Iroquois Healthcare Alliance

IHA'S SFY 2026-2027 State Budget Testimony

Joint legislative hearing of the Senate Finance and Assembly Ways and Means committees in the Matter of the 2026-2027 Executive Budget on Health

Lauren Ford, LMSW
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Chairs Pretlow, Krueger, Rivera, and Paulin and other distinguished members of the legislature, I am grateful for the opportunity to speak about this year's proposed budget and the items within it that have an impact on the future of healthcare, especially as it relates to Upstate and rural hospitals and the New Yorkers they serve.

I am Lauren Ford, Vice President of Government Relations and Strategy for the Iroquois Healthcare Alliance (IHA), testifying today on behalf of nonprofit and public member hospitals and health systems. IHA represents more than 50 hospitals and health systems spanning 32 counties across nearly 28,000 square miles of Upstate and rural New York. Our membership includes the smallest critical access hospital in the state, the first rural emergency hospital, as well as some of the largest academic medical centers in Upstate New York.

THE CURRENT LANDSCAPE

The federal changes enacted through H.R. 1 represent the largest reduction in Medicaid funding in the program's history. Rural hospitals nationwide face an estimated $50.4 billion reduction in federal Medicaid spending over the next decade, with coverage losses projected to reach 1.8 million individuals in rural communities by 2034[1]. For hospitals in Upstate and rural New York already operating on razor thin or negative margins, these cuts threaten both their viability and their ability to continue serving their communities.

Hospital expenses outpace revenue year over year. Staffing costs more, New York's population is getting older and sicker, and everything from utilities to medical supplies costs more than it did last year. Medicaid and Medicare reimbursement rates haven't kept pace. Hospitals operating on slim margins have no room to continue absorbing these increases.

As of June 2025, 62% of Upstate and rural hospitals were operating with unsustainable margins (below the 3% benchmark), with many in the red or barely breaking even[2]. The Governor's budget acknowledges this reality, noting that 29% of New York's hospitals are financially distressed, a 200% increase since FY 2017[3]. When these anchor institutions struggle, entire communities feel the impact.

THE FY 2027 EXECUTIVE BUDGET

The Governor’s Executive Budget includes a multi-year hospital funding plan through the MCO tax and other measures. IHA has been supportive of this approach to address the Medicaid funding gap. However, with the MCO tax revenue ending early, the State must put funding mechanisms in place that go beyond temporary revenue sources.

IHA’s budget priorities include:

- Honoring the Healthcare Stability Fund commitments beyond MCO tax sunset
- Restoring proposed VAPAP reductions
- Including 340B anti-discrimination protections
- Expanding capital funding opportunities beyond Safety Net Transformation Program (SNTP)

- Supporting workforce flexibility measures (Interstate Nurse Licensure Compact, temporary practice authorization, and CRNA statutory recognition)
- Providing regulatory relief (Clinical Staffing Committee exemption)
- Releasing previously appropriated funds

The MCO tax, enacted in last year's budget, was originally planned to run for nine quarters through March 31, 2027. H.R. 1 restrictions threatened to cut that short, with CMS preliminary guidance in November indicating the tax would end on March 31, 2026, allowing only five quarters of revenue collection. Following sustained advocacy with Republican members of New York's congressional delegation, CMS released a final rule in late January of this year extending the MCO tax through December 31, 2026[4]. This extension secures eight of the nine originally planned quarters; three more than the November guidance allowed. While this provides additional resources for the FY 2027 budget, the tax still ends one quarter early, and long-term sustainable funding solutions remain necessary.

The Executive Budget continues support for the Healthcare Stability Fund with up to $1.5 billion in hospital and nursing home support in FY 2027, originally proposed to be funded through a General Fund transfer, though the recent MCO tax extension will likely provide for this funding instead. The budget maintains the previously enacted 10% Medicaid outpatient rate increase for hospitals and continues scheduled Medicaid rate increases for nursing homes. Although these commitments are appreciated, it's worth noting that many providers still haven't received the increases promised in last year's budget. Timely implementation is just as critical as the funding itself.

