Community Service Society | Fighting Poverty Strengthening New York

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Testimony of the Community Service Society of NY

Before the New York State Joint Senate and Assembly Hearing on COVID-19 and Hospitals

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The Community Service Society of New York (CSS) would like to thank the Chairs and members of the Senate and Assembly Committees on Health, Investigations and Government Operations, and Administrative Regulations Review Commission for holding this hearing.

CSS is a 175-year-old non-profit organization dedicated to fighting poverty. Our health programs help New Yorkers enroll into health insurance coverage, find healthcare if they are ineligible or cannot afford coverage, and help them use their coverage or otherwise access the healthcare system. We do this through a live-answer helpline and through our partnerships with over 50 community-based organizations operating in every county in New York State. Throughout the COVID-19 crisis, our helpline has maintained a live-answer rate of above 95 percent to ensure that New Yorkers are able to access the care they need during these difficult days. Annually, CSS and its partners serve approximately 130,000 New Yorkers in multiple languages.

CSS would like to begin its testimony on the important topic of the COVID-19 pandemic and New York's hospitals by saluting the incredible dedication of the staff who work in our hospitals and their allied health care facilities. These workers, including nurses, janitors and physicians—at enormous personal peril—have worked tirelessly and selflessly to care for their patients and their communities in the face of this highly infectious and devastating pandemic.[1] We are grateful for and saddened by their sacrifice.

[1] *See* Kaiser Health News & The Guardian, "Lost on the Frontline," documenting nearly 1,000 medical worker deaths in the United States due to the COVID-19 pandemic, August 10, 2020, available at: https://khn.org/news/lost-on-the-frontline-health-care-worker-death-toll-covid19-coronavirus/

The remainder of this testimony will focus on the dramatically disparate impact the COVID-19 pandemic has had on communities of color in comparison to white communities—and the structural policies in New York's hospital financing and planning system that contributed to these disparities. In June 2020, CSS published a detailed analysis of this issue in our report, *How Structural Inequalities in New York's Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform*.

The Disparate Impact of COVID-19 on Communities of Color is Socially Constructed

The age adjusted death rate per 100,000 population for white New Yorkers outside of New York City is 29. This same rate is double for Asian New Yorkers (62) and four times as high for African Americans and Latinx New Yorkers (115 and 103, respectively).[2]

Age-Adjusted Rate of COVID-19 Fatalities per 100,000 in New York State (Excluding New York City)	
Race/Ethnicity	**Fatality Rate per 100,000**
Hispanic	**103**
Black	**115**
Asian	**62**
White	29

Source: New York State Department of Health COVID-19 Tracker, August 10, 2020.

Disparities are also occurring in New York City, the epicenter of the epicenter, where African American and Latinx New Yorkers not only experience a death rate twice that of whites (261 and 246 compared to 123), but also are more likely have a COVID case and be hospitalized with COVID.[3]

Age-Adjusted Rate of COVID-19 Cases per 100,000 in New York City			
Race/Ethnicity	**Cases**	**Hospitalizations**	**Deaths**
Hispanic/Latino	1,754	711	**261**
Black/African-American	1,731	685	**246**
Asian/Pacific Islander	699	264	111
White	1,083	320	123

Source: New York City Department of Health, August 10, 2020.

Medical literature has documented the pervasive nature of racial and ethnic health disparities long before the pandemic and reiterates that there is no genetic or biologic basis for them.[4] Rather, it is well settled that these disparities are social constructions related to social

[2] New York State Department of Health COVID-19 tracker, as of August 10, 2020, available at: https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-FatalityDetail?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n

[3] New York City Department of Health, https://www1.nyc.gov/site/doh/covid/covid-19-data.page.

