New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

Joint Legislative Hearing: FY 2022-2023 Health Budget
February 8, 2022
Testimony of the New York State Nurses Association
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The FY23 Executive Budget, benefitting from billions of dollars in federal pandemic emergency funding from the American Rescue Plan Act, invests significantly in expanding healthcare coverage and capacity while also investing in education and other vital services, expanding state "rainy day" reserves, and projecting balanced state budgets for the next five years.

The Governor's Executive Budget proposals related to healthcare are centered on the goal of increasing the healthcare workforce by 20% over the next five years to meet the growing needs of an aging population for more healthcare services, to expand coverage and access to services, to improve the quality of care, and to address long-standing racial and socio-economic inequities in access to and quality of care that produce poorer health outcomes. The budget also recognizes the impact of the COVID crisis on the healthcare system and workforce and the need to rebuild and fortify a system that was severely stretched by the pandemic and to prepare for future crises.

NYSNA welcomes the ambitious goals set by the Governor and agrees that stabilizing and growing the direct care workforce will be an essential element in overcoming the current pandemic crisis, bolstering and restructuring the hospital and nursing home industries, as well as the broader healthcare system, and meeting the future healthcare needs of New Yorkers.

NYSNA supports the proposals in the executive budget to increase funding for hospitals and nursing homes, to expand healthcare coverage to cover more of the uninsured, and to improve the recruitment and retention of nurses and other direct care workers.

We are concerned, however, many of the concrete policy proposals and funding commitments in the budget are not consistent with or adequate to fully implement the state's aspirational goals.

1. Expanding the RN Workforce: Recruitment, Retention, and Improved Working Conditions

In order to meet the Executive Budget's goals of increasing the healthcare workforce by 20%, improving the quality of care, and addressing racial and social inequities in the health system, the state will necessarily have to substantially increase the existing RN workforce.

Nurses are the backbone of the hospital and nursing home sectors, but are also increasingly in short supply. The nursing shortage is bad and getting worse. The COVID pandemic has stretched the nursing workforce to the breaking point and nurses are leaving or considering leaving the bedside at an accelerating pace.

To address the continuing nursing shortage, it is imperative to take active measures to keep the nurses we have and to bring in large numbers of new ones. This will require a comprehensive and robust approach to improve nurses' working conditions, increase wages, provide better health care and retirement benefits, protect the health and safety of the workforce, address poor staffing conditions, and ultimately make nursing an attractive career choice.[1]

The Executive Budget contains several positive proposals to address this problem, but the proposals need to be more expansive to increase recruitment and, more importantly, the retention of existing nursing staff.

Fix the Retention Bonus Proposal to Include All Nurses (Art. VII, Health and Mental Hygiene, Part D)

The Executive Budget proposes to pay $3,000 retention bonuses to healthcare workers who stay in their positions for a year. The proposal, however, is capped at an "annualized base salary" of $100,000.

This cap will end up excluding thousands of registered nurses who have borne the brunt of the pandemic. We estimate about 20,000 of our 40,000 members will not qualify for the retention bonus. This is particularly true in high-cost regions with higher wages (NYC, Westchester, Long Island), for the senior nurses who are the backbone of the nursing workforce, for nurses with specialty or advanced practice titles, and for nurses working night shifts and weekend positions.

The Executive proposal also fails to properly consider that the regular full-time workweek in our hospitals and nursing homes is generally 37 ½ hours per week. The full $3,000 bonus is only payable to workers with a regular 40-hour workweek. As a result, even those nurses who manage to meet

[1] See: DOH "Study of Nurse Caregiver Minimum Staffing Levels and Other Staffing Enhancement Strategies and Patient Improvement Initiatives" (August 2020), at page 4. The DOH study recognized the importance of good working conditions in maintaining a stable nursing workforce and addressing the shortage of nurses:
"All of these factors suggest the need for a comprehensive approach to ensure that New York State has a highly trained, skilled nursing workforce that will continue to meet the needs of patients and residents in a safe work environment. A workforce development approach should include strategies to ensure:

- nursing continues to be an attractive career;
- enough capacity exists to educate and train the workforce of the future;
- nurses have training opportunities to advance their careers;
- programs exist to support work-life balance for nurses;
- a safe work environment that minimizes the stressors that nurses experience;
- New York State has the necessary data to conduct nurse workforce research that informs future workforce planning; and
- State workforce policy provides flexibility to allow providers to align workforce capacity with patient and resident needs in a dynamic, continually evolving delivery system."

the $100,000 salary cut-off will only be eligible for a partial bonus ($2,000), effectively treating them as part-timers.

The exclusion of large numbers of nurses from eligibility will negatively affect morale and will be seen by nurses as insulting and yet another failure by the state to recognize the sacrifices made by the frontline workforce in the course of the pandemic. Offering a $3,000 bonus may not dissuade a nurse who is planning to retire or take a less stressful job, but denying the bonus to tens of thousands of nurses who worked through the hellish conditions of the pandemic will be embittering and may cause even more nurses to make the decision to leave the bedside.

The Part D retention bonus proposal should be fixed to cover all RNs, regardless of base salary levels and to define full time schedules as 37 ½ hours or more.

Tuition and Loan Forgiveness for Nurses

The Executive Budget proposes to increase the number of new nurses in the workforce by creating a new "Nurses Across New York" program to provide loan forgiveness in exchange for a commitment to work for 3 years in an underserved community (Health and Mental Hygiene, Article VII, Part A).

