New York State NURSES ASSOCIATION an affiliate of National Nurses United AFL-CIO

Joint Legislative Hearing: FY 2025-2026 Health & Medicaid Executive Budget
February 11, 2025
Testimony of the New York State Nurses Association
Presented by Leon Bell, Director of Public Policy

The New York State Nurses Association (NYSNA) is a leading advocate for universal access to healthcare, safe patient care, healthcare equity, and protecting the professional practice and working conditions of Registered Nurses. NYSNA represents more than 42,000 members across New York and is an affiliate of National Nurses United, the largest union of RNs in the country, with more than 225,000 members nationwide.

NYSNA welcomes and supports proposals in the FY2026 Executive Budget that will increase capital and operating funding for safety-net hospitals and other providers, expand access to healthcare services, including reproductive healthcare and protections for physicians against out-of-state criminal and civil actions seeking to interfere with the provision of abortion and other services in New York, and strengthen state oversight and regulation of the business practices of healthcare providers and insurers.

NYSNA, accordingly, supports the following proposals in the Executive Budget:

- The allocation of an additional $1 billion in capital funding and $300 million in operating support for certain safety net providers;

- Cracking down on Medicaid Managed Care abuses and violations of their contractual obligations (HMH Article VII, Part E);

- Enactment of the recently approved MCO Tax, which will raise $3.7 billion for healthcare programs over the next two years and will allow for increased Medicaid reimbursement rates for hospitals and other providers (HMH Article VII, Part F);

- Expanded authority for the DOH to remove incompetent or abusive management and appoint temporary operators of healthcare facilities to preserve access to vital health services and ensure safe patient care (HMH Article VII, Part K);

- More stringent reporting requirements for general hospital community benefit spending to ensure that these non-profits are earning their tax-exempt status and focused on providing needed services rather than maximizing their revenues and profits (HMH Article VII, Part M);

- Protecting access to maternal and reproductive health services by increasing reimbursement rates for abortion providers ($20 million), requiring hospitals to provide emergency terminations when needed by the patient or implementing safe transfer protocols if the facility does not have the capacity to provide the service, and protecting physicians from out-of-state harassment, criminal charges or civil actions brought by states that have banned abortion and/or authorized private parties to enforce their state bans on such care against New York practitioners (HMH Article VII, Part P);

- Expanded access to fertility-related treatment for Medicaid recipients (HMH Article VII, Part Q);

- Declaring that effective and timely EMS services are a right, creating coordinated state-wide and local planning processes to ensure that timely emergency services are being provided to all New Yorkers, and establishing uniform training standards for EMTs (HMH Article VII, Part R);

- Tightening information reporting requirements for approval of healthcare business transactions (particularly targeted at the practices of private equity investors) and enhancing state authority to review transactions, conduct deeper cost and market analyses of their impact, review post-transaction impacts, and impose conditions on or reject transactions that will negatively affect access to services (HMH Article VII, Part S);

- Requiring all hospitals to maintain properly trained Sexual Assault Forensic Examiner (SAFE) services on a 24/7 basis (HMH Article VII, Part T);

- Expanding access to dental care for Medicaid and underserved populations by expanding the role of dental hygienists to provide more dental services independently of supervising dentists (HMH Article VIII, Part X);

- Allowing homeless youth to consent to receive mental health services (such youth are only permitted to consent to receive medical, dental, health and hospital services under current law)(Article VII, Part DD);

- Providing a targeted 2.1% COLA increase to offset higher labor costs for non-profit mental health and human services providers, though NYSNA believes the amount of the increase is not sufficient and should be increased (HMH Article VII, Part FF); and,

- Requiring Pharmacy Benefit Managers (highly concentrated for-profit entities that manipulate the opacity of the prescription drug manufacturing, pricing, and distribution system to profit at the expense of consumers and employee health plans) to provide detailed reports on rebate payments they receive from manufacturers to the state and health plans (TED Article VII, Part Z).

Matters of concern to NYSNA In the Executive Budget

While NYSNA supports positive proposals in the Executive Budget that will improve access to care and support healthcare providers, we also have concerns about what is missing from the proposals and oppose proposals that will undermine the stability of the nursing workforce, endanger quality of care and nursing practice, weaken the financial viability of safety net providers, and threaten access to needed health services.