On capital investments, we are grateful that the Executive Budget proposes $1 billion in new capital funding to expand and continue the Safety Net Transformation Program (SNTP), with at least $330 million in new operating support[5]. This program provides capital and operating support for safety net hospitals that meet certain criteria. The Governor recently announced seven projects, but requests for this support far exceeded available funding. This new $1 billion investment will help address that gap and enable more Upstate and rural hospitals to undertake sorely needed transformation projects.

The Executive Budget proposes scope of practice expansions, including authorizing certified nursing assistants to administer medications in nursing homes, permanently extending the authority for physician assistants to issue non-patient specific orders for routine COVID-19 and influenza testing, and permitting medical assistants to administer vaccinations[5]. The budget also includes a $3 million nursing home staffing campaign targeting rural areas and $4.2 million for the Department of Health to develop guidance on securing temporary staff more effectively.

These investments depend on the MCO tax in future years. The extension through December 31, 2026, helps this fiscal year, but the early end date continues to create substantial risk to every commitment outlined above. We ask the state to develop sustainable funding solutions beyond the MCO tax to ensure continuity of these critical programs when hospitals can least afford additional uncertainty.

New York State will receive $212 million in federal funding for Year one of the Rural Health Transformation Program, though uncertainty remains around CMS renewals for years two through five[5]. All investments in rural healthcare are welcome, but it is important to note that this funding does not come close to offsetting the multi-billion-dollar federal Medicaid cuts New York's rural hospitals face from H.R. 1. This program represents an opportunity for some rural hospitals to access transformation resources, but it is not a panacea for the broader federal funding crisis.

There are several significant concerns and omissions in the FY 2027 Executive Budget that require attention. The Executive Budget proposes a $520 million state share reduction to the Vital Access Provider Assurance Program[5] (VAPAP). VAPAP remains a lifeline for financially distressed hospitals. The budget does not include 340B anti-discrimination protections, despite pharmaceutical manufacturers increasingly restricting access to this program that helps safety net hospitals stretch scarce federal resources. Finally, the budget omits the Interstate Nurse Licensure Compact (NLC), despite 43 jurisdictions participating[6].

CRITICAL PRIORITIES REQUIRING LEGISLATIVE ACTION

While we appreciate the investments proposed in the FY 2027 Executive Budget, this is the moment to truly step up for Upstate and rural healthcare. The principle guiding this budget process must be simple: do no harm. Several priorities require immediate attention and support.

First, we need a sustainable solution for healthcare funding beyond the MCO tax termination. The extension through December 31, 2026, is very appreciated, but hospitals face a funding cliff on January 1, 2027. Hospitals made operational decisions based on the commitments in the FY 2026 budget, including VAPAP restoration, SNTP, and the 10% outpatient rate increase. Without sustained funding to replace MCO tax revenues after the early termination, these commitments are at risk. We urge the State to utilize reserves and rainy-day funds to fully honor the commitments made to hospitals and ensure continuity of the programs hospitals are relying upon beyond the MCO tax sunset.

Second, the proposed $520 million state share reduction to the VAPAP pool threatens hospitals at their most vulnerable moment. Reducing VAPAP will harm hospitals serving vulnerable populations. At a time when federal support is contracting, reducing state support for our most financially fragile hospitals threatens their viability. We ask the Legislature to restore this funding and maintain a full commitment to supportive funding programs for distressed hospitals.

Third, 340B anti-discrimination protection must be included in the final budget. Well-resourced pharmaceutical manufacturers are increasingly restricting access to the 340B Drug Pricing Program, undermining a program intended to help safety net hospitals stretch scarce federal resources. For many providers, 340B savings help sustain essential services such as labor and delivery services, behavioral health programs, mobile mammography, oncology care, and meds-to-beds initiatives that keep patients from being readmitted. Legislation prohibiting manufacturers from denying, conditioning, or limiting the dispensing of 340B-eligible drugs would protect a critical

resource while costing the state nothing. This protection is not in the Executive Budget, and we urgently request its inclusion.