NYSNA supports the creation of a new state program targeted at direct care nurses. The budget proposal, however, is only funded at $2.5 million in FY23 and $3 million per year thereafter. The funding level being proposed is totally inadequate to attaining the goal set by the Governor to increase the nursing workforce by 20% over the next five years. Assuming an average annual loan forgiveness credit of $10,000 per applicant (which is probably too low), this program will be available to no more than 125-150 nurses per year.

To effectively increase recruitment and retention of new nurses in the workforce, NYSNA would propose the following more robust measures be incorporated in the Part A proposal:

- Make nursing students eligible for STEM scholarships/tuition support;
- Significantly Increase funding for the Nurses Across NY proposal in Part A;
- Create additional tuition support/loan forgiveness programs targeted to a commitment to work for safety net hospitals, in hard to recruit positions or shifts within a hospital, or in additional targeted shortage areas;
- Create a variety of longer-term programs that would, for example, require a 10-year commitment to work for a hospital anywhere in New York State.

Expand Nursing School Capacity

- Increase capital and operating funding for CUNY and SUNY to substantially increase the number of available slots in nursing schools;
- Increase existing tuition support/loan forgiveness program for nurses to qualify as instructors;

- Allow a wider range of nurses to be eligible to teach based on experience and practical knowledge rather than solely on qualifying degree earned;
- Encourage nurses retired from public hospitals to become faculty by waiving the public pension plan limits on earnings (the Executive Budget includes a proposal in Article VII, Education, Labor and Family Assistance, Part HH to waive the limits, but this applies only for public school teachers –this exemption should also apply to retired RNs who teach in a nursing school);
- Provide direct salary subsidies for nursing schools to increase instructor pay and benefits;
- Allow the use of simulation training where appropriate and provide funding to expand the availability of clinical placements of students in hospitals and nursing homes.

Residency and Preceptorship Programs to Support New Nurses

- Provide funding for hospitals and other providers (particularly safety-net providers) to establish nursing residency programs in partnership with nursing schools to provide better training and support to new graduates as they transition into direct care roles and reduce high turnover rates of new hires;
- Provide funding, including funds to pay for backfilling facility staff, to support robust preceptorship programs in every hospital and nursing home.

Implement and enforce minimum infectious disease protocols and standards in healthcare workplaces

The 2021 NY HERO Act (Labor Law Section 218-b) requires the DOL to formulate industry specific standards to protect workers from COVID and other airborne infectious diseases. The DOL has issued regulations and minimum standards applicable to various industries, but has not created a standard for hospitals and other healthcare settings. Existing DOH standards and guidance to employers rely on CDC guidelines, but these are often ineffective, are subject to frequent changes in policy, and fail to provide consistent minimum protective standards (there are wide variations in PPE, isolation, return to work and other policies from facility to facility – there should be uniformity and high protective standards). The federal government issued an OSHA emergency temporary standard (OSHA ETS) in 2021 applicable to healthcare workplaces, but it was allowed to expire and a final permanent regulation may not be issued and in effect for a year or more).

The lack of a consistent and safe infection control standard for hospitals and other care settings negatively affects retention of nursing staff and impedes efforts to expand the workforce. The inadequacy of infection protections and inconsistency in their application from week to week and from facility to facility exposes nurses to illness and increases the strain on the workforce as nurses are forced to go into isolation or are sickened. Recent changes in return-to-work protocols issued by the CDC and the DOH, which employers are using to require nurses to return to work after 5 days, even if they are still experiencing COVID symptoms are a particular source of anger and demoralization of nursing staff.

The budget legislation should include an amendment of Labor Law Section 218-b to require the DOL to issue a COVID/airborne infectious disease standard that is based on the expired OSHA ETS and includes the following provisions: standardized minimum PPE and source control protocols; environmental controls (ventilation, negative pressure rooms, physical barriers); consistent and scientifically determined testing, contact tracing and isolation standards to protect workers and patients from exposure; and fully paid leave benefits and relief from work for ill or exposed workers. A full list of the elements that should be included in a safe and proper COVID infection control standard for healthcare workers can be accessed at: https://www.nysna.org/omicron-demands.

In addition, funding should be provided to the DOL to implement and enforce compliance with the COVID infection control standard for the duration of the COVID pandemic.

Classify COVID as an occupational disease for Workers Compensation claims filed by front line essential workers

Nurses and other essential workers who worked during the pandemic were regularly exposed to COVID and many were sickened. Current law requires these workers to establish that they contracted the virus on the job to qualify for workers compensation benefit and many employers and insurance carriers routinely challenged their eligibility.

The legislature should enact budget legislation (based on A6117-A/S1241-A) to create a rebuttable presumption that nurses and other frontline essential workers with COVID contracted the disease at work and qualify for workers compensation. We have asked much of the nursing and direct care workforce during this crisis, and we should treat those who were sickened or died fairly and recognize their sacrifice. Frontline essential workers should not be required to prove that they got sick at work.

Improve the Tier 6 pension to recruit and retain nurses in the public sector

In 2012 the Cuomo administration pushed through a new Tier 6 pension plan for public sector workers that included a higher retirement age, lower pensions benefits, and higher mandatory employee contributions than was required of nurses and other public sector workers who were hired before 2012.

The new Tier 6 pension system has had a negative impact on recruitment and retention of nurses in public sector hospitals and public health systems. Wages for nurses in the public sector are significantly lower than comparable jobs in the private sector. The adoption of Tier 6, coupled with lower wages, has made retention of nurses in the public sector more difficult.

The Tier 6 pension plan should be restructured to create a more attractive pension structure for registered nurses and other hard to recruit health care workers as follows:

- Lower the regular retirement age to 60 from 63;
- Reduce employee pension contribution rates for the first 10 years and eliminate contributions after 10 years of employment;

- Create a new special 55/25 retirement plan applicable to Tier 6 nurses and other hard to recruit health care workers.

