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COMMISSION ON THE PUBLIC'S HEALTH SYSTEM (CPHS)

TESTIMONY FROM ANTHONY FELICIANO, DIRECTOR FOR THE JOINT SENATE AND ASSEMBLY ONLINE VIDEO PUBLIC HEARING on COVID-19 AND HOSPITALS

SENATE STANDING COMMITTEE ON HEALTH; SENATE STANDING COMMITTEE ON INVESTIGATIONS AND GOVERNMENT OPERATIONS; SENATE ADMINISTRATIVE REGULATIONS REVIEW COMMISSION; ASSEMBLY STANDING COMMITTEE ON HEALTH; ASSEMBLY STANDING COMMITTEE ON OVERSIGHT ANALYSIS AND INVESTIGATION; ASSEMBLY ADMINISTRATIVE REGULATIONS REVIEW COMMISSION

Purpose: To review the impact of COVID-19 on New York State's hospitals as well as how current state hospital policies impacted the approach to address the COVID-19 pandemic.

My name is Anthony Feliciano, I am the Director of the Commission on the Public's Health System (CPHS). We believe in putting the public back in public health. For over 25 years, we have been addressing inequities in the care, treatment, delivery and distribution of health care services, programs, and resources. I am here to magnify necessary information and efforts that center equity in our hospital and health care delivery system. We must have all key hospital, and decision-makers to address concerns around the funding distribution for the Indigent Care Pool (ICP), health reforms disguised as cuts to Medicaid, other safety-net protections, ill-proposed and approved hospital closures, mergers, and downsizing, data collection, testing and tracing -These are areas that have been subjected to a stigmatizing, discriminatory, xenophobic, homophobic, transphobic. misogynistic and racist environment. **We have attached a one-pager. It is focused on what we need to be done going forward. Major priorities are in my testimony with few more demands from CPHS.**

The COVID-19 virus does not discriminate — it may not infect everyone, but it is affecting everyone. However, when an indiscriminate virus is unleashed in a city, state, and country where racially unjust systems have long decided who lives, who gets by, who thrives, and who dies, the impact is anything but equal. The alarming rate of deaths in Black and Brown communities due to the inequities have glaringly laid bare the entrenched systems of healthcare apartheid through the continued forced marginalization and disparagement of communities of color within our healthcare system. These structural determinants of poverty, violence, inadequate housing, and immigration policies underlie these horrific disparities. This is not new, this has been an issue a cancer, that seems to never be rid of from the body of our city, it has eaten away underserved communities for centuries and was the result of thousands of decisions made by local, state, and federal authorities, in both the public and private sectors -whom never had a night of rest in the counties they ruled upon. For decades we have addressed these issues through advocacy, education, policy, and provisions of vital services. Therefore, we have been the voice of the people because we are the people.

New Yorkers have suffered through more than our fair share of disasters that include September 11 and Hurricane Sandy. And while disasters are devastating on their own, our response, recovery, and mitigation efforts have often compounded the tragedy by diminishing or ignoring our most vulnerable communities, particularly poor immigrant, communities of color, people with disabilities, low-income workers, LGBTQ+, especially the youth and seniors, homeless individuals and families, those who are and who have been incarcerated, those whose

lives have been affected by a criminalistic justice system, and those individuals, those women, children, and men who are who are gripped in the cycles of domestic and other acts of violence, and low-income workers.

The COVID-19 crisis has touched all aspects of infrastructure and economic activity in New York City, but it has not affected all New Yorkers proportionately. Frontline food service, grocery store, and health care workers (i.e. home health aides and Home care workers) are disproportionately people of color, immigrants, uninsured and women. We think that has played a role in how we value those lives within the response. However, this segment of the workforce has allowed most New York residents to stay at home, helping to flatten the curve of new infections. It is not an exaggeration to say that low-income New Yorkers have saved thousands of their neighbors' lives by allowing them to shelter in place.

We also suspect that the unique reach and capacity of the NYC Health + Hospitals may have played a role in saving the lives of low-income, Medicaid enrollees and uninsured that depend on it. As we move forward in restarting the economy, it will be necessary to remind decision makers that low income workers are protagonists in the city and the state's recovery.