1. The Executive Budget fails to address continued understaffing and hospital non-compliance with the staffing law (PHL 2805-t)

Unsafe RN staffing levels in hospitals do not only threaten patient safety and the quality of care, but are a major contributor to the destabilization of the RN workforce. When nurses are assigned too many patients to care for safely, they experience increased physical and emotional stress at work, face frustration and moral hazard, and become burned out. Understaffing and heavy workloads, in turn, lead to high turnover levels, as more nurses opt to retire, quit their direct care jobs to seek less stressful roles in non-care settings, or to leave the nursing workforce entirely.

The recently enacted hospital staffing law (PHL 2805-t) was intended to address understaffing of RNs and other direct care workers by requiring hospitals to form joint committees to collaboratively establish enforceable local staffing plans, jointly oversee hospital compliance with annually adopted staffing plans, and, in cases where minimum staffing ratios are violated, empowering the DOH to step in to enforce hospital compliance. The hospital staffing law did not impose minimum state-wide staffing ratios for hospital units (except for a minimum 1:2 nurse-to-patient ratio in ICU/Critical Care units), instead implementing a compromise solution that allows each hospital staffing committee to agree on minimum staffing levels in each hospital. The new staffing law was enacted in 2021 and the mandatory staffing plans for each hospital became effective in January 2023.

The effectiveness of the new law in addressing patient safety and improving staffing levels for direct care workers, however, has been undermined by widespread and persistent failures of hospitals to comply with the staffing committee process and adhere to their adopted staffing

plans. NYSNA has found that most hospitals are not fully complying with their obligation to publicly post their staffing plans and regularly disregard the staffing obligations that they themselves adopted. NYSNA has found, for example, that about half of ICU/Critical care units are staffed in violation of the minimum 1:2 ratio required by the law.[1]

It should also be noted that the law required the DOH to collect and publicly post quarterly staffing data for each hospital to allow the public, legislators, and workers to compare actual hospital staffing levels and gauge compliance with adopted staffing plans. This data was to be posted on the DOH website starting in July 2023, but the DOH has failed to comply with this statutory requirement.

NYSNA recommends that the legislature consider the following measures to address understaffing and stabilize the direct care RN workforce:

- Increase funding for DOH oversight and enforcement of the new hospital staffing law;
- Expand minimum nurse-to-patient ratios to alleviate RN work stresses and improve patient care by including minimum ratios for maternity, pediatric, and other types of units;
- Increase funding for the Nurses Across New York (NANY) loan forgiveness program to encourage RNs continue working in shortage areas above the current $3 million appropriation;
- Create new RN loan forgiveness and tuition assistance programs that are targeted to practice settings and regions with the most acute staffing shortages.
- Reduce RN turnover rates and help newly licensed nurses stay in the workforce by funding expanded clinical training slots for nursing students and preceptorship and mentorship programs to reduce new nurse turnover rates.
- Improve recruitment and retention of nurses in public hospitals and local public health programs by improving pension benefits.

2. Reject the Interstate Nursing Compact – protect the nursing workforce and patients, insulate NY from out-of-state and federal attacks on vital reproductive health, abortion and gender-affirming health services, and maintain state sovereignty

The Executive Budget resurrects last year's proposal that New York join the Interstate Nurse Licensure Compact. This proposal is premised on the false assumption that New York does not

[1] See: The State of Safe Staffing in New York, a report issued by NYSNA in December 2024, available at https://www.nysna.org/resources/2024-nysna-staffing-report. See also, The Staffing Crisis in Upstate Hospitals, issued by the Fiscal Policy Institute and the CWA, finding widespread understaffing of RNs and other direct care staff in upstate hospitals, available at https://fiscalpolicy.org/the-staffing-crisis-in-upstate-hospitals.

have enough licensed nurses to provide patient care and that the state should, accordingly, join the Compact to increase the number of out-of-state nurses who would be available to take jobs in New York.

The fact of the matter is that New York does not have a shortage of licensed RNs who are available to alleviate the ongoing understaffing crisis. According to data from the NYS Education Department, which oversees professional licensure for RNs, the number of actively licensed RNs increased from 305,585 in April of 2018 to 453,832 in January of 2025 (a 49% increase). At the same time, according to BLS data, the number of licensed RNs employed in New York has remained relatively flat, increasing only slightly from 182,490 in April 2018 to 190,470 in April 2023 (a 4% increase). It should also be noted that the SED issued 224,416 new RN licenses between January 1, 2018 and December 31, 2024, indicating that licensure is not the problem.[2]

New York does not need more licensed RNs or to join the interstate compact to address the staffing crisis. As we noted above, the number of licensed RNs has increased at a far faster pace than the employed RN workforce. The solution to the RN staffing crisis lies in improving working conditions, lessening workloads and on-the-job stress, and improving pay and benefits to keep the RNs we have working at the bedside.