2. Nursing Practice and Quality of Patient Care

NYSNA believes that high standards of nursing practice are inextricably interconnected with the quality of patient care in hospitals and nursing homes and are directly correlated to better job satisfaction and retention of staff. Frustration with impediments to meeting professional standards of care for patients contributes to staff turnover and the exodus of nurses from the bedside. It is accordingly important to maintain nursing scope and practice regulations and resist industry efforts to reduce costs through deskilling and dilution of patient care standards.

NYSNA Supports the Expansion of Independent Practice Rights for Nurse Practitioners (HMH, Art. VII, Part C)

Nurse Practitioners (NPs) are advanced practice RNs who are trained and qualified to engage in an expanded scope of practice that includes the diagnosis patient conditions, assessments of patient health, and prescription of medications. The Nurse Practitioner title has long been established nationally and in New York and NPs play a vital role in providing high quality care to patients in a wide range of settings, particularly in medically underserved communities.

New York law currently allows NPs to practice pursuant to collaborative agreements and practice protocols under the supervision of physicians, with experienced NPs with 3,600 or more practice hours allowed to practice with less physician oversight and without requiring collaborative agreements. The current law, however, will sunset in 2022. If the law sunsets, all NPs regardless of their level of experience, will be required to reenter into collaborative agreements and practice protocols. If the current law lapses, it will significantly disrupt current provider networks and access to vital health services.

The legislature has introduced the Nurse Practitioner Modernization Act (NPMA - A1535/S3056) that would allow NPs with more than 3,600 hours to practice independently of physicians, to oversee and supervise less experienced NPs (those with less than 3,600 hours of experience) and make the existing law permanent.

The Executive Budget incorporates parts of the NPMA, but the proposal budget legislation in HMH Article VII, Part C, will not allow qualified NPs to supervise less experienced NPs and it limits the authorization for experienced NPs to practice independently only to those who are practicing in primary care areas. This will disrupt existing healthcare services and may result in reducing the number of NPs available to provide care in underserved areas (where there is also a lack of physicians to supervise NPs).

NYSNA supports the incorporation of all the provisions of the Nurse Practitioner Modernization Act in the Part C budget legislation.

NYSNA Opposes Authorizing Nursing Aides to Administer Medications (HMH, Article VII, Part C)

Part C of the budget legislation also proposes to create a new title of "certified medication aides" who would be authorized to administer certain kinds of medications to residents of nursing homes.

Administration of medications in hospitals and nursing homes is currently limited to licensed nurses. The rationale for the proposed change in the law is to address nursing shortages in certain parts of the state.

Though NYSNA understands this rationale, we believe that the budget proposal is not the correct way to address the staffing problems in those nursing homes. The law would require RNs to supervise the administration of medications by these aides, adding to their existing patient care loads and exposing them to liability for medication errors committed by unlicensed aides, which will exacerbate the recruitment and retention of licensed nurses and could result in even worse staffing. We also believe that this proposal will undermine current practice standards and result in harm to nursing home residents.

For these reasons, NYSNA opposes this provision and urges that it be removed from the budget legislation. If there are shortages of licensed nurses in certain areas of the state, they should be addressed by improving working conditions and providing funding to allow those facilities to increase nurse pay to recruit more nurses.

NYSNA Opposes Joining the Interstate Nurse Licensure Compact (HMH, Article VII, Part B)

The Executive Budget proposes to have New York join the formal compact under which party states recognize the nursing licenses of other states. The rationale for this proposal is to help to ease the current nursing shortage by opening New York to the free movement of nurses licensed in other compact states.

NYSNA strongly opposes this proposal because it will cede the state's current authority to independently set its own standards for nursing education, training, and licensure. Under the terms of the interstate compact, New York would be required to recognize and allow any nurse licensed by another state to practice in New York.

The interstate compact is governed by a board made up of representatives from the member states, most of which are less regulated southern and midwestern states with less lower standards and poorer health outcomes than New York. Because these states make up the majority of the compact, they will exert more power over licensing standards in the governing body and will be able to outvote New York in any disputes about who is qualified to practice nursing in our state. New York would be bound to recognize and allow nurses to practice in New York who do not meet our qualifying and practice standards.

Based on these considerations, NYSNA opposes joining the compact and ceding authority to regulate the practice of nursing to these other states.

Joining the interstate compact will not necessarily lead to more nurses working in New York – nurses will be able to come to New York from other states, but New York nurses will be equally able to leave New York to practice in other compact states.

Finally, we note that in the event of future emergencies that require us to allow nurses from other states to practice in New York, the state could temporarily waive licensing requirements through

executive order or temporary suspension of licensing requirements. We can allow nurses from other states to practice in New York, when necessary, without completely ceding our power to set standards of care and qualifications for licensure. These temporary waivers were successfully employed by the state to increase staffing needs during the pandemic and can be again employed to address future emergencies.

NYSNA Opposes the Transfer of Oversight of Nursing from Higher Education to DOH (HMH, Art. VII, Part G)

This legislation would remove regulation of all licensed healthcare professions, including nursing, from the jurisdiction of the State Education Department and shift it to the Department of Health effective 1/1/23.

The Education Department has a long history of regulating practice standards and licensure requirements for healthcare professionals. They have an experienced cadre of nursing staff who are well versed in nurse practice issues and are more insulated from political and lobbying efforts to dilute or deregulate health care professions than would be the case if jurisdiction was transferred to the DOH.