The Fiscal Policy Institute (FPI) has noted that New York City has one million individuals that fall under the umbrella of essential worker. More than half essential workers in the city were born in another country, and a third of these workers are Black. A recent article in Modern Health Care reported that Healthcare workers of color nearly twice as likely as whites to get COVID-19.

In early April, the entire nation watched in horror as New York City hospitals like H+H Elmhurst were deluged by patients with COVID-19 in respiratory distress. Harlem is 84% people of color and at the height of the pandemic, Harlem Hospital was one of the most overwhelmed hospitals in NYC. This was true for non-public hospitals like Brookdale Hospital in Central Brooklyn. While the shortages of protective personal equipment, respirators, and COVID-19 test infrastructure have been broadly reported on, the potential impact of policy changes made amid the epidemic on Medicaid enrollees and uninsured has not been fully described. On April 3, Governor Cuomo slashed the Medicaid budget, even as record numbers of low-income patients were seeking services from hospitals that depend on the stability and capacity of the public hospitals for care in the crisis. The layoffs and potential closures flowing from these reductions in investments will continue to have immediate impacts in individuals' ability to access care from health care facilities with a mission to care for low-income patients and communities

By April, The New York State Department of Health reported that 34% of New York City deaths due to COVID-19 are among Latinx populations, although Latino individuals only make up 29% of the city's population. Similarly, 28% of New York City deaths were among black New Yorkers, even as they only make up 22% of the city's population. These number became worse over a period and while New York State has much fewer deaths and slow down the infections rates, we not too far from this all happening again.

On April 8, Governor Cuomo wondered aloud to the world in a press conference what could possibly be causing Black and Brown New Yorkers to contract and die from COVID-19 and made a pledge to understand why. We noted at the time, especially a charge to GNYHA President Kenneth Raske and Northwell Health CEO Michael Dowling to devise ways to increase the state's supply of hospital beds to accommodate an expected surge of patients. Both events are disrespectful to those who died and advocates who worked hard for change. We also saw the request to the federal government that a ship with 1,000 hospital beds be sent to New York to help address the shortage of beds.

12 big hospital systems now control 70% of the acute care beds in NYS. So, control of all these hospital beds that we needed early on in this pandemic have come into the hands of just a dozen health systems. The ones in NYC Northwell, Mount Sinai, Montefiore NYU Langone are the big players. They have outsized role in determining the future of hospitals in NY. The state does not go to these systems and say you must do the following during crisis like this - instead, they come to state and say we would like to do this and seek approval. So, the power and control are more in the hands of the hospitals. Governor Cuomo's executive orders that waived

certain hospital regulations allowed for the control be even more in their clutches. I fear that patient health care rights were violated, hospital policies are not congruent to current conditions, and hospitals will find ways to slash services or clinics, or not return service that had to be halted or rooms that had to be converted for the surge.

Therefore New York's health care system is a study in contrasts: In some places, it can provide excellent care; in other areas, especially those with residents of low income and high need, it is woefully inadequate. It is unacceptable to be this blatantly unaware of what was going to happen when a virus like this becomes widespread. The arrival of the coronavirus in New York City reminded us once again of a rigid system of healthcare resources that benefits elites and deprives communities of color. **The State has significant power through its regulatory authority, its control of Medicaid and other funding, ensuring safety-net hospitals and/or health services are not teetering towards closure, and to influence the shape of the services offered in our City to be more equitable, accessible, and funded properly and fairly distributed.** But neither the City government nor the residents can significantly influence State actions. **What is lacking is a process that will connect the services provided to the needs of the communities of this city. This chasm of a tool has allowed for the health care and hospital care delivery system to fail to protect the health and well-being all New Yorkers, especially those who unnecessary had to suffer and many cases die during this pandemic**.