Fourth, we strongly support the proposed $1 billion in new capital funding for the Safety Net Transformation Program. However, we strongly recommend that the Legislature works to ensure equitable distribution across providers and prevent funds from pooling in one or a handful of institutions. We also encourage broader capital support for hospitals not eligible for SNTP. Many hospitals across Upstate and rural New York need resources to modernize aging infrastructure, address workplace violence concerns, invest in technology, and maintain essential services. A new Statewide Health Care Facility Transformation Program would help address the capital needs of hospitals that may not meet SNTP criteria but are nonetheless essential to their communities. We also urge the continued release of previously appropriated transformation funds without delay.

WORKFORCE SOLUTIONS

The workforce shortage remains the most persistent challenge facing Upstate and rural New York hospitals. Vacancy rates continue at levels far exceeding pre-pandemic norms, with a 10.5% vacancy rate and 16.3% year-end turnover across all hospital staff[7]. These vacancies impact every role, from clinical to administrative and technical positions.

We support the workforce proposals included in the FY 2027 Executive Budget, particularly the scope of practice expansions. However, we note that the Interstate Nurse Licensure Compact (NLC) was not included despite being proposed in previous years. The NLC is essential and would provide no-cost workforce flexibility. Forty-three jurisdictions have joined the NLC, allowing their hospitals access to a broader workforce pool. New York's continued absence from the NLC puts our hospitals at a competitive disadvantage, particularly in rural areas where the labor pool is already limited.

The Executive Budget also proposes expanded oversight of temporary staffing agencies, requiring registration, reporting on compensation and contracts, and authorizing DOH to set maximum profit margins. We support transparency around staffing costs, but profit margin caps have the potential to make New York an unattractive market for agencies, cutting off access to travel staff that many hospitals need to stay operational. We urge caution with respect to enacting cost containment policies that could limit access to a critical staffing resource without alternatives in place.

We also urge support for temporary practice authorization legislation, which would permit out-of-state nurses to work while awaiting New York licensure approval. Current delays commonly range from six weeks to three months or longer[8], during which qualified clinicians cannot work despite being fully licensed in their home states, and hospitals continue to struggle to meet staffing demands. This creates an equity issue, as this disproportionately impacts nurses who are predominantly women and represent an increasingly diverse workforce. Asking these essential healthcare workers to go without work and income while relocating to New York is unacceptable. These are practical, no-cost solutions that would provide critical workforce flexibility when vacancy rates remain stubbornly high, particularly in Upstate and rural New York.

Additionally, during the COVID-19 emergency, Executive Order 4 provided critical workforce flexibility by allowing out-of-state licensed professionals to practice in New York. That flexibility worked then, and it worked again most recently during the downstate nursing strike when similar executive action was utilized. We ask that this proven approach be made available statewide to help all hospitals address persistent workforce shortages while permanent solutions are pursued.

REGULATORY RELIEF

The combination of federal funding reductions and state regulatory burden creates an untenable environment for hospitals operating on thin margins. We submitted a comprehensive regulatory reform analysis to the Department of Health in October in response to the Division of Budget's directive. Several recommendations require legislative action and could be included in the final budget.

The Clinical Staffing Committee workforce shortage exemption would address an unsustainable compliance requirement where hospitals must approve staffing plans that they cannot fulfill due to workforce shortages. An explicit safe harbor exemption for hospitals documenting good-faith recruitment efforts would provide needed relief.

Additionally, New York is the only state in the nation that does not formally recognize Certified Registered Nurse Anesthetists (CRNA) in statute[9]. This directly impacts rural hospitals' ability to maintain surgical services when anesthesiologist coverage is frequently unavailable. Statutory recognition of CRNAs is long overdue.

More broadly, we ask that the State continue to foster a regulatory environment that encourages innovation. Hospitals operating in good faith should have room to pilot new care models and staffing approaches. We appreciate DOH's willingness to engage productively with providers, and we believe there is an opportunity to build on that foundation.

THE PATH FORWARD

The federal government has signaled its retreat from healthcare investments. New York must not follow that path. At minimum, the State must do no harm.