The DOH is responsible for regulating health care employers, including hospitals and nursing homes, and may find itself facing a conflict between its role in regulating the healthcare industry and its interest in reducing Medicaid and other healthcare cost on the one hand, and maintaining professional practice standards. Higher Education has a demonstrated record of competence and knowledge of the intricacies of professional practice standards and is less susceptible to industry pressures to dilute those standards in response to financial factors.

If there are concerns about the Education Department's ability to issue standards or modify existing standards in a timely manner, the solution is to increase its funding and staffing, not to move its jurisdiction to the DOH.

For these reasons, NYSNA opposes this proposal.

NYSNA Opposes Expanding the Scope of Practice of Emergency Services Personnel (HMH, Art. VII, Part F)

The Executive Budget proposes various measures to revamp and improve the coordination of the state's EMS services. NYSNA has no objection to creating integrated statewide governing bodies to oversee and standardize the training of EMS personnel, to more closely monitor the effectiveness of EMS services, and to provide better coordination and regulation of services at the state and local county level.

We are troubled, however, by the proposed expansion of the scope of practice of EMS personnel.

Under current law, EMTs and Paramedics have wide ranging authority to assess, diagnose and treat persons suffering from trauma or other emergency conditions (stroke, cardiac arrest, etc.), but this wide latitude is restricted to stabilizing the patient at the site of the emergency and during transport to a receiving site of medical and nursing care. Upon transferring the patient to the appropriate site,

the patient's care is taken over by licensed physicians, nurses, and other staff under established standards of care.

The proposed legislation would maintain this broad scope of practice but entirely remove the time and place restrictions. This will result in EMS personnel being allowed to and used to provide more sophisticated nursing or medical care that they are not trained or educated to properly carry out.

The legislation would define EMS scope to include "care of a person to, from, at, in, or between the person's home, scene of injury, hospitals, health care facilities, public events or other locations" (i.e., everywhere and anywhere), for "emergency, non-emergency, specialty, low acuity, preventative…assessment, treatment, transportation, routing, referrals and communications with treatment facilities…public education, injury prevention…administration of immunizations…and follow-up and restorative care."

As defined in the proposed statute, EMS personnel will essentially be able to practice medicine, nursing, pharmacy, physical therapy, teaching, public health functions, rehabilitation therapy, and other functions almost without limitation. The DOH would be authorized to promulgate specific regulations with little or no statutory parameters. This amounts to allowing EMS personnel to effectively practice nursing without meeting the educational criteria and practice skills of licensed nurses.

NYSNA opposes this almost unrestricted expansion of EMS scope of practice licensed nursing functions and to supplant the role of RNs in the care of patients.

3. Safe Staffing

A centerpiece of the Governor's budget proposals is the goal of increasing staffing of nurses and other direct care staff by 20% over the next five years.

Ensuring safe staffing in our hospitals, nursing homes and broader healthcare system is a necessary component of addressing inequalities in care, poor patient outcomes and the stability of the healthcare workforce. The COVID pandemic has worsened the staffing crisis and revealed the importance of nurses and other direct care workers to meeting the healthcare needs of the population. The state was able to increase bed capacity to meet surging COVID patient loads, but finding enough nurses and other staff to care for the patients in those beds was a more elusive task.

Poor staffing of RNs and other direct care workers is endemic throughout the hospital system, particularly in underfunded safety net hospitals and other financially precarious providers. When hospitals and nursing homes are poorly staffed, patients receive poorer quality care and the exodus of nurses from the bedside is accelerated.

In 2021 the legislature enacted legislation to improve staffing in hospitals and nursing homes. The hospital legislation requires all general hospitals to form committees, adopt specific and enforceable staffing standards, and provide greater transparency and inform the public about their staffing plans

and actual staffing levels. The nursing home legislation imposes minimum daily hours of care by licensed nurses and nursing aides for each resident and further requires that nursing homes make minimum spends on direct resident care and staffing.

The hospital legislation also requires the state DOH to implement new stand-alone minimum staffing standards for intensive care and critical care patients (requiring a 1:2 ratio or a minimum of 12 hours of RN care per day for each patient) effective January 1, 2022.

To meet the staffing requirements of the new staffing laws and to reach the stated goal of increasing the workforce by 20% above pre-pandemic levels, New York hospitals and nursing home will have to add tens of thousands of nurses and other direct care staff.

With respect to RN staffing in the hospital and nursing home sectors, the state DOH staffing study issued in August 2020 estimated that there was a total of 73,000 FTE RNs employed in hospitals and 7,800 FTE RNs employed in nursing homes. That DOH study further estimated that implementing minimum safe staffing ratios in hospitals would require an additional 14,000 RNs.[2] To meet the state's goal of increasing the nursing workforce by 20%, we will need to maintain the pre-pandemic workforce of 80,000 nurses and add at least 16,000 more to reach an expansion target of about 96,000 nurses. It should be noted that the Governor acknowledges that New York's direct care workforce in 2021 was 3% below pre-pandemic levels and 11% below where it should be to reach the 20% growth target.

To fully address understaffing, allow hospitals and nursing homes to comply with the new staffing laws, stabilize and expand the nursing workforce, and reach the growth targets set by the state, NYSNA believes that the following measures must be included in the state budget:

Create a Hospital Nurse Recruitment and Retention Fund

The Executive Budget proposes to increase across-the-board Medicaid reimbursement rates (rescinding the 2021 1.5% rate reduction and adding a new 1% increase). The Executive Budget is also proposing to make permanent the Local Distressed Hospital Funding Pool created in 2020 and to increase funding from $250 million to $350 million per year. With matching federal funding, this proposal will provide $700 million per year to support financially stressed safety net hospitals, or $2.8 billion over the next four years.