[4] C.W. Yancy and A.J. Kitane, "Race/ethnicity-based outcomes in cardiovascular medicine," JAMA, 2(2017), pp. 1313-1314, https://jamanetwork.com/journals/jamacardiology/article-abstract/2657545; Jason Silverstein, "Genes Don't Cause Racial-Health Disparities, Society Does," The Atlantic, April 13, 2015,

determinants of health as experienced in communities of color, such as: the nature and quality of employment opportunities; the quality of housing stock; the proximity to toxic environments; the widespread prevalence of food insecurity; and limited educational opportunities.[5]

For example, many people of color work and live in environments that are injurious for their health and impose higher risks of exposure to COVID-19. Many of these jobs have been classified as "essential" during the pandemic and the workers who fill them have been asked to risk their own health for relatively low pay. In New York City, more than 75 percent of essential and front-line workers are people of color.[6] A recent study found that only 17 percent of Latinx workers and 20 percent of African American workers have jobs that permit working remotely, while 30 percent of white workers can do so.[7] Not only do many of these "essential" jobs have a higher risk of viral exposure but they often lack essential supports such as paid sick leave and comprehensive health coverage.

Similarly, housing policies founded on racially biased zoning and redlining policies have left communities of color living in low-quality housing that engenders poor health.[8] Hypertension, obesity, chronic lung disease, diabetes, and cardiovascular disease— conditions that often lead to severe complications for COVID-19 cases— are more prevalent in non-white communities.[9] In the Bronx, which now has the highest rate of COVID-19 in the state, 68 percent of apartments have maintenance defects.[10] Housing disparities also mean that people of color are more likely to live in crowded conditions – when one member of the household is exposed, the effect is multiplied because of the difficulty of social distancing under crowded conditions.[11]

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https://www.theatlantic.com/health/archive/2015/04/genes-dont-cause-racial-health-disparities-society-does/389637/.

[5] Keith C. Ferdinand and Samar A. Nassar, "African American COVID-19 Mortality: A Sentinel Event," Journal of the American College of Cardiology (2020), doi: https://doi.org/10.1016/j.jacc.2020.04.040.

[6] Yoav Gonen, Ann Choi, and Josefa Velasquez, "NYC Blacks and Hispanics Dying of COVID-19 at Twice the Rate of Whites, Asians," The City, April 8, 2020, https://thecity.nyc/2020/04/nyc-blacks-and-hispanics-dying-of-covid-19-at-twice-the-rate.html.

[7] Economic Policy Institute, "Not Everybody Can Work From Home: Blacks and Hispanic Workers Are Much Less Likely to Be Able to Telework," March 19, 2020, https://www.epi.org/blog/black-and-hispanic-workers-are-much-less-likely-to-be-able-to-work-from-home/.

[8] RR Habib et al., "Housing quality and ill health in a disadvantaged urban community," Public Health, Feb. 2009: 174-81, doi: 10.1016/j.puhe.2008.11.2002. J. Valasquez et al., "COVID sends Public Housing-Zone Residents to Hospitals at Unusually High Rates," The City, May 15, 2020.

[9] Shika Garg et al., "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID-NET, 14 States, March 1-30, 2020," Center for Disease Control and Prevention, Morbidity and Mortality Weekly Report, April 8, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm.

[10] New York City Department of Health Community Health Profiles, https://www1.nyc.gov/site/doh/data/data-publications/profiles.page.

[11] Keeanga-Yamahtta Taylor, "The Black Plague," The New Yorker, April 16, 2020, https://www.newyorker.com/news/our-columnists/the-black-plague and Dan Vergano and Kadia Goba, "Why the Coronavirus is Killing Black Americans at Outsize Rates Across the US," Buzzfeed News, April 10, 2020, https://www.buzzfeednews.com/article/danvergano/coronavirus-black-americans-covid19. *See also,* Tenants on the Edge, Community Service Society, April 2018, https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/Tenants_at_the_Edge_-_4_18_18_-_web_2.pdf

These social determinants of health are major drivers of the substantial racial disparities observed during the COVID-19 pandemic. ***But it is also important to recognize that before the pandemic, many people of color were already experiencing significant health disparities and relied on an under-resourced health care system—especially in the amount of resources allocated to the hospitals that serve communities of color.***

The remainder of this testimony outlines how these structural deficits in New York's health care system have exacerbated the impact of the COVID-19 pandemic on low-income communities of color.

