Testimony
of
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before the
New York City Council Committee on Health
on
Examining the Effects of Hospital Closures on Community Needs

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Good morning, Chair Schulman, Chair Narcisse, and members of the Committee on Hospitals and the Committee on Health. I am Dr. Michelle Morse, Interim Health Commissioner at the New York City Department of Health and Mental Hygiene. I am joined here today by my colleague Dr. Laura Iavicoli, Chief Medical Officer from New York City Health + Hospitals Elmhurst. Thank you all for the opportunity to testify today on the Effects of Hospital Closures on Community Needs in New York City. The mission of the New York City Health Department is to improve and protect the health of all New Yorkers and to promote health equity. As you are well aware, hospitals are an essential infrastructure and vital partners to the New York City Health Department. I have witnessed the impacts of hospital closures firsthand as a medical doctor. These closures pose significant risks and wide-ranging impacts on communities, patients, health care workers, public health, socio-economic stability and the overall health care system, especially hospitals located in marginalized communities. But before we address solutions, we must identify the problems.

Today I will outline the business of health care in the context of structural racism as a root cause of hospital closures, and the critical role of safety net hospitals for health equity for our city.

The New York City Health Department does not regulate health care, including hospitals. Under New York State law, that authority lies with the New York *State* Health Department. However, we do have a critical role in using data, narrative-change, community engagement, and technical assistance to ensure a more accountable and equitable health care system. As a public health agency, we analyze and describe root causes of inequitable health outcomes. I have previously addressed the impact of structural racism and economic inequity on our health care system during last year's hearing on health care accountability. For example, structural racism and health care business practices – such as decisions about what insurance plans to accept, what prices to charge, where to build facilities, and how to distribute resources and services between facilities – are clear and entrenched causes of hospital closures and health inequities in New York City.

Hospital closures are not an unfortunate side effect in our health care system; rather, such closures are a central feature of a highly inequitable system and related payment and policy choices. As I testified last year, New York City is one of the most racially segregated health care markets in the United States. Many New Yorkers know this from experience.

Our public and private safety-net hospitals and facilities care for more of the city's low-wealth and Black, Indigenous, and people of color populations. Racial segregation in health care is in part maintained by reimbursement systems that directly incentivize health care providers to deliver care to those who can pay more. Our health care system routinely prioritizes those who can pay more and those who are commercially insured, at the direct expense of those who pay less – such as those who do not have insurance.

The power inequities that result means that it is often easier to close a hospital if the people who use that hospital are not considered important. Their voices are more likely to be ignored, and their health care needs are more likely to be sidelined. Teams at the New York City Health Department are implementing City Council's recent health care accountability mandate, through the passage the Health Care Accountability and Consumer Protection Act – or Local Law 78 of 2023, and using an approach that combines data, direct engagement with New Yorkers, and policy development to address the root causes of health care segregation in New York City.

Institutional accountability has been a strategic focus during my tenure as the New York City Health Department's Chief Medical Officer and will continue to be a strategic focus in my new role as Interim Commissioner. We are committed to working with all nonprofit hospitals in New York City to ensure they provide high-quality care for all, regardless of immigration status, race, ethnicity, ability to pay, or other social factors. Furthermore, our aim is to work alongside hospitals and health care systems to identify

business practices and behaviors that have led to systemic inequities, including segregated care, and address harms.

More can be done to equip hospitals and health care systems with the tools they need to hold themselves accountable by taking measurable, verifiable steps to combat structural racism and promote health equity. One useful example: in Illinois, health care leaders have created a statewide Racial Health Equity Progress Report Action Tool which is a self-assessment questionnaire that hospitals and health systems can use to measure their performance addressing racial health and other health inequities. This is a valuable tool that highlights the importance of examining all aspects of an organization — not patient care alone — to successfully eliminate health inequities. Actionable tools like this can help organizations measure their progress over time, support greater transparency around their actions and decisions, and promote accountability.

Nonprofit hospitals receive substantial public subsidies in the form of tax exemptions. According to a 2022 report by the Lown Institute, 21 New York City hospitals received over, an estimated, $1.5 billion in federal, state, and local tax exemptions.[1] To earn these tax benefits, hospitals must legally provide a community benefit. Several major New York City private hospitals have what Lown identifies as a "Fair Share" deficit — spending less on *"meaningful"* community health initiatives than the value of the tax exemptions they receive. This spending data reveals that some New York City hospitals have a deficit of hundreds of millions of dollars. When not all institutions do their part to care for uninsured and publicly insured patients the inequities that are created are compounded when unfairly overburdened safety-net hospitals are left to face increased demand.