We call for better coordination of the hospital systems. New York state health care has followed a policy of loosened regulation and reliance on market principles to structure the delivery of care. Hospitals have increasingly consolidated into large systems, some of which cross state lines, that compete with each other for market share, revenues, profitable patient segments with good insurance coverage, the most profitable types of services (with the highest reimbursement rates and lowest labor costs), and to shed services that are money losing. The shortcomings of this competitive private enterprise model became glaringly apparent during the height of the first round of the pandemic, as safety net hospitals serving poorer communities were flooded with COVID patients while nearby hospitals remained underutilized. The disparate distribution of necessary medications supplies, and personal protective equipment led hospitals to desperately scramble to locate supplies on domestic and foreign markets. The richer hospitals were able to use their connections and cash reserves to secure what they needed while safety net hospitals were forced to conserve equipment and supplies to the detriment of staff and patients. The State DOH and the Governor were forced to address this lack of coordination and planning, and engage in some coordination at the systemic level, but these efforts were inadequate and failed to address underlying disparities. **Accordingly, the entire hospital system should be shifted from a market competitive model to a more regulated and coordinated model in which the state and localities, health care workers and local communities take a more active role in setting goals and policies, distributing resources and funding, and directing shared responsibility for meeting local health care needs in a transparent and planned manner.**

It is beyond the time when the state needs to change its priorities and begin to address inequities. Of importance is the creation of community-accountable, knowledgeable sources of public information and analysis that can support community solutions, and a supportive environment for public and private safety net health care providers to be funded fairly well and directed to provide the needed services. It should be doing it in a way that addresses the inequities that were always have been evident before the virus pandemic. The following demands are priorities to be enacted, but our legislators and state need to ensure its does not get riddled with politics and profiteering.

Demands on Fair Play and Shared Sacrifice

Provide guaranteed operating support for safety net hospitals: Safety net hospitals are already financially fragile due to the misallocation of federal DSH and state ICP funds and chronic structural imbalances that favor large academic hospital systems to the detriment of public and private safety net

hospitals. The decline in revenues from elective procedures and the increased costs of caring for acutely ill COVID patients has hit safety net providers harder than other systems.

Safety net hospitals have had higher levels of COVID patients in general and have fewer financial reserves and assets to draw on to maintain operations. The State must guarantee that all safety net hospitals receive continuing operational funding to prevent closures, layoffs, or reduction in services. End the "Two Tier" health system. The rural safety net hospitals face similar disparities in funding as they provide services to poor rural communities and come under increasing pressure to close or reduce services. **The ongoing health care and economic effects of the crisis will increase the pressures on safety net hospitals and reinforce the two tier natures of our health care system** – with the quality and scope of services available to our most marginalized communities being worse than those available to more affluent communities that are targeted by the large private hospital networks.

- **No cuts to Medicaid:** if the federal government does not act to send aid, then the state should look to alternative revenue sources. Across the board cuts are not equally felt by hospitals and if there are cuts to Medicaid, enhanced safety net hospitals (ESN) must be excluded. Enhanced Safety Net Hospital" definition in state law includes all public hospitals, designated rural sole community and critical access hospitals, and private hospitals with the highest levels of uninsured and Medicaid patients (PHL 2807-c(34)). Cutting Medicaid will exacerbate class and race disparities. Cutting Medicaid is irresponsible during a continuing pandemic. Cutting Medicaid to balance the budget takes $2 dollars or more out of the economy for every dollar cut, making the budget situation worse. **The current cuts should be revisited and expanded Medicaid funding must be provided to provide for the spike in enrollments that will follow from the spike in unemployment and the loss of existing health coverage resulting from the severe and ongoing economic crisis.**

- **Medicaid reimbursement rates should be targeted to support safety net hospitals:** We must have reimbursement increase for safety net hospitals for providing behavioral health (BH) given the failure of private hospitals for providing BH services. Cuts to reimbursements for non-ESN hospitals should be means tested - profitable hospitals or systems should have the greatest cuts, lower cuts to mid-level hospitals, no cuts (or enhancements) to ESN hospitals. **Enhanced Safety Net Hospitals must receive the bulk of federal and state funding support to continue to operate throughout the crisis.**

- **Indigent care pool/DSH distribution formula must be targeted to ESN hospitals:** Wealthy/profitable hospitals should receive no ICP/DSH funds, **ESN ICP/DSH distributions should be targeted exclusively or largely to ESN hospitals.** For too long, lost in this discussion was the principle and intent of the ICP funding- to pay for the uninsured and to target high Medicaid hospitals. Most of it has been distractions solely on paying for Medicaid losses. –The public and private urban safety net hospitals provide care for a vastly disproportionate share of uninsured and Medicaid patients, provide most of the low reimbursed services and rely most heavily on government funding to stay afloat.