Disparities in Health Care Affordability: Insurance & Medical Debt

The most immediate cause of COVID-19's disproportionate impact on people of color may be an inability to access quality, affordable health care. Patients at well-resourced hospitals in Manhattan – hospitals where almost all patients have insurance – may have had significantly higher survival rates than those at safety-net hospitals that have been repeatedly underfunded due to hospital financing and health coverage policies.[12]

According to the Kaiser Family Foundation, lack of access to insurance and high medical costs are major deterrents to seeking testing and treatment.[13] Both issues are more prevalent for people of color than for white people.[14] Enormous numbers of New Yorkers have lost health coverage because of the pandemic and its resultant economic downturn. But loss of coverage has been worse for communities of color: African Americans in New York City reported losing health insurance twice as often as white New Yorkers (14 percent of all households compared to 6 percent);[15] and Latinx New Yorkers reported losing health insurance nearly four times as often as white New Yorkers (23 percent compared to 6 percent).

Likewise, in many parts of New York there are huge differences in the number of residents with medical debt in collections depending on whether the community is majority people of color or majority white. For example, in Onondaga County, 14 percent of residents in white communities had been put into collections because of medical expenses – but in

[12] Bryan Rosenthal et al., "Why Surviving the Virus Might Come Down to Which Hospital Admits You," The New York Times, July 1, 2020, https://www.nytimes.com/2020/07/01/nyregion/Coronavirus-hospitals.html.
[13] Kaiser Family Foundation, "What Issues Will Uninsured People Face with Testing and Treatment for COVID-19," March 16, 2020, https://www.kff.org/uninsured/fact-sheet/what-issues-will-uninsured-people-face-with-testing-and-treatment-for-covid-19/.
[14] Samantha Artiga, Kendal Orgera, and Anthony Damico, "Changes in Health Coverage by Race and Ethnicity since the ACA, 2010-2018, Kaiser Family Foundation, March 5, 2020, https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/ and Jamila Taylor, "Racism, Inequality, and Health Care for African Americans," The Century Foundation, December 19, 2019, https://tcf.org/content/report/racism-inequality-health-care-african-americans/.
[15] James A. Parrott and Lina Moe, "The New Strain of Inequality: The Economic Impact of COVID-19 in New York City," The New School Center for New York City Affairs, April 15, 2020, https://static1.squarespace.com/static/53ee4f0be4b015b9c3690d84/t/5e974be17687ca34b7517c08/1586973668757/NNewStrainofInequality_April152020.pdf.

communities of color, 41 percent of residents had.[16] The table below reveals the profound medical debt disparities in many New York counties.

Disparate Impact of the Share of Residents with Medical Debt in Collections			
County	**White Communities**	**Communities of Color**	**Difference**
Onondaga	14%	41%	27%
Monroe	7%	26%	19%
Albany	10%	26%	16%
Erie	8%	22%	14%
Schenectady	14%	28%	14%
Franklin	11%	19%	8%
Westchester	6%	11%	8%
Kings	5%	7%	4%
Rockland	5%	8%	3%
Nassau	4%	5%	2%
New York	3%	4%	2%
Richmond	4%	5%	1%
Suffolk	5%	5%	1%
Bronx	6%	6%	0%
Queens	5%	5%	0%

Unfortunately, New York's non-profit, charitable hospitals are substantially responsible for these observed disparities in medical debt. In March 2020, CSS published a report, *Discharged into Debt*, which documented that some of New York's non-profit hospitals are highly litigious, contrary to their putative charitable missions. In the past five years, these non-profit hospitals have sued over 40,000 New Yorkers in nearly every county of the state. An interactive map of these lawsuits by county, listing the hospitals who bring them, is posted on our website.[17]

COVID-19 appears to have had no impact on this behavior and is likely to exacerbate this situation. The case of Janet Mendez, recently profiled in the *New York Times* with a $400,000 bill for her COVID treatment, underscores the problem.[18] Many hospitals aggressively have continued to file lawsuits against patients throughout the pandemic. A search of just the 14 most litigious hospitals in the New York State Ecourts database indicates that they have filed 689 cases between March and August 2020, despite the fact that courts prohibited new civil case filings for the two months between March 22 and June 9, 2020.