Hospitals fill multiple vital roles in their communities as economic drivers, innovators, and caregivers. They are anchor institutions in Upstate and rural communities, often the largest employer and the essential safety net for the populations they serve. The Executive Budget provides an important starting point, but substantial work remains to address both immediate funding gaps and long-term sustainability challenges.

The Budget's projected outyear deficits of $6 to $12 billion by FY 2030[5] underscore both the uncertainty facing healthcare providers and the critical importance of securing sustainable funding solutions through this legislative process. We cannot build a healthcare system on temporary fixes and one-time funding sources.

We applaud the Governor's investment in healthcare in recent years and welcome the partnership reflected in this Executive Budget. As you assemble your one-house budget proposals, IHA is available to work with you to strengthen the provisions that protect healthcare access for Upstate and rural communities.

Specifically, we ask the legislature to:

- Ensure full funding of Healthcare Stability Fund commitments, utilizing reserves and rainy-day funds if necessary to address MCO tax uncertainty
- Restore the proposed VAPAP cut and maintain adequate funding for safety net hospitals
- Include 340B anti-discrimination protections
- Support the Safety Net Transformation Program capital investment and explore broader capital opportunities for hospitals not eligible for SNTP
- Support workforce flexibility measures, including the Interstate Nurse Licensure Compact, temporary practice authorization, and CRNA statutory recognition
- Include regulatory relief provisions, particularly the Clinical Staffing Committee exemption
- Continue to release previously appropriated funds without delay

We stand ready to provide additional information, data, or analysis as budget discussions proceed. Thank you for your leadership and for the opportunity to testify today.

FOOTNOTES

[1] American Hospital Association, 'Rural Hospitals at Risk: Cuts to Medicaid Would Further Threaten Access,' June 2025

[2] 2025 IHA Mid-Year Financial Survey Results

[3] NYS FY 2027 Executive Budget

[4] https://www.federalregister.gov/public-inspection/2026-02040/medicaid-program-preserving-medicaid-funding-for-vulnerable-populations---closing-a-health

[5] NYS FY 2027 Executive Budget

[6] https://www.nursecompact.com/

[7] IHA Annual Vacancy and Turnover Survey Report 2025

[8] New York State Education Department, Office of the Professions, Registered Professional Nursing Licensure Status

[9] New York State Association of Nurse Anesthetists, https://www.nysana.com/info

IROQUOIS
Healthcare Alliance

2026
Legislative Priorities

In addition to the priorities below, IHA is requesting the immediate release of the funds appropriated in previous budgets to support the needs of Upstate New York hospitals and health systems.

About Iroquois Healthcare Alliance

IHA is a nonprofit regional trade organization representing more than 50 hospitals and health systems across 32 Upstate NY counties. Our membership spans 28,000 square miles, serving a diverse network of healthcare facilities, from Critical Access and Sole Community Hospitals, Rural Emergency Hospitals, to major academic medical centers and teaching institutions, making us the only independent and unified voice in Upstate and rural New York.

Prioritize Sustainable Funding

- H.R.1 impacts include early termination of the MCO tax revenue. To fulfill the commitment of the Healthcare Stability Fund, the state must either extend the MCO tax or utilize the rainy-day fund to stabilize hospital finances.
- 340B Anti-Discrimination | S.1913 / A.6222 | Prohibits pharmaceutical manufacturers from denying, restricting, or conditioning the sale of drugs to covered entities. 21 states have passed similar legislation.
- Continue distressed hospital funding for Upstate hospitals through Vital Access Providers (VAP) and Vital Access Provider Assurance Program (VAPAP), along with continuation of the Directed Payment Template (DPT) program.
- Ensure allocation of all hospital funding creates meaningful parity. For context: over $1 billion has been allocated to a single hospital, while rural hospitals struggle with far less support.

Address the Healthcare Worker Shortage

No-cost, high-impact. Now is the time to act.