- **Penalize wasteful executive pay and non-patient care spending**: Many private hospital networks are operated in a manner that is increasingly indistinguishable from the activity of private for-profit corporations. These hospitals pay exorbitant salaries to their CEOs and scores of top executives, spend inordinate amounts of money on advertising and marketing, and focus entirely on increasing market share (of the most lucrative patients and health services) and increasing net revenues. In taking this approach, they are motivated more by profits and expanding their power than they are on

enhancing the public's health. **State funding and reimbursement policies should be adjusted to prohibit or claw-back excessive management compensation and non-patient care expenditures.**

- **Seek alternate revenue options**: New York needs tax reform by ensuring everyone pays their fair share to support our state—this means Wall Street and big corporations, New York's billionaires, and millionaires**. Our state Legislature to raise the tax rates for very wealthy New Yorkers** should not be deterred with the myths about they would be mass exodus of the ultra-rich. There are plenty of credible think-tanks that have said the contrary with data to back it up. Since a small millionaires' surcharge tax was first levied in 2009, the number of millionaires has grown substantially, as has our combined income.

Demands on Prioritizing Frontline Communities and Workers

Inequitable conditions existed long before COVID-19, and this pandemic will have repercussions for years. Recently, we had such a great opportunity to address this, but it was mostly wasted when $ 8 billion dollars were invested in the State's Medicaid Waiver project known as Delivery System Reform Incentive Payment (DSRIP) program. Underserved immigrant and low-income communities will never receive the full benefit of available heath care services if these services are not delivered in a manner that understands and is attuned to the culture and language of the communities that are being served.

We demand a health care system that centers racial, immigrant, gender, housing, environmental, energy, and climate justice to advance regenerative economies and improve the well-being of marginalized New Yorkers. Only then can we reclaim the space and discourse for an equitable response to pandemics and other public health crises and build a public health and hospital system grounded in dignity and respect that works for and by the people. We have the right to be supported in our communities.

- **Addressing Racial Disparities**: Black and Brown people are dying from COVID-19 at twice the rate of white New Yorkers. Reversing these longstanding inequalities must be a central focus in addressing the health care system during the pandemic and in any planning for the post-COVID period. The state must prioritize funding for significant expansion of health care infrastructure and services targeted to the hardest hit communities**. We can expand funding for systemic responses to social determinants of health.** The state must in addition target funding to address the various social and environmental factors that contribute to poor health outcomes, including upgrading housing infrastructure, eliminating environmental contaminants and sources of pollution, improving access to health food sources, and improving culturally sensitive health services.

- **Community-based leadership at the Core of Decision-Making:** The leadership and power of Black, Afro-Descendent, Latinx, APA and Indigenous communities have never been fully integrated in all decisions by the hospital systems and State health department. **Invest in a wide range of POC-led community-based support services, both now and in the longer-term.** Marginalized and poor New Yorkers must have access to nutritious food, social and financial supports, job training, home care, secure housing, health, and mental health supports, and more! **These cannot be temporary investments. We believe the state can do more and there is a need for a broader empowered body that makes recommendations on access and response issues**. We can work towards **building community health safety-nets**. Partner in concrete ways with community organizations on the front lines to protect those hardest hit by pandemic from barriers to accessing health and violations of rights to healthcare; to help navigate ways to ease financial costs of care; to support public health efforts to trace/quarantine/isolate; and to address the stigma and fears around testing, treatment, and tracing efforts. This especially includes **building supports for communities that are traditionally excluded from healthcare and other support systems**, and not covered by any current or existing labor protections (i.e.

sick leave). Community-based Chronic Disease Prevention and Control Infrastructure Integrated with the State's COVID Response and Contract Tracing would be important step. But the role of community-based organizations cannot be reduced to crisis prevention. **It necessary that leadership is a more comprehensive and respected co-designer and contributor role.**

- **Address the growing mental health crisis and improve the availability of mental health care and services**: Mental health services in low income and communities of color must be expanded and private hospital systems must be required to maintain and expand their existing role in providing these unprofitable services. **The safety net hospital system should not be left to provide the bulk of these services, it is time to force the private academic hospital system to shoulder their fair share of these vital services.**

- **Safe Staffing Across the State:** Hospitals cut staffing to the bone before COVID-19 and us patients paid the price when the pandemic hit. Going forward, **we need far more staff to protect patients**, and we need the same staffing standard in every hospital. With over 19,000 fatalities statewide, an imminent risk of outbreak in every community, no hospital can justify layoffs or other reductions in the healthcare workforce.