In addition to my role as Interim Health Commissioner, I am a practicing physician at New York City Health + Hospitals/Kings County, a public institution that is located in a community that has inequitable health outcomes and would be deeply impacted by hospital closures. Supporting safety net hospitals has also been a focus of mine throughout my tenure at the New York City Health Department. The impacts of hospital closures are unfairly felt by communities that have faced decades of disinvestment. During the proposed closure of SUNY Downstate, the New York City Health Department shared concerns regarding this closure and advocated to the New York State Department of Health for key steps to limit harm to the local community and to advance health equity in Brooklyn. A key recommendation included in the New York City Health Department's letter to the State was the development of an advisory board which is currently being created and will be led by the New York State Health Commissioner, Dr. Jim MacDonald.

I will now provide an overview of our sentiments: Firstly, the importance of safety net hospitals cannot be overstated. They provide indispensable services that ensure access to health care for all individuals, contribute to public health, support the economy, and help build a more equitable health care system. Their role is fundamental in promoting the health and well-being of communities, particularly those that are most in need. Secondly, safety net hospitals are under-resourced at baseline because of how the health care payment system is built. Most notably, some services, such as specialty care are reimbursed at higher rates than other services, and commercial, private insurance also reimburses at higher rates than public insurance programs, such as Medicaid and Medicare. In addition, essential services such as maternal and neonatal, mental health, and injury services are disproportionately provided by safety-net hospitals.[2] However, these essential services are less profitable, placing financial strain on safety-net hospitals. People in communities

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[1] Lown Institute, Are New York City Hospitals Earning Their Tax Breaks? A Fair Share Spending Analysis (2022), lown-fair-share-nyc-20221118.pdf (lowninstitute.org).

[2] Sutton JP (Social and Scientific Systems), Washington RE (Council for Affordable Quality Healthcare), Fingar KR (Truven Health Analytics), Elixhauser A (AHRQ). Characteristics of Safety-Net Hospitals, 2014. HCUP Statistical Brief #213. October 2016. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb213-Safety-Net-Hospitals-2014.pdf.

with unfair health outcomes are more likely to be hospitalized and, are more likely to seek care at safety net hospitals, straining safety-net hospital capacity. Despite these headwinds. safety net hospitals continue to provide high-quality care. I serve alongside committed providers when I work at H+H/Kings County.

In addition to providing high-levels of uncompensated care, many safety net institutions also provide services to address social needs such as food and housing assistance that shape health.

The New York City Health Department supports state-level proposals that aim to address persistent funding gaps for safety-net hospitals. These include expanded Medicaid access to historically excluded populations, use of the state's 1115 Medicaid waiver, exploration of all-payer rates and other forms of Medicaid payment parity, and adequate funding and equitable distribution of Indigent Care Pool and similar funds. The New York State Department of Health's Study of Health Care System Inequities and Perinatal Access in Brooklyn serves a recent example of using some of these state levers to support safety net institutions and address inequitable access to care. The Study highlights New York State actions such as the launch of the Safety Net Transformation Program, increased Medicaid primary care rates, and expanded access to Medicaid and Child Health Plus through an 1115 waiver amendment.

Some safety net hospitals have experienced increased overcrowding and wait times in their emergency departments, which can be dangerous and lead to increased mortality risk. As we have documented in our research on COVID-19 hospitalizations and inequities, these closures contributed to a surge in patient load during the first wave of the COVID-19 pandemic that was not adequately spread across safety net and non-safety net hospitals and led to preventable deaths across the city. Emergency department overcrowding may be made worse with the closure of a nearby hospital.

Safety-net hospital closures are part of a vicious cycle. Demand by the health care industry for maximum profits in all areas of health care and a lack of accountability when large public subsidies are given in the form of tax exemptions to nonprofit hospitals pose threats to safety-net hospital viability and the patients and families they serve. Addressing these dynamics requires proactive work on the part of state and local health departments.

Thank you for holding this hearing today. Hospital closures are a direct consequence of structural racism. Closures represent a failure of health policy and medical institutions to meet their responsibility, and of government to set the proper incentives for institutions to do better. We look forward to working with the Council to further our commitment to health care transparency, accountability, and equity. Thank you for the opportunity to testify and I am happy to answer any questions.