Indeed, we are concerned that joining the Compact will *further destabilize* the RN workforce and jeopardize patient care.

Under the terms of the Compact, RNs working in New York under an interstate license will be vulnerable to investigations, disciplinary actions, civil suits, and criminal prosecutions brought by out-of-state AGs, nursing boards, or private individuals for providing legal or mandatory reproductive health care, abortion services, gender affirming care, and other types of care that are now illegal in most Compact member states. We have already seen increasing efforts by state authorities in Texas and Louisiana to civilly and criminally prosecute New York doctors for providing abortion care that is legal in New York to residents of their states.[3] If New York joins the Compact, it will be inviting similar attacks on New York RNs and exposing them to multiple actions in other states. We should not allow foreign states to exploit the provisions of the Compact to restrict New Yorker's access to legal reproductive health, abortion or gender affirming care.

We also note that joining the Compact will further undermine the New York RN workforce by allowing out-of-state, for-profit corporations to replace New York RNs through the provision of telehealth services across state lines.

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[2] SED RN licensure data is available at https://www.op.nysed.gov/about/registration-license-statistics; BLS estimates of RN employment in New York are available at https://www.bls.gov/oes/tables.htm.

[3] See: https://www.texasattorneygeneral.gov/news/releases/attorney-general-ken-paxton-sues-activist-new-york-doctor-illegally-providing-abortion-drugs-across; https://www.cnn.com/2025/02/01/us/louisiana-abortion-ny-doctor-arrest-warrant/index.html. Interestingly, given these developments and ongoing threats to access to legal care in New York, the Executive Budget dropped last year's proposal to join the Interstate Medical Compact for physicians and to propose increased protections for physicians against out-of-state interference. The Executive Budget thus seeks to protect physicians from these threats, but seems unconcerned about threats to RNs.

Finally, joining the Compact will undermine New York's sovereign right to set its own practice, education and training standards for nurses. New York will be required to allow any out-of-state nurse from a Compact state unrestricted practice privileges in our state, without regard for New York standards for licensure.

Given the current threats to the stability of the RN workforce and access to legally protected healthcare services in New York, the legislature should reject the proposal to join the Interstate Nurse Licensure Compact. Now is not the time to open the door to allow outside interference in our healthcare system by malicious out-of-state actors.

3. Protect Access to Vital Services and Support Safety Net Providers

NYSNA firmly supports providing single payer universal health coverage for all New Yorkers by enacting the New York Health Act (A1466/S3425) We also believe that the enacting the New York Health Act would allow the state to set uniform and fair reimbursement rates for hospitals and other health care providers to ensure the continued viability of vital safety net hospitals and guarantee high quality healthcare for all.

In the absence of a single payer health system in New York, NYSNA supports increased funding for Medicaid, the Essential Plan, CHP and other safety net programs that are among the most generous benefits and coverage provided by any state Medicaid program and have helped to reduce the uninsured rate in New York to about 5%. We also support measures to extend coverage to undocumented immigrants with or without Federal support to further reduce the uninsured rate in our state.

To maintain and expand access to care, protect safety-net services, and prepare for looming cuts in federal support for healthcare services, NYSNA urges the legislature to make the following changes in the Executive Budget proposals:

- **Provide across-the-board Increases in Medicaid reimbursement rates**
  Though the budget includes substantial new funding for capital and operating expenses through the Safety-Net Hospital Transformation Program and also provides for unspecified increases in Medicaid reimbursement rates through the use of the MCO tax revenues, there are no specific commitments to increase inadequate Medicaid rates that now pay for only a fraction of the costs of care. The budget should include specific across-the-board reimbursement rate increases, particularly targeted at safety net providers.

- **Repeal or Suspend the Medicaid Cap (HMH Article VII, Part A)**
  Medicaid plays an important role in providing care for low-income communities. It is also an important counter-cyclical stabilizer – its costs increase during economic downturns or public health emergencies as more people lose employer coverage due to layoffs and

reduced incomes. With severe federal funding threats looming, including proposals to slash federal support by lowering state FMAP formulas, convert Medicaid to a block grant program, set per capita spending caps, or impose other reductions in federal support, New York should have the flexibility to temporarily increase state share spending in order to cushion the impact and allow time to explore alternative funding approaches to maintain healthcare services. We urge the legislature to consider repealing or suspending the Medicaid cap at this critical juncture.