[2] The DOH "Study of Nurse Caregiver Minimum Staffing Levels and Other Staffing Enhancement Strategies and Patient Improvement Initiatives" (August 2020), at page 62, estimated that implementing safe staffing ratios in hospitals would require an additional 24,779 nurses, but that number included a glaring error that miscalculated the need for additional operating room nurses. The report estimated the need for an additional 10,416 OR nurses to comply with a 1:1 ratio in operating room procedures, but state law already requires a 1:1 OR ratio and hospitals are already meeting that standard – there would be no need to hire more OR nurses except as necessary to increase the number of OR procedures performed. Accordingly, after correcting for that error, the total RNs needed to comply with safe staffing ratios in hospitals would be 14,363, not 24,779.

This additional funding is welcome but is not enough to allow hospitals and nursing homes to generate the operating income they will need to expand their workforces and recruit and retain nurses and other direct care staff. A 2.5% increase in Medicaid reimbursement rates is on its face insufficient to support a 20% increase in hospital staffing. This is particularly the case for the dozens of financially precarious safety net hospitals that are barely keeping their heads above water now.

Accordingly, NYSNA supports the creation of a dedicated funding stream to enhance hospital nursing care and RN staffing in the FY2022-2023 budget. To address ongoing RN shortages worsened by the pandemic, and add at least 16,000 RNs to the workforce, hospitals will need an additional $1.6 billion in annual revenues above current levels to hire and maintain the expanded workforce.[3]

NYSNA urges the legislature to provide supplemental funding for hospitals to support improved pay and benefits, fund efforts to recruit new hires and retain existing nursing staff, enhance staffing to comply with the new hospital nurse staffing law, and meet the Governor's workforce expansion goals.

The available funding should be increased annually based on the annual Consumer Price Index and distributed to hospitals based on an analysis of local healthcare needs and inequities in staffing levels. Allocations should prioritize grants to safety net hospitals that serve a disproportionate share of Medicaid, uninsured and/or medically underserved populations.[4]

Increase DOH Funding to Oversee and Implement the new Hospital Staffing Law

The recently enacted hospital staffing law (PHL Section 2805-t) requires clinical staffing committees in each hospital to develop staffing ratios, grids, or other specific staffing standards for all hospital units. The annual staffing plans developed by the committees must be implemented and complied with by each hospital. In addition, the adopted staffing plans and data regarding actual hospital staffing must be publicly posted and reported by the hospitals and posted by the DOH.

The new nursing home staffing law (PHL Section 2895-b) directly sets minimum nursing home staffing standards, expressed as "hours per resident per day" (HPRD), including a minimum of 3.5 HPRD, of which at least 2.2 HPRD must be nursing aide time and at least 1.1 hours HPRD of licensed nurse time for each patient.

The DOH is required to oversee and enforce compliance with the hospital staffing law and nursing home law. In its mid-year updated budget, the DOH added $2 million to hire staff to enforce the new nursing home staffing law. That mid-year adjustment did not refer to or include compliance costs for the new hospital staffing law.

[3] We assume an average statewide average cost of $100,000 per nurse, including salary and benefits (health and pension). These costs will vary depending on the region and the experience and education of the newly hired nurses.

[4] We are not at this time proposing a separate fund for nursing home staffing, as last year's budget already established dedicated funding for that industry.

The Executive Budget, however, does not provide any additional funding or added DOH staff to enforce the new hospital law. The legislature should add at least $5 million to the DOH budget to hire staff dedicated to enforcement and implementation of the new hospital staffing law.

Amend the new Hospital Staffing Law (PHL 2805-t) to Include Additional Minimum Staffing Ratios

Understaffing in hospitals is a major cause of high RN turnover rates, job dissatisfaction, and ongoing recruitment and retention issues that will impede reaching the state's target of growing the workforce by 20% over the next five years.

To address the vicious cycle of poor staffing that drives even more nurses from providing bedside care in our hospitals, NYSNA believes the legislature should consider amending the hospital staffing law to set uniform minimum staffing standards for more types of units and patients, including emergency departments, pediatric units, psychiatric units, adult medical/surgical units, maternity units, and other units that continue to be understaffed or in which there are wide and variations from hospital to hospital that undermine equal access and quality of care.

NYSNA supports amendment of PHL Section 2805-t to add the following additional minimum staffing ratios that must be incorporated into hospital staffing plans:

- Pediatric units: 1 RN to 3 patients;
- Obstetrics: 1 RN to 3 patients;
- Well Baby Nursery: 1 RN to 6 patients (mother and child couplets);
- Step Down/Telemetry: 1 RN to 3 patients;
- Psychiatric (adult, adolescent): 1 RN to 4 patients;
- Medical/Surgical: 1 RN to 4 patients;
- Emergency: 1 RN to 3 patients.

The addition of minimum staffing levels for pediatric, obstetric and well-baby units, according to the DOH study, would require only 271 total additional FTEs. The addition of minimum ratios for telemetry, psychiatric, medical/surgical and emergency units would require about 12,000 additional FTEs, but those units could be phased in to allow hospitals to adjust their staffing levels.[5]

[5] According to the DOH staffing study issued in August 2020, at page 62, the implementation of the above staffing ratios would require the following numbers of additional RN FTEs above 2018 staffing levels:

Pediatric units: 1 RN to 3 patients	91 FTEs
Obstetrics: 1 RN to 3 patients	168 FTEs
Well Baby Nursery: 1 RN to 6 patients (mother and child couplets)	12 FTEs
Step Down/Telemetry: 1 RN to 3 patients	926 FTEs
Psychiatric (adult, adolescent): 1 RN to 4 patients	2,718 FTEs
Medical/Surgical: 1 RN to 4 patients	2,799 FTEs
Emergency: 1 RN to 3 patients	5,704 FTEs
Total:	12,418 FTEs

4. Expanded Healthcare Coverage and Equity

NYSNA supports universal healthcare coverage for all New Yorkers and recommends the enactment of the single payer health coverage that would be provided under the **New York Health Act (A6058/S5474)**.