- Temporary Practice Authorization | S.8341-A / A.8472-B| Permits out-of-state nurses, LPNs, and physicians to practice temporarily while awaiting licensure.
- Interstate Nurse Licensure Compact | S.3916 / A.4524| Enables interstate nursing practice based on a common set of licensing requirements. 43 participating jurisdictions.
- Workplace Violence Prevention and Staff Protection
  - S.2080 / A.6051|Expands class of healthcare workers protected under Penal Law 120.05
  - A.9536 | Permits the removal of last names from healthcare worker badges and allows workers to use their employer's address on criminal complaints.
- Expand scope of practice for healthcare professionals like PAs and CRNAs to practice at the full extent of their training and credentials.

Rural Health Transformation Fund

With New York receiving $212 million in 2026 but facing uncertainty about funding levels for the remaining four years of the five-year program, ensure that:

- Only truly rural hospitals are eligible to receive funding and the Department of Health provides clear, timely communication on implementation.
- Rural hospitals and organizations like IHA have a seat at the table in determining how funds are allocated and distributed.

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We are the independent and unified voice of hospitals in Upstate and rural New York.

IROQUOIS Healthcare Alliance

Step up for Upstate and Rural Hospitals

IHA supports Upstate hospitals and the communities they serve by providing state leaders with comprehensive, real-time data on hospital needs, challenges, and community impact.

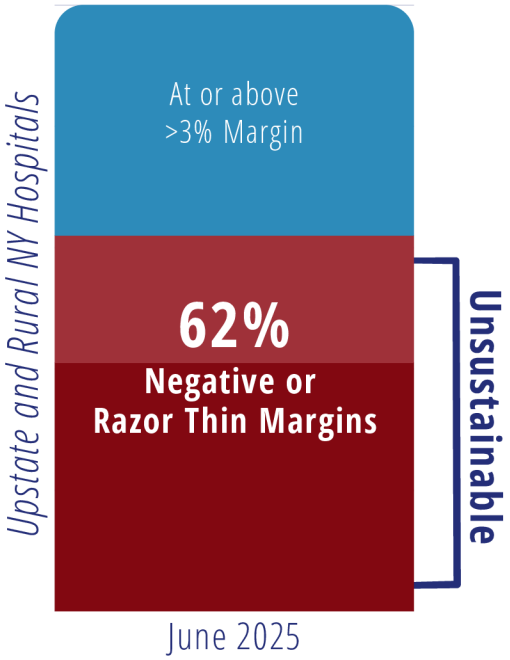
Continued Financial Volatility	Our anchor institutions are at risk. Upstate and rural New York hospitals are caught between federal cuts and state budget gaps, and the financial strain is unsustainable. As of June 2025, 62% of IHA members are operating at or below the 3% target benchmark, with 41% reporting negative operating margins. This is with state and federal supportive funding already factored in. Of those in the red, nearly a third are severely negative (below -5%). The average operating margin across all respondents sits at 0%. Nearly 80% of IHA members have fewer than 100 days cash on hand, with a median of just 50 days.
Persistent Workforce Shortages	As of January 1, 2025, the 36 facilities who participated in our annual vacancy survey reported 8,188 vacant positions, reflecting a **10.5% vacancy rate** and **16.3% turnover rate** across all staff. Nursing remains the most critical challenge, with **RN vacancy rates at 15.4%**, particularly in long-term care (**19.5%**) and emergency departments (**12.9%**). Contract labor continues to fill gaps, with **8.0%** of RN positions held by temporary staff, and facilities face lengthy recruitment cycles, averaging 80 days to fill permanent RN positions. While the healthcare sector shows some signs of stabilization, these persistent staffing shortages, especially in critical care areas, indicate ongoing workforce challenges that require sustained strategic attention.

103% ↑
increase in RN vacancy rates since 2018

80 Days
on average to fill an RN position

Over 8,000 Vacant Positions
in Upstate NY Hospitals

Total Operating Margins



Data Sources: 2025 IHA Mid-Year Financial Survey and January 2025 IHA Semi-Annual Vacancy and Turnover Survey. Margins below 3% are considered "unsustainable" according to Kaufman Hall standards.