- **Reject cuts to DSH/ICP funding for safety-net hospitals and New York City Health + Hospitals (HMH Article VII, Part D)**
  The Executive Budget proposes to eliminate the Upper Payment Limit (UPL) pool that distributes $339 million in Medicaid DSH and state ICP funds to private safety-net hospitals, and the $113 million pool that is available for the NYC H+H public hospital system.

  The Governor has stated that the NYC H+H system has a pending application for approval of a Directed Payments program (DPT) application that would allow H+H to receive reimbursement from Medicaid managed care plans at the average regional commercial rate, making the state DSH funding unnecessary. That application, however, is still pending and has not been approved. This proposal should be withdrawn given current federal threats to existing healthcare programs and funding.

  We also note that this proposal amounts to yet another effort by the state to shift Medicaid costs onto New York City, which is inconsistent with state policy to assume responsibility for local Medicaid share spending.

  NYSNA opposes reductions in funding for safety-net providers and urges the legislature to remove this proposal or condition any DSH/ICP funding changes to hold NYC H+H harmless if the federal government rejects or rescinds the DPT application.

- **Reject the proposal to eliminate provider prevails in Medicaid (HMH Article VII, Part C)**
  Medicaid recipients should receive the medications they need based on the professional judgment of their treating practitioners. We urge the legislature to reject this proposal.

- **Reject reductions in funding for public health programs (HMH Article VII, Part H)**
  The Executive Budget proposes to eliminate the EQUAL program (which provides funding for improve quality of life in adult care facilities), the Enriched Housing Program (which supports social services in public and non-profit adult living programs), the ECRIP program (which funds medical research positions under GME programs), and the Tick-Borne Disease Institute (which conducts research into Lyme and other diseases). NYSNA generally

opposes any reductions in public health spending and notes that the savings from eliminating these programs is minimal ($11 million per year once fully implemented).

4. Reject Paramedicine Proposals (HMH Part R, Sections 7 and 8; Part B, Section 8; Part O, Section 24)

The Executive Budget proposes to extend current authorization of previously approved paramedicine demonstration projects (HMH Article VII Part B, Section 8), to allow unspecified flexibilities "to promote innovation" and develop "novel delivery models and care strategies" to improve the delivery of care through EMS services (HMH Article VII, Part R, Sections 7 and 8), and to allow EMTs to administer methadone or other drugs that counter-act opioid withdrawal symptoms.

NYSNA is not opposed to coordinating health services under a state-wide plan and incorporating emergency services into broader healthcare delivery system planning.

We are concerned, however, that paramedicine programs should be designed and regulated to ensure that they do not divert EMS resources in a way that undermines emergency response capacity, opens the door to for-profit corporate EMS providers (many of whom are out-of-state entities) to increase their role in our health system for their own financial benefit, or undermine the nursing workforce and quality of care.

We accordingly urge the legislature to remove these items from the budget process and allow them to be considered in a more deliberative manner, with input from the public, local communities, worker representatives, and other stakeholders.

5. Reject Certified Medication Aides in nursing homes - stop adding to the workload of an already stressed nursing home workforce (Part V, Sub-Part A)

The Executive Budget proposes to create a new certified medication aide title that would be permitted to administer medications to residents in long-term residential care facilities.

This proposal, which is patterned on the Advanced Home Health Aide model, will add to the workloads and responsibilities of the existing nursing home RN workforce and could undermine patient safety and quality of care.

Under the proposal, the DOH (in consultation with the DOE) would draft regulations listing the range of medication dispensing tasks that could be performed by medication aides, the types of medications that could be dispensed, and setting minimum qualifications and training standards for certification.

This proposal is likely to further destabilize the nursing home RN workforce. RNs would be *entirely* responsible under the proposed legislation to assess the ability, capacity and competency of each medication aide to dispense each permitted medication, decide whether it is appropriate for each patient, supervise and be responsible for the proper administration of medications to patients by aides, determine their ability to communicate with the patient during the dispensing of medications, and require the RN to decide on an ongoing basis whether to revoke or refuse to approve medication tasks for each aide.

In addition, the statute would allow multiple RNs to supervise and oversee the work of each aide but allow only one RN to determine their competency. Aides would be required to document the medications dispensed independently of the supervising RN who will be legally responsible for the actions of each aide. The proposed legislation does not seem to limit the number of medication aides that can be assigned to each supervising RN.