Notwithstanding our continued support for a single payer health system, however, NYSNA is supportive of intermediate steps to increase health insurance coverage and notes that the Executive Budget contains many provisions to expand access to Medicaid and Essential Plan coverage, reduce the number of uninsured New Yorkers, and improve covered services and the quality of care for Medicaid enrollees.

NYSNA, accordingly, supports the following provisions in the proposed budget:

- **HMH, Article VII, Part N** - Increased Medicaid eligibility for low-income seniors and the disabled;
- **HMH, Article VII, Part O -** Improve Medicaid Long Term Care programs by expanding eligibility for private duty nursing for medically fragile adults, implementing a uniform standard for tasking tools to expand eligibility for home care services, and the expanding at-home alternatives to nursing home care for seniors;
- **HMH, Article VII, Part P -** Expand the criteria for approval of Managed Care Organizations to require an assessment of services provided to disabled populations, inclusion of public hospital systems in provider networks, preference for non-profit operators, cultural and language service capacity aligned with the needs of the population served, review of past performance metrics and records of violations and complaints, and other factors to improve care; cap the number of providers in each region to avoid duplicative and wasteful competitive practices; and, require insurers on the state exchange and Medicaid managed care plans to include a nationally designated cancer treatment center in their network of providers;
- **HMH, Article VII, Part Q -** Authorize the DOH to seek a federal waiver to expand Essential Plan eligibility from 200% of the federal poverty level to 250%, expand newborn coverage for a full year after birth, regardless of changes in family income, and expand covered services for long-term chronic illnesses to be equivalent to Medicaid coverage;
- **HMH, Article VII, Part R -** Require all health plans to provide full abortion coverage without co-pays, deductibles, or coinsurance; and, for exempt religious employers, require the insurer to offer an abortion services rider to the employee;
- **HMH, Article VII, Part S –** Subject to federal approval, expand Medicaid coverage of prenatal and post-natal coverage and extend coverage for a full year after birth regardless of changes in family income;
- **HMS, Article VII, Part T –** Require syphilis testing in the third trimester for all mothers;
- **HMH, Article VII, Part U –** Expand Child Health Plus program coverage to parallel regular Medicaid, thus adding ambulance and various other health services; eliminate the $9 monthly

premium for families between 160% and 223% of the poverty level; and authorize the DOH to increase provider reimbursement levels in the program;

- **HMH, Article VII, Part V –** Establish parity in telehealth reimbursement rates under Medicaid and private insurance plans, and establish parity for mental telehealth services – NYSNA is concerned however, that the legislation would disallow the hospital facility fee add on if both the originating site and the distant site are located off campus- NYSNA believes that hospitals should be able to receive the hospital add on in these circumstances if the service is being provided by hospital staff and the remote service is the result of pandemic accommodations;
- **HMH, Article VII, Part AA –** Further reduce surprise billing of patients by expanding the current applicability of the law to include any "provider" (in addition to physicians and hospitals) and imposing more transparency and reporting of provider participation in insurers' networks.

NYSNA, however, opposes the proposal in **HMH, Article VII, Part BB** to eliminate the current "provider prevails" rule in Medicaid drug prescriptions. The proposed budget legislation removes the current provision that the reasonable professional judgment of the prescriber that the drugs are medically necessary is controlling – this will give too much power to for-profit managed care plan operators to reduce costs against the advice of the patient's medical provider.

5. Hospital and Healthcare Funding

NYSNA believes that the current state structure for funding hospitals and the broader healthcare system is a major factor in fostering and perpetuating racial and socio-economic disparities in healthcare coverage, the quality of care, and community health outcomes.

The hospital reimbursement system is predicated on the assumption that hospitals will maintain a balance of payers sufficient to produce enough revenues from higher paying private insurers and more complex services to offset the intentionally low reimbursement rates for Medicaid and Medicare patients and the cost of caring for the uninsured. Medicaid and Medicare pay below the costs of providing care. Hospitals with a "healthy" payer mix are able to make up those losses and generate net revenues to support improved care, expansion of services and investments in improved equipment and physical plant.

This payment structure, however, encourages the state to generate fiscal savings by driving Medicaid reimbursement rates lower or to lag behind the rate of medical and labor cost inflation. It also gives private providers (non-profit and for-profit alike) an incentive to try to shed Medicaid and uninsured patients and increase their share of the private insurance market to drive higher revenues and profits.

This dynamic is especially destructive of the financial stability and ability to provide quality care of safety net providers that disproportionately serve communities of color, working people, immigrants, and low-income areas.

The end result is a two-tiered hospital system in which safety net hospitals are under constant financial strain, struggle to provide the level of staffing that their patients need, find it difficult to recruit and retain nurses and other direct care staff, and are unable to make needed investments in physical plant and equipment.

This two-tiered hospital system directly affects the health and well-being of the communities that rely on safety net providers for their health services. COVID laid this contradiction bare and worsened the differences in outcomes. Black and Latino New Yorkers disproportionately are covered by Medicaid or uninured. It thus comes as no surprise that the hospitalization and mortality rates from COVID in these populations were much higher than those of whiter and wealthier communities.

NYSNA supports the following proposals in the Executive Budget that will increase funding available to providers, some of which are targeted to safety net providers:

- **HMH Article VII, Part H – Increase the Global Medicaid Cap**
  The proposal would retain the Global Cap but change the formula for calculating annual increases by switching from the 10-year rolling average of the healthcare component of the CPI to the 5-year rolling average of the CMS projections of Medicaid spending; this proposal will increase the spending authority under the Medicaid cap by $366 million in FY23 and by $899 million in FY24.