[16] Urban Institute, "Debt in America: An Interactive Map," retrieved May 13, 2020, available at https://apps.urban.org/features/debt-interactive-map/?type=overall&variable=pct_debt_collections.

[17] Mapping How New York's Hospitals Due Vulnerable Patients, available at: https://www.cssny.org/news/entry/mapping-how-new-yorks-hospitals-sue-vulnerable-patients

[18] J. Goldstein, "She Survived the Coronavirus. Then She Got the $400,000 Bill." The New York Times, June 15, 2020.

Month	Number of Lawsuits Filed by Hospitals	Timeline
March	333	Courts closed March 22
April	0	
May	0	
June	215	Courts reopened June 9
July	122	
August	19	Search results as of August 7
Total	**689**	

The chart below lists the medical debt lawsuits between March and August 2020 by the name of the hospital:

Hospital	Number of Lawsuits Filed
John T. Mather Memorial Hospital	353
Nathan Littauer Hospital	89
Samaritan Hospital	68
NYU Winthrop Hospital	45
United Health Services Hospitals, Inc.	42
North Shore University Hospital	35
Albany Medical Center Hospital	16
Corning Hospital	13
Crouse Health Hospital Inc	13
Huntington Hospital	7
Samaritan Medical Center	5
Lenox Hill Hospital	3
New York Presbyterian	0
South Nassau Communities Hospital	0
Grand Total	**689**

In the absence of adequate planning and financial support for safety-net hospitals, these disparities in the ability to pay for healthcare contribute to the loss of healthcare infrastructure in communities where people of color live. Reducing disparities in the ability to pay for care would provide more revenue to safety-net hospitals and protecting consumers from unfair medical debt would ensure that all New Yorkers are treated fairly no matter where they seek health care.

Proposed Legislative Response

The legislature could address the affordability disparities in coverage and medical debt by:

- ***Enacting the New York Health Act to provide universal health coverage based on residency in New York State (A4738A/S4840A).***
- ***Establishing a State-funded Essential Plan for immigrants to increase revenue for hospitals serving our immigrant communities (A5974/S3900).***

- ***Enacting the Patient Medical Debt Protection Act (A8639/S6757) to eliminate disparities between hospitals in financial assistance policies and protect New Yorkers who need healthcare from unfair medical debt.***

Disparities in Hospitals and Healthcare Services for Communities of Color

Further, decisions about health care resources in New York favor wealthier neighborhoods. Since 2003, in the wake of hospital rate deregulation and the elimination of regional health planning agencies, 43 hospitals have closed around New York State, dropping the number of beds statewide from almost 74,000 in 2000 to just 53,000 in 2020.[19] Previously, New York's all payer rate regulation system ensured that safety-net hospitals had adequate support to survive.[20] These hospital closures mostly occurred in poor neighborhoods where there were fewer patients who could pay – not fewer patients.[21]

As shown in the table below, in New York City, most of these closures occurred in the same neighborhoods where there are more New Yorkers that are falling ill and dying from COVID-19. Manhattan, which only has 12 COVID-19 cases per 1,000 residents, has 6.4 hospital beds per resident. In the Bronx, with a COVID-19 rate over twice as high, there are only 2.7 hospital beds for every 1,000 residents. Queens has the biggest population of the five boroughs and a high rate of COVID-19 cases – but has the least hospital beds at only 1.5 per 1,000 residents.