NYSNA has the following concerns about the proposed legislation:

- It will add to the workload of the RN nursing home workforce and worsen recruitment and retention of RNs;
- RNs will be legally and professionally responsible for any errors or patient harm since they are solely responsible for assigning and overseeing the aides medication tasks;
- RNs will not know whether medications have been administered properly or diverted by the aides, which will affect their assessments and care for residents/patients;
- RNs will be subject to pressure from employers to favorably assess aides capacities and use them widely to administer medications, with the RNs assuming the legal and professional liabilities while the operator of the nursing home gains financial benefits in the form of cheaper labor costs;
- Notwithstanding the "no retaliation" language in the legislation, RNs will be under increased employer pressure to "get with the program" and allow the widest possible use of aides; and
- There is a higher likelihood that residents will suffer harm or reduced quality of care.

For these reasons, NYSNA urges the legislature to reject this proposal or to remove it from the budget process and allow a more deliberative approach that includes input from the public, nursing home residents and the family councils, long term care ombudsmen, and worker representatives.

6. Reject state codification of Hospital At Home programs (HMS Article VII, Part Y)

The Executive Budget proposes to codify current CMS authorization of Medicare hospital at home (HaH) demonstration projects under state law and permit the state to reimburse New York hospitals for these programs under Medicaid.

Though CMS has authorized such programs in 299 hospitals in 30 states, including New York, the impact on quality of care and costs remains an open question. We note that CMS authorization for HaH programs was extended to March 2025 in the budget extension agreement reached by Congress last year, but the future of the program remains uncertain.

NYSNA has serious concerns about the safety, quality and efficacy of HaH programs and believes that CMS standards for operating these programs do not provide adequate staffing or standards of care to protect patient safety. Our concerns about the safety of HaH include the following issues, including the following:

- CMS was required to produce a study analyzing the cost effectiveness, safety, and quality of care of the program by September of 2024, but to our knowledge has not issued any findings;

- CMS standards only require a limited number of in-person visits by nurses and other practitioners, and allow daily check-ins with care givers to be conducted by telehealth methods;

- CMS standards allow programs to respond to a crashing patient or other emergency within 30 minutes, as opposed to the immediate response available in an in-patient hospital setting; and,

- The expansion of the program will increase pressure to close in-patient hospital units, reduce bed capacity, and reduce capital investment to maintain needed in-patient capacity; and

- The program will be susceptible to upcoding or other billing abuses, particularly when for-profit providers are included in the provision of telehealth "visits" or other particular services under the program.

At this point it is not clear that these programs are safe for patients, that they are not liable to encourage upcoding or other fraudulent practices to increase provider revenues, or that they will not encourage disinvestment in hospital infrastructure and staffing.[4]

[4] See: National Nurses United, MEDICARE'S HOSPITAL AT HOME PROGRAM IS DANGEROUS FOR PATIENTS (Sept. 2022), available at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwi_kIfij--DAxWsv4kEHb1CA5EQFnoECBQQAQ&url=https%3A%2F%2Fwww.nationalnursesunited.org%2Fsites%2Fdefault%2Ffiles%2Fnnu%2Fdocuments%2F0922_Medicare_HospitalAtHome_Report.pdf&usg=AOvVaw1OHj9YpknFvRElty3_mCZu&opi=89978449.

For these reasons we urge the legislature to reject this proposal or in the alternative to remove it from the budget process and allow a more deliberative process that includes more extensive studies of their efficacy and input from relevant stakeholders.

7. Reject the proposal to expand involuntary commitment and involuntary assignment to assisted outpatient treatment (HMH Article VII, Part EE)

NYSNA supports the expansion of in-patient and out-patient psychiatric and substance use services, particularly for low-income and homeless people needing care.

We also understand that many homeless people seem to be suffering severe mental illness and are clearly in need of healthcare services to address their underlying conditions and the resulting threats to their own health and safety and that of others.

We are concerned, however, that the proposed legislation, which seeks to make it easier to impose involuntary treatment, is too broadly drafted and may deprive people of their rights and autonomy based solely on the fact that they are homeless or poor.

We also note that in-patient and out-patient psychiatric services continue to be in short supply and that the state does not have the capacity to provide proper treatment for these and other patients. We believe that the state should fully implement the existing Executive Order directing hospitals to restore in-patient psychiatric units and beds that were closed during the COVID emergency and remain off-line. We also believe that the state should increase funding and reimbursement rates to increase treatment capacity.

Accordingly, we urge the legislature to reject this proposal. Increasing services and changing the requirements for involuntary treatment should be discussed through a more deliberative process that includes input from the public, mental health advocates, providers, and worker representatives.

For questions or further information, please contact Leon Bell, Director of Public Policy at leon.bell@nysna.org