  NYSNA welcomes this increase in Medicaid spending authority, but continues to support the elimination of the cap in its entirety. Medicaid spending should be driven by the health needs of the population, and it makes no sense to limit spending in a program that is vital to the more than 35% of New Yorkers who are Medicaid recipients, and which receives more than $1.20 in additional federal matching funds for every $1 in state spending.

- **HMH Article VII, Part I – Increase Medicaid Reimbursement Rates by 1%**
  This proposal would provide a 1% across the board increase in Medicaid reimbursement rates in FY23. In addition, the budget proposes to eliminate the 1.5% reduction in Medicaid rates that was implemented in 2021. The combined effect of the rate increases is an additional $3.7 billion in reimbursements to all Medicaid providers over the next five years.

  NYSNA supports the rate increases, but notes that the net effect for hospitals will not be sufficient to support the broader goals enunciated in the Governor's budget. A 2.5% increase in Medicaid rates does not translate into a 20% increase in the hospital workforce or provide a basis for ensuring that hospitals and nursing homes will have the financial ability to comply with the new staffing laws.

- **HMH Article VII, Part K – Statewide Health Care Facility Transformation Program Phase IV**
  This proposal appropriates $1.6 billion in capital funding to support transformation, redesign, and enhanced health care services that align with statewide and regional health needs and address ongoing pandemic response needs. The funding is available to hospitals, residential health care facilities, adult care facilities, diagnostic and treatment centers, various behavioral health programs, and independent practice associations or organizations.

The capital funding will be widely dispersed to different types of providers through an application process and will be further broken down in the following categories: $750 million for healthcare providers generally, $450 million to unfunded programs from Phase III, $200 million for emergency department modernization, $150 million for IT/telehealth infrastructure projects and $50 million for nursing home innovation/pilot projects.

NYSNA supports the appropriation of additional capital funds for hospitals and other providers, but again notes that the amount is not sufficient to meet the needs of financially precarious safety net hospitals.

- **HMH Article VII, Part CC - Distressed Provider Hospital Fund**
  In 2020 the state created a Distressed Provider Hospital Fund in the amount of $250 million with the funding drawn from a diversion of local sales tax revenues ($200 million from NY City and $50 million from the remaining counties on a proportional basis).

  Part CC proposes to extend the sales tax appropriation permanently (it is slated to sunset in 2022). In addition, the budget proposes to increase the fund by $100 million to $350 million in FY23.

  We also understand that the state is seeking federal approval to convert this $350 million state share funding into a $700 million federal matching program and to use this fund to increase reimbursement rates for safety net hospitals with high (36% or more) proportions of Medicaid patients. It is our understanding that the increase in reimbursement would be accomplished through the federal authority to approve Medicaid managed care "directed payments" targeting safety net hospitals. Over four years, this proposal would provide $2.8 billion in funding targeted to safety net hospitals.

  NYSNA supports the permanent continuation of the fund and the proposed $100 million increase. We also are in support of the effort to leverage federal funding to increase the total impact to $700 million per year.

  We note that while this proposal will increase funding to support safety net hospitals and distribute the money in regular reimbursement payments instead of lump sum infusions that are often delayed, it is not enough to correct the structural imbalances in the hospital financing system or to allow safety net hospitals to improve their staffing, expand services, or otherwise generate funding to allow long-term planning. This issue is addressed in more detail below.

  We also note that it appears that the NYC Health + Hospitals system and other public hospitals are not eligible for funding from this pool, notwithstanding the fact that NY City residents pay $200 million (or 80%) of the total sales tax contributions that provide the bulk of the state share of the proposal. We believe that public hospitals should also be eligible for support under this program.

- **HMH Article VII, Part E – General Public Health Work County Support**
  This proposal would increase the state reimbursements to county health departments from $0.65 to $1.30 per capita and would also allow health departments to be reimbursed for up to 50% of employee fringe benefit costs that were not previously eligible. It is projected that the proposal will increase total funding by $25.7 million in FY23 and by $51.4 million in FY24 and thereafter.

  NYSNA supports increased funding for local health departments. Given the burdens of the COVID pandemic and the likelihood of future disease outbreaks and climate related health effects, however, we believe that this funding is not sufficient to fortify local public health infrastructures to the degree needed to protect the public health in the current COVID emergency or to prepare adequately for future needs.

  We also note that it does not correct a prior cut the reduced NY City's reimbursement rate to 20% while maintaining a 36% cap for the rest of the state. This inequity should be corrected.

NYSNA Supports Substantial Increases in Safety Net Hospital Funding

As previously discussed, the distorted structure of hospital funding in New York traps safety net hospitals in a perpetual state of financial distress and makes it difficult if not impossible for them to provide the level of staffing and services that the communities they serve require to fully address their healthcare needs. Inadequate safety net funding is also a major contributor to existing racial and class disparities in care and health services.

We also noted that the level of funding proposed for the Distressed Provider Hospital Fund is not sufficient to break the vicious cycle caused by low reimbursement rates for Medicaid and uninsured patients who rely on safety net hospitals for their care. Even with the proposed increases in funding, our safety net hospitals remain barely able to keep themselves in operation and are not able to improve or expand their services and address local needs.

The state must accordingly consider a deeper restructuring of current reimbursement methodologies to the substantially increase safety net hospitals regular operating revenues and give them the steady income they need to engage in sustained planning and development of the services and facilities that their underserved communities need.