Hospital Beds Compared to COVID-19 Cases in New York City's Five Boroughs		
Borough	**Beds per 1,000 People**	**COVID-19 Cases per 1,000 People**
Bronx	2.7	27
Brooklyn	2.2	17
Manhattan	6.4	12
Queens	1.5	22
Staten Island	2.5	25

All hospitals in New York are non-profits that pay no taxes and receive billions of dollars in federal and state support every year. However, state funding is not allocated based on rigorous

[19] David Robinson, April 10, 2020, LoHud/USA Today, "Why NY hospital closures, cutbacks made COVID-19 pandemic worse," https://www.recordonline.com/news/20200410/why-ny-hospital-closures-cutbacks-made-covid-19-pandemic-worse. C. Campanile, "New York Has Thrown Away 20,000 Beds, Complicating Coronavirus Fight," New York Post, March 17, 2020, https://nypost.com/2020/03/17/new-york-has-thrown-away-20000-hospital-beds-complicating-coronavirus-fight/.

[20] Sharon Shallit, Steven Fass, and Mark Nowak, "Out of the Frying Pan: New York City Hospitals in the Era of Deregulation," Health Affairs, January 2002, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.1.127.

[21] Lena Afridi and Chris Walters, "Land Use Decisions Have Life and Death Consequences," Association for Neighborhood & Housing Development, April 10, 2020, https://anhd.org/blog/land-use-decisions-have-life-and-death-consequences.

health planning that takes population need into account. State support often goes to hospitals with no allowances for their patient mix or revenue. When this support is given to hospitals that are otherwise already well-resourced, it means less for those hospitals that are not.

The allocation of New York's $1.1 billion Indigent Care Pool is yet another example of structural policy decisions that result in profound disparities in communities of color and the safety-net hospitals that serve them. This funding is provided to relatively well-heeled hospitals even when they fail to provide patients with financial assistance.[22] The safety-net hospitals that logically would receive most of this support because of their high volume of uninsured or Medicaid-covered patients are often at the bottom of the list for Indigent Care Pool funding, while hospitals with huge surpluses receive the most funding.

To make matters worse, the non-profit hospitals that sued the most patients received millions of dollars from the Indigent Care Pool in excess of the costs of indigent care they provided.[23] Unlike every other state in the nation, New York does not target these funds to safety-net hospitals, which are defined to be the top quartile of hospitals in a state that serve Medicaid and uninsured patients.[24] Instead, New York only apportioned $520 million (or 46%) of the $1.13 billion ICP funds to the top 25 percent of safety-net hospitals and $672 million to the bottom 75 percent of hospitals that do not serve nearly as many low-income people.[25]

Taken over the past 20 years, New York's choice to direct over half of its ICP allocation to hospitals that do not serve a substantial number of Medicaid and uninsured patients has meant its safety-net hospitals received roughly $13.4 billion less in funding than they would have if they had been located in any other state in the country.

Federal COVID-19 financing has only exacerbated these fiscal disparities between the rich and poor communities. The initial distributions of the Provider Relief Fund created by the federal Coronavirus Aid, Relief, and Economic Security (CARES) were based on the provider's revenue in 2018 – a formula guaranteed to short-change safety-net providers that serve low-income patients.[26] Additional funding waves attempted—but failed—to address this initial inequity. Two rounds of High Impact payments went to hospitals who had served over 160 COVID-19 patients between January 1 and June 10 and other rounds of funding went to

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[22] Carrie Tracy, Elisabeth Benjamin, and Amanda Dunker, "Unintended Consequences: How New York State Patients and Safety-Net Hospitals Are Shortchanged," Community Service Society of New York, January 2018, https://nyshealthfoundation.org/wp-content/uploads/2018/01/new-york-state-patients-safety-net-hospitals-jan-2018.pdf.

[23] Amanda Dunker and Elisabeth Benjamin, "Discharged Into Debt: New York's Non-Profit Hospitals Are Suing Patients," March 2020, https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/2020_Hospital_Report_V3_web.pdf.