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Critical Access Hospitals (14)
A rural hospital with 25 or fewer beds located at least 35 miles from other hospitals, providing 24/7 emergency care and short stays under Medicare guidelines.

Medicare Dependent Hospitals (2)
A rural hospital with 100 or fewer beds where Medicare patients account for at least 60% of inpatient days.

Sole Community Hospitals (12)
A hospital that's either 35+ miles from similar facilities or serves as the primary healthcare provider in a rural area due to geography or weather conditions.

Health Systems (13)
An organization of multiple healthcare facilities and providers operating under single management to deliver comprehensive medical services.

Acute Care Hospitals (15)
A hospital providing short-term medical treatment for severe injury, illness, surgery, or other urgent conditions.

Rural Emergency Hospital (1)
A Rural Emergency Hospital (REH) is a Medicare provider type that offers 24/7 emergency care and outpatient services, but no inpatient beds, designed to help sustain healthcare access in rural communities.

NORTH COUNTRY

Clinton
- 26 The University of Vermont Health Network Champlain Valley Physicians Hospital (UVMHN)

Essex
- 27 The University of Vermont Health Network Elizabethtown Community Hospital (UVMHN)

Franklin
- 28 Adirondack Health
- 29 The University of Vermont Health Network Alice Hyde Medical Center (UVMHN)

Jefferson
- 30 Carthage Area Hospital
- 31 River Hospital
- 32 Samaritan Medical Center (SH)
- S Samaritan Health (SH)

Lewis
- 33 Lewis County General Hospital (LCHS)
- L Lewis County Health System (LCHS)

St. Lawrence
- 34 Canton-Potsdam Hospital (SLHS)
- 35 Claxton-Hepburn Medical Center
- Ns North Star Health Alliance
- 36 Clifton-Fine Hospital (SH)
- 37 Gouverneur Hospital (SLHS)
- 38 Massena Hospital (SLHS)
- St St. Lawrence Health System (SLHS)

CENTRAL NEW YORK

Cayuga
- 1 Auburn Community Hospital

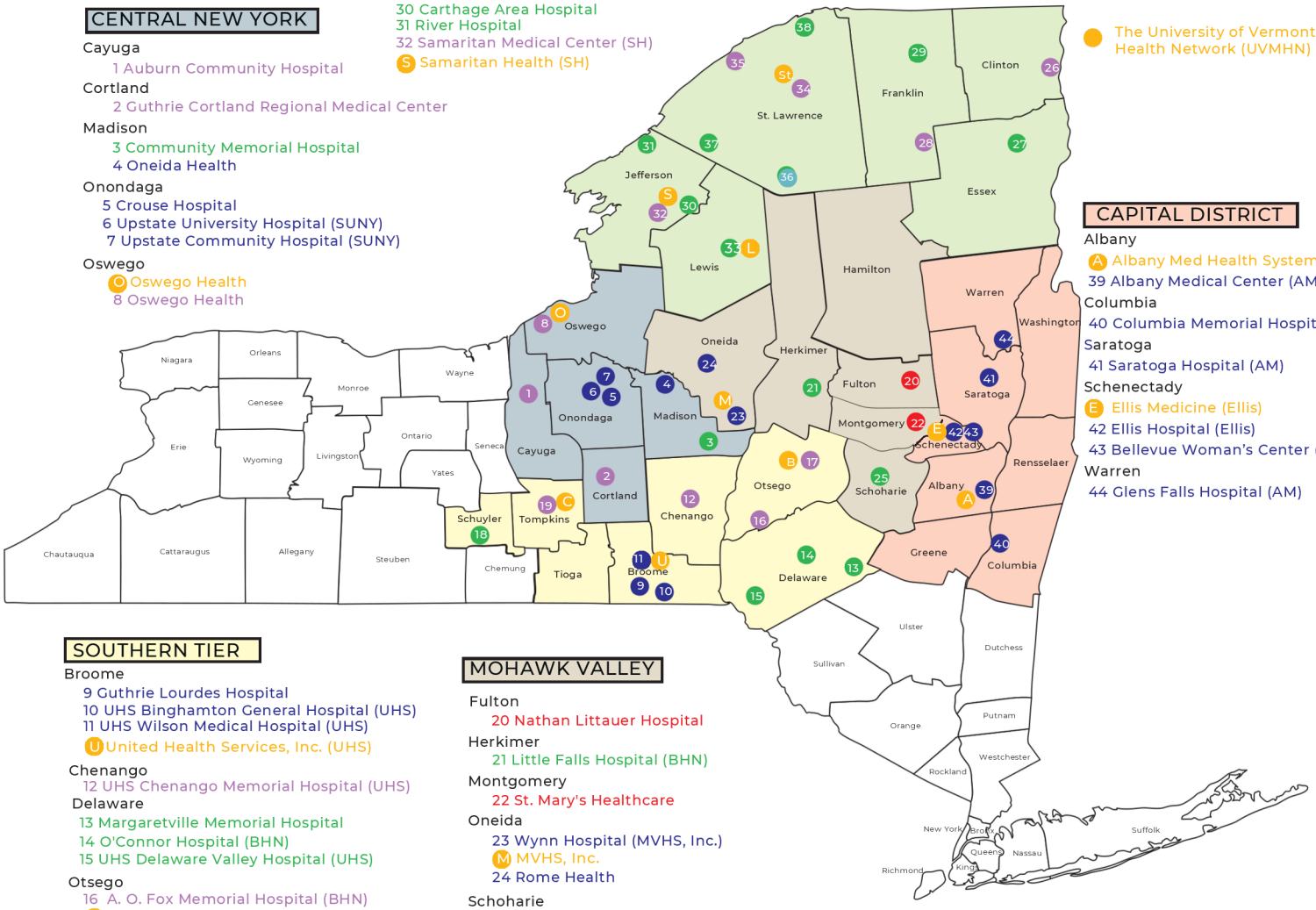
Cortland
- 2 Guthrie Cortland Regional Medical Center

