proposes to consolidate various individual Public Health Programs into four groups and to reduce total spending from \$45.9 million to \$36.7 million. Public health programs to address chronic health conditions and to support health workforce retraining efforts are of critical importance to maintaining community health and reducing the systemic costs of unnecessary emergency and acute care services. NYSNA strongly opposes the consolidation and reduction of funding for these vital programs and supports increased funding for local health initiatives and public health workforce development.

Expand Lead Paint Inspections and Remediation Regulations

The Executive Budget proposes to introduce new lead paint regulations and require periodic inspections in high-risk municipalities. Though this is a laudable program proposal, NYSNA feels that it does not go far enough to protect our children from the debilitating effects of lead in their home environments. NYSNA supports more stringent inspection schedules and the expansion of the defined geographic areas that will be subject to the law.

Codification of the State Women’s Agenda

NYSNA supports proposals to codify in New York law the requirement that health insurers provide contraceptive coverage without cost sharing/co-pays, the removal of outdated regulations in the penal and health law related to abortion rights, creation of a Maternal Mortality Review Board, provision of free feminine hygiene products in public schools and adding new requirement for diaper changing stations in all newly built public restrooms.

First 1000 Days Program

NYSNA supports this proposed program to promote early childhood services and implement policy recommendations, but feels that the initial allocation of \$1.4 million dollars is inadequate. The program should be consolidated with the Nurse Family Partnership and funding for both programs should be substantially increased to provide universal coverage throughout NY State.

Drug Costs and Pharmaceutical Distributor Payments

NYSNA supports the extension the program to cap the prices of drugs in the Medicaid program and to collect surcharges to prevent price gouging increases. This program should be expanded to more aggressively target improper market practices and the price gouging practices of pharmaceutical companies.

HCRA Renewal/Extenders

NYSNA supports the renewal and extension of provisions of the Health Care Reform Act (HCRA) legislation that was due to expire in 2017. We are concerned, however, that the proposal does not address the methodologies by which these funds are allocated and would support revisions of the indigent care pool and other methodologies to more closely and fairly track services to Medicaid and uninsured patients. NYSNA is also concerned that the legislation would give the DOH the authority to make changes in the allocation of HCRA monies without setting specific standards or parameters to ensure a fair allocation to health care providers that most need the funding.