[24] J.P. Sutton et al., "Statistical Brief #213: Characteristics of Safety-Net Hospitals, 2014," Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality, October 2016.

[25] New York State Department of Health, 2018 Hospital Institutional Cost Reports and 2016 Hospital Inpatient Discharges (SPARCS de-identified), Bureau of Health Informatics, Office of Patient Quality and Patient Safety, New York State Department of Health.

[26] United States Department of Health and Human Services, "CARES Act Provider Relief Fund Frequently Asked Questions," available at https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

hospitals based on their patient mix (those with many uninsured patients, for example).[27] But as of August, it still appears that New York's safety-net hospitals have been short-changed by the provider relief payments.[28]

New York City's Health and Hospitals Corporation received the highest total payment ($745 million). However, that was for all 11 of its hospitals, which is just about $68 million per hospital. Other hospitals in the top ten received much more than $68 million, though they appear to be individual facilities. For example, New York Presbyterian shows up twice in the top ten, receiving about $570 million for The New York and Presbyterian Hospital and an additional $160 million for its hospital in Queens.[29]

Ten Highest Provider Relief CARES Act Payments to New York Providers, as of August 6, 2020

Hospital	Payment
NYC Health and Hospitals Corporation	$745,000,000
The New York and Presbyterian Hospital	$570,000,000
Montefiore Medical Center	$468,000,000
NYU Langone Hospitals	$427,000,000
Long Island Jewish Medical Center	$377,000,000
Mount Sinai	$263,000,000
North Shore University Hospital	$203,000,000
Westchester County Health Care Corporation	$178,000,000
Beth Israel Medical Center	$161,000,000
NewYork-Presbyterian-Queens	$160,000,000

Displaying federal provider payments by county makes it clear that the High Impact targeted distribution failed to target funding to the hospitals in the areas with the most COVID-19 cases.[30] As of August 6, New York State had almost 419,000 COVID-19 cases confirmed by testing. Providers in New York received a total of $9.2 billion, on average about $22,000 for every positive COVID-19 test. Outside of New York City, the totals awarded to providers in each county varied enormously. Providers in Franklin County, where there were 56 cases, received a total of $15 million or $297,000 for every case. That is almost 150 times more than

[27] These funds were meant to provide hospitals with $50,000 per eligible admission plus some additional funding based on their portion of Medicare Disproportionate Share (DHS) payments and their Medicare Uncompensated Care Payments. Another targeted distribution went to hospitals with low profit margins or surpluses, uncompensated care costs of at least $25,000 per bed, and a Medicare Disproportionate Patient Percentage of at least 20.2 percent.
[28] United States Centers for Disease Control and Prevention, "HHS Provider Fund," data downloaded August 6, 2020 at https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6. The payment totals in this dataset include general and targeted distributions for which the provider accepted the payment.
[29] Similarly, Montefiore Medical Center is in the top ten, receiving $468 million, but also received additional separate payments for its hospitals in New Rochelle and Mount Vernon. North Shore University Hospital and Long Island Jewish Medical Center are both part of the Northwell Health System, yet received two separate payments of hundreds of millions of dollars.
[30] New York State Department of Health, "COVID-19 Tracker," accessed August 6, 2020 at https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Map?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n.

providers in Putnam County, where there were 1,444 cases. Putnam County providers received a total of $2.8 million, just about $2,000 per case.

In New York City, these disparities continue to occur. Providers in Manhattan received almost ten times as much relief funding per case as those in Queens.[31] Residents from all over New York City seek care in Manhattan, so it is expected that providers there would treat more patients for COVID-19 than just the residents of Manhattan who tested positive. However, fatalities are reported by place of death – so relief funding per fatality reflects the burden experienced by the providers. Using that metric, providers in Manhattan received five times more relief funding than those in Queens – and twice as much as those in Staten Island, whose providers received the next highest payments.