Madison
- 3 Community Memorial Hospital
- 4 Oneida Health

Onondaga
- 5 Crouse Hospital
- 6 Upstate University Hospital (SUNY)
- 7 Upstate Community Hospital (SUNY)

Oswego
- O Oswego Health
- 8 Oswego Health

The University of Vermont Health Network (UVMHN)



CAPITAL DISTRICT

Albany
- A Albany Med Health System (AM)
- 39 Albany Medical Center (AM)

Columbia
- 40 Columbia Memorial Hospital (AM)

Saratoga
- 41 Saratoga Hospital (AM)

Schenectady
- E Ellis Medicine (Ellis)
- 42 Ellis Hospital (Ellis)
- 43 Bellevue Woman's Center (Ellis)

Warren
- 44 Glens Falls Hospital (AM)

SOUTHERN TIER

Broome
- 9 Guthrie Lourdes Hospital
- 10 UHS Binghamton General Hospital (UHS)
- 11 UHS Wilson Medical Hospital (UHS)
- U United Health Services, Inc. (UHS)

Chenango
- 12 UHS Chenango Memorial Hospital (UHS)

Delaware
- 13 Margaretville Memorial Hospital
- 14 O'Connor Hospital (BHN)
- 15 UHS Delaware Valley Hospital (UHS)

Otsego
- 16 A. O. Fox Memorial Hospital (BHN)
- B Bassett Healthcare Network (BHN)
- 17 Bassett Medical Center (BHN)

Schuyler
- 18 Schuyler Hospital (CH)

Tompkins
- 19 Cayuga Medical Center (CHS)
- C Cayuga Health System (CHS)
- C Centralus Health (CH)

MOHAWK VALLEY

Fulton
- 20 Nathan Littauer Hospital

Herkimer
- 21 Little Falls Hospital (BHN)

Montgomery
- 22 St. Mary's Healthcare

Oneida
- 23 Wynn Hospital (MVHS, Inc.)
- M MVHS, Inc.
- 24 Rome Health

Schoharie
- 25 Cobleskill Regional Hospital (BHN)

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