- **Maintain and Increase Surge Capacity**: New York will see another wave of COVID-19 and we need to be prepared. While many facilities will need to lower their current bed capacity to restore suspended services, we can maintain surge capacity with a **moratorium on hospital closings,** including **pausing those actions that already have state approval** to go forward and the **reactivation of shuttered units**. New York must maintain enough hospital beds and adequately trained staff for repeated outbreaks—this is not a one-time event. For example, Queens has 2.4 million residents, yet the lowest number of hospital beds per capita of any county in the nation that has a hospital in it. The borough has only 8 hospitals and 1.5 beds per thousand residents, whereas Manhattan has 1.6 million residents, 21 hospitals, and 6.4 beds per thousand people. The national average is 2.8 beds per thousand.

- **Ensure all hospitals protect patient privacy and confidentiality during the contact tracing efforts**. A thank to the New York's legislature for passing essential bill - A.10500-C/S.8450-C - to protect the confidentiality of contact tracing information and prohibit access by law enforcement and immigration enforcement. Sponsored by the chairs of the Senate and Assembly Health Committees, Senator Gustavo Rivera and Assembly member Richard Gottfried, this **bill helps ensure that contact tracing achieves its public health goals and is not weaponized against communities of color.**

Demands on Data Disaggregation and Hospital/Health Care Readiness

Either by design or lack of political will, communities of color have often been denied many tools, resources, information-basically left in the dark. It is only because of the community capital and assets that we have built up mostly on our own that **we can take care of each other**. It is true that what is not measured cannot be managed, and what has become very apparent is the need to effectively manage the direct and indirect impact of COVID-19. **Without disaggregated data on our communities, we cannot effectively identify where the problems exist, nor can we properly allocate the limited resources available to minimize that harm.**

Community health planning seeks to provide the data and analysis that can connect the needs of the community to the services that can be provided to them. As the American Public Health Association has declared, "Community health planning is a deliberate effort to involve the members of a geographically defined community

in an open public process designed to improve the availability, accessibility, and quality of healthcare services in their community as a means toward improving its health status."

In the past, there have been efforts at community planning and advocacy, from the Health Systems Agency of New York City (HSA) to the Health Policy Advisory Center (HealthPAC), both of which flourished in the 1970s into the 1980s but no longer exist today. **State should enact legislation to establish transparent local bodies to conduct local health needs assessments, make local health plans to meet identified needs, have authority to regulate and direct cooperative or coordinated provision of services by all local providers, and determine the allocation of health resources at the local level.** The aim would be to replace the existing waste and duplication of services under the current private enterprise competitive model with a more streamlined planned provision of necessary care and services at the local level.

This need is especially important to bring back in a period when, because of the Affordable Care Act, changes in the Medicaid program, and restructuring within the health care industry itself, transformations are taking place that demand the involvement of those in our communities who will affected by them.

We have been focusing on the fact that state oversight of what these big systems are doing is not transparent, not patient friendly or engaging of community at all and t's not protective of the need for community access to care. We amplify the sentiment of many allies for public notice and review of any preparations that are underway, for a potential second round of a Covid-19 outbreak. **We need to know the determining factors for all hospital plans around readiness for spikes but in general to ensure community needs are met regardless of this pandemic.**

In addition, **major reforms need to be made to existing hospital Certificate of Need process**. New York's 55-year-old CON process was created at a time when many new hospitals were being built or expanded, and policymakers wanted to avoid having too many facilities and expensive hospital equipment. This outdated CON process is not well suited to the current era of hospital mergers, downsizings, and closings.