Upstate Counties Receiving the Highest and Lowest CARES Act Provider Relief Funds As of August 6, 2020

County	Positive COVID-19 Tests	Relief Funds per Positive Test
Franklin	52	$297,000
Otsego	115	$291,000
Clinton	127	$266,000
Schuyler	22	$217,000
Lewis	39	$175,000
Statewide	**418,928**	**$22,000**
Wayne	249	$6,000
Washington	256	$5,000
Hamilton	8	$4,000
Tioga	193	$3,000
Putnam	1,444	$2,000

Relief Funds Given to NYC Providers by COVID-19 Cases and Deaths

Borough	Positive COVID-19 Tests	Relief Funding per Positive Test	Relief Funding per COVID-19 Death
Manhattan	30,799	$72,000	$662,000
Staten Island	14,877	$16,000	$323,000
Brooklyn	62,890	$15,000	$212,000
Bronx	49,980	$10,000	$172,000
Queens	68,368	$7,000	$126,000
Statewide	**418,928**	**$22,000**	**$366,000**

Policies like this established nearly insurmountable structural inequities. As a result, the hospitals that anchor care in low-income communities of color that are suffering the most from COVID-19 were already under-resourced, even before the pandemic started.

[31] After redistributing Health & Hospitals' total payment across the boroughs according to where their hospitals are located.

Proposed Legislative Response:

- ***Ensure adequate resources go to hospitals defined by State law as Enhanced Safety Net Hospitals[32]***
    - ***Do not approve Medicaid cuts to Enhanced Safety Net Hospitals as defined by State law***
    - ***Increase the Medicaid reimbursement rate for Enhanced Safety Net Hospitals to ensure that they are able to continue to operate in low-income communities of color***
    - ***Restrict Indigent Care Pool funding to Enhanced Safety Net Hospitals***
- ***Return to an all payer hospital reimbursement system or adopt a global budgeting system for hospital reimbursements.***
- ***Restore a meaningful state health planning system that ensures that communities of color and low-income communities have adequate hospital capacity.***

Thank you again for providing me with the opportunity to testify at today's important hearing. Information about programs that CSS operates that can assist your constituents is provide below.

Should you have any questions or seek further elaboration, please do not hesitate to contact me at: ebenjamin@cssny.org or (212) 614-5461.

[32] Jill Furillo, "The Key to Funding New York's Hospitals," New York State Nurses Association, https://www.nysna.org/key-funding-new-york%E2%80%99s-hospitals#.XzLWca-Sk2w

Community Health Advocates (CHA)
Community Health Advocates is New York's statewide health insurance consumer assistance program under the Affordable Care Act. CHA helps New Yorkers navigate the complex health care system, use their health insurance, and access the health care they need. CHA helps New Yorkers through a toll-free live-answer Helpline and a statewide network of 27 community-based organizations.

CSS Navigator Network (CNN)
CNN offers health insurance enrollment assistance through community based and small business serving groups. We help New Yorkers and small businesses shop for and enroll in health coverage through NY State of Health Marketplace. CSS partners with 18 community-based organizations and small business-serving groups to serve 54 of New York's 62 counties.

Independent Consumer Advocacy Network (ICAN)
ICAN is the New York State Ombudsprogram for people with Medicaid who need long term care or behavioral health services. ICAN helps New Yorkers with enrolling in and using managed care plans that cover long term care or behavioral health services. ICAN provides education and one-on-one assistance through a statewide network of 17 community-based organizations and a toll-free live-answer Helpline.

Community Health Access to Addiction and Mental Healthcare Project (CHAMP)
CHAMP is the New York State Ombudsprogram to help individuals and their families resolve issues in accessing substance use disorder and mental health services. CHAMP is a joint project of the Office of Alcoholism and Substance Abuse Services (OASAS) and the NYS Office of Mental Health (OMH). CSS partners with three specialist agencies and five community-based organizations and operates CHAMP's toll-free live-answer Helpline.