NYSNA urges the state to consider the following measures to address the looming disaster that would result from a sudden wave of bankruptcies, closures, layoffs, and reductions in vital healthcare services:

- **Implement a Rate Setting Mechanism to Equalize Hospital Incomes**
  Consider the creation of a state-controlled rate setting mechanism to ensure that each hospital in the state receives sufficient funding to guarantee revenues that exceed costs and produce a surplus that can be invested in improving care and infrastructure. Maryland has implemented such a system and it has successfully stabilized the finances of its hospitals.

The foundation of such a system would entail the pooling of all payer revenues (Medicaid, private insurance payment, supplemental state and federal payments (ICP/DSH), and the redistribution of the funds to each hospital based on local cost structures and community needs.

In the alternative the state could accomplish the same redistributive goal by assessing fees on hospitals with high revenues, favorable payer mixes and positive cash flows and redistribute the funds generated to safety net providers to attain the same goal of equalizing revenues and providing all hospitals with a defined net margin (or "profit") to pay for cost increases and invest in expanded or improved care.

A rate setting or assessment system for redistributing and equalizing hospital revenues would mean less money for the financially well-off networks and more money for the safety net hospitals.

- **Create a $1 billion Funding Pool to Provide Increased Operating Income for Safety Net Hospitals**
  In addition to the proposal to create a $700 million program with federal matching funds to increase reimbursement rates for safety net hospitals discussed above, the state should also allocate an additional $1 billion to further supplement safety net hospital reimbursement rates, targeted to high Medicaid use public and private safety net hospitals.

  This approach would leave the revenues of the financially secure hospital networks untouched, but would require a substantial commitment of state funding (and federal matches if possible) to be distributed to individual safety net hospitals by closely analyzing local community health needs and determining how much regular operating income is necessary for each hospital, and appropriating the necessary amounts on a regular monthly basis.

- **Target State Indigent Care Pool and Federal Disproportionate Share Funding to Safety Net Hospitals**
  New York receives about $1.8 billion per year in federal DSH funding, which is intended to compensate safety net hospitals for the losses incurred by providing care for a disproportionately high amount of Medicaid and uninsured patients. The federal DSH funding is matched by $1.8 billion in state share contributions (currently paid for with $1.1 billion in ICP funds generated by various HCRA fees and assessments and $700 million in inter-governmental transfers, mostly paid by the City of NY). The total $3.6 billion in DSH/ICP funding is then supposed to be distributed as supplemental lump sum payments to "disproportionate share" hospitals to allow them to continue to operate.

  New York uses formulas for distributing the ICP and DSH funds that disperse the money much more widely than is the case in other states. Under the NY formulas, almost every hospital in the state receives a portion of the ICP or DSH funds. Though most goes to safety net hospitals, it is also the case that extremely wealthy hospitals with high net profits, large reserves of net assets, and relatively fewer Medicaid and uninsured patients also receive

significant DSH/ICP payments. For example, NYU Langone in Manhattan regularly generates hundreds of millions in annual profits, yet still receives millions from the DSH/ICP fund because it "loses" money on its small numbers of Medicaid patient and "charity care." This broad dispersion wastes limited DSH/ICP funds and leaves less available for safety net providers that truly need it.

The state could follow the example of many other states and distribute the entire ICP/DSH fund exclusively to the hospitals with the highest percentages of Medicaid and uninsured patients and distribute no funds to hospitals with minimal Medicaid "losses." A proposal to fix the distribution of DSH/ICP funds and target them exclusively to safety net providers is pending in the legislature and would serve as a first step to the safety net hospitals has been introduced in the legislature (A6883/S5954).

This approach would make $3.6 billion available to support safety net hospitals through redistribution of existing funds and would not entail any additional state spending.

6. Other Issues of Note

- **HMH Article VII, Part L – Notices for Change in Ownership of Licensed Entities (CON Process)** This provision would amend the Certificate of Need process applicable to hospitals, nursing homes and other facilities regulated by Article 28 of the PHL.

  NYSNA supports the provisions of this legislation that increase the persons subject to character and fitness review when an application is filed to establish a new operator or transfer ownership shares to another owner or owning entity. Specifically, the proposal would add "controlling persons," "principal members," "persons," and "members" to the list of persons with an interest in the facility who are subject to review.

  The legislation also expands the types of facilities or ownership structures that are subject to the CON review to include corporations that own nursing homes (previously the statute only applied to partnerships and LLCs), home care services or certified home health agencies, and hospices.

  NYSNA supports these measures.

  We oppose, however, the proposal to reduce the "look back" period for character and fitness review from 10 years to 7 years. The DOH and PHHPC should not be making it easier for bad actors to own or operate health care facilities. This provision should be removed from the proposed legislation.

  We are also concerned that the proposal revises the statute to require a review to be completed within 90 days of completion of the application process. We are concerned that this language could be read to create an automatic or default approval of the application if a

decision is not issued within the 90-day period. The legislation should clarify that the statute will not create such a default approval process.

- **HMH Article VII, Part GG – Extend Delivery System Reform Incentive Payment Practices**
  Under the prior DSRIP Demonstration Project (which granted the state more than $7 billion in funding to support restructuring of the health care system, the DOH, OMH, OPWDD and OASAS were granted unilateral authority to waive existing regulations in the interests of implementing the DSRIP waiver and avoiding "duplicative requirements." This state authority to waive existing regulations expires in 2022 and the budget proposal would extend it through 2025.

  NYSNA is opposed to granting blanket powers to state agencies to waive regulations to further the private interests of Medicaid providers. The legislature should remove this provision or in the alternative, require a public review process to determine the legitimacy of the regulatory waiver before it can be approved.