- **Data should reflect more accurately COVID 19 Impact and Hospital Care**: Specific and granular disaggregated data on infection rates, hospitalizations, and deaths: Disaggregate existing data collection around race/ethnicity, sex, and age. **Expand data to include collecting information on primary written and spoken language, disability status, sexual orientation, gender identity, and socioeconomic status of participants.** Data collection should also be carried out in nursing homes, residential facilities, homeless shelters, and detention centers. Deaths at home or in the streets must be counted.

  More transparency and accurate data are needed. City and State are using 7 metrics to assess moving to next phases of reopening, **we are calling for a key 8th measure that tracks disproportionately. Not all neighborhoods or communities are improving at the same rate, and averaged or aggregated data creates a false sense of recovery and security**. The data from hospitals have not been readily or timely available and should provide a fuller picture for better decision-making and planning.

  Collecting and making public data specific to state-funded facilities. **The data made public must show the discharge or transfer of older and disabled adults from nursing facilities to hospitals in terms of number deaths related to COVID-19.** This is essential for garnering a better understanding of the coordination between hospitals and nursing facilities and we would include shelters. Al can be done in concert with state and federal resources. As you know, the sooner this information is made available, the faster action can be taken and the more lives we can avoid lost in future spikes.

- **Data that can help target resources and needs:** Provide the data and the analysis that program planners and advocates can use to assess the health care needs of our communities and identify resource gaps as well as excess resources that could be distributed more rationally and equitably. It should seek the thinking and the most effective use of the highly trained and dedicated health care workforce. **It**

should also enhance the accountability and effectiveness of the process by engaging residents and communities in the process, informing the public of these needs and gaps, and generating the local support needed to leverage State government to provide the resources the City's residents and communities need.

- **All discharges must be voluntary**. The state must ensure that individuals in community hospital psychiatric units who are being considered for transfer to state hospitals must give their approval and that the state must promptly reverse the trend towards increased use of the state facilities as the virus abates, **ensuring that New York meet its legal obligation to deliver services for people with disabilities in the most integrated settings across New York.** Similarly, individuals in nursing facilities should not be discharged or transferred against their will.

- **Expand the role of the public and local government in the Certificate of Need regulatory process**: In keeping with the market oriented structure of the health care system, the current certificate of need process allows private hospitals and other providers to make their own self-interested decisions to expand or reduce services and then to seek out approval with little or no public input or consideration of the broader needs of local communities. The CON process must be revamped to require a more critical showing of local needs (both for new services driven by revenue projections of the provider and for reductions or elimination of services that don't generate revenues even though they may be needed in the community). **Require by state law public hearings in the affected communities when CON's are submitted and increase the number of community/patient representatives on the Public Health & Health Planning Council (PHHPC)**:

- **Pass The New York Health Act**: It would provide universal healthcare for everyone in the state, and lawmakers must take the first steps in that direction by paying for all COVID- related healthcare costs for unemployed, uninsured, underinsured, or undocumented New Yorkers. **We know that Black and Brown communities are large proportion of those uninsured. We should address this disparity and take one more important step for an anti-racist health system.**

- **Coordinated Purchasing Pools**: The state should take on a more **active role in monitoring and distributing supplies and equipment to hospitals** and directing the flow of patients based on local needs and disregarding the institutional interests of competing systems.

We agree with many that we cannot go back to normal lives. Normal allowed for structural racism to exist at all levels of life including in our healthcare system and hospital infrastructure. But it is this normal that we seemed to be going back to. This is apparent with some of Governor's actions and some legislators are doing without a plan on how we get our hospitals better prepared , our health care safety-net strengthened, community needs targeted and met, and trusted front line community groups in the leadership of shaping how it is done. We have a health care delivery system that is not so evenly structured in its taking care of New Yorkers. **Our demands should be part of the planning and implementation process immediately and should also serve as a roadmap for the kind of long-term reforms needed to enact a more equitable public health approach in New York City and State. We cannot return to a healthcare system where your zip code determines your life expectancy.**

We supports structural changes to increase the level of state and local oversight of the hospital system, to require hospitals to coordinate and cooperate in the provision of care based on local needs, to curb wasteful market and revenue maximizing behaviors, to create integrated operating structures to link hospitals in local and regional cooperative networks, and to more equitably distribute resources within an integrated state hospital system that responds to public health needs rather than pursuing each private system's individual financial interests.

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