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November 24, 2025

Brian K. Mahanna,
Counsel to the Governor
Executive Chamber, New York State Capitol
Albany, New York 12224

Re: A.6004/S.1226

Dear Mr. Mahanna,

On behalf of the Suburban Hospital Alliance of New York State, which represents hospitals and health systems on Long Island and in the Hudson Valley, I strongly urge the governor to veto A.6004/S.1226, the Local Input in Community Healthcare (LICH) Act.

This legislation would mandate hospitals contemplating a full closure, unit closure or certain service reductions to undergo extensive notification, public engagement, and review processes. While we appreciate the need for engaging stakeholders and ensuring a transparent process, the pending legislation is both duplicative of existing requirements and unduly burdensome.

Unit/Program Closures Addressed by Community Needs Assessments and HEIAs
While full hospital closures are extremely rare, unit and service line changes are not and should not be subject to the same regulatory process. Hospitals and health systems are continuously reassessing changes in community needs. This is not just good business; as nonprofit institutions, hospitals are required by the federal and state governments to assess their communities' needs through the Community Health Needs Assessment and Community Service Plan processes, respectively, and adapt their service offerings accordingly. They are also adapting to changes in the competitive landscape, physician contracts, workforce availability, and advances in treatment modalities and technologies that shift care to other settings. Many of these elements are out of the control of the hospital, and demand decision-making on a much shorter timetable than this law allows.

Although the current version of this legislation has modified the timelines for proposed unit service reductions or closures, compared to the timeline for a proposed closure of a hospital, and created some exceptions from the requirement, many of these exceptions are poorly defined. It would be up to the Department of Health (DOH) to determine whether hospitals qualify for the law's exceptions, requiring the use of data that may not be available or is outside of the Department's scope.

Furthermore, we already have robust processes in place to address such cases. In 2021 the Legislature established the Health Equity Impact Assessment requirement as a mechanism for soliciting community input on significant service changes, ensuring that the needs of medically underserved individuals are assessed and addressed, and requiring that hospitals mitigate any negative impacts. The law took effect just over two years ago; it should be given a chance to work before adding a redundant process. The legislation should be rejected for this reason alone.

Hospital and Unit Closures Addressed in Updated DOH Guidance

The issue of facility and unit closures also was recently addressed in a Dear Administrator Letter issued by the DOH in August 2023 (DAL# 23-06). In fact, that guidance goes beyond existing regulations, which were limited to full facility closures; it establishes new requirements for notification to DOH, hospital staff and elected officials, submission of closure plans, and the holding of a community forum in the case of a proposed closure of units, or even the temporary closure or limitations of services. Although we have several concerns about the Department's guidance, DAL# 23-06 specifically preserves the confidentiality of closure information to avoid the consequences discussed below.

Like the HEIA requirement, this new guidance has only been in effect for a short time and has been given limited opportunities to be tested. The LICH Act is again redundant.

Extended Public Process Creates Challenges

Under previous regulations and reinforced by the August 2023 DOH guidance, information about a proposed facility closure is tightly controlled, for good reason. Once the public becomes aware that a hospital is about to close, the reaction can be swift and severe: staff may leave for jobs at other institutions, non-employed physicians may stop providing emergency coverage or performing surgeries at the facility, vendor relationships disintegrate, lenders may demand immediate payment. It can become very difficult for the institution to continue operating safely.

Yet that is exactly what the LICH Act would prompt. If enacted, community members would be made aware of a closure proposal a minimum of seven months in advance due to the community outreach components of the Health Equity Impact Assessment, followed by more prescriptive public notifications and community forums at the six-month mark. An institution that's closing because it is in or near bankruptcy cannot weather seven months or longer of crisis that this will generate.

A.6004/S.1226 then goes one step further, near the end of this process, to add another layer of public review, by bringing closure applications before the Public Health and Health Planning Council (PHHPC). This is not currently required for hospital closures and serves only to lengthen the duration of the process, as an extensive public and state regulatory review already will have been completed. PHHPC will be required to issue a recommendation on each application, though the statute does not address what the consequence will be if it is unable to reach consensus on these applications for closure.

Depleting Provider and State Resources

Hospitals and health systems must have the flexibility to make business decisions in this challenging environment if they are to remain solvent, or they will be unable to keep their doors open to care for any patients. Being forced to continue operating underutilized or outmoded programs or services for an extended period will only further their financial distress and jeopardize the availability and quality of other care that the institution can provide. If entire hospitals must remain open throughout this process, beyond their financial viability, that also will place a burden on state finances to support them. Nearly one-third of New York hospitals currently meet the DOH's criteria for financial distress. Distressed hospital spending has increased by more than 400 percent since FY2017. Severe cuts to Medicaid enacted by the federal government earlier this year, which not only will reduce the number of insured New Yorkers but sharply increase hospitals' charity care obligations, make it more imperative that hospitals have the ability to respond to changing conditions.

Hospitals and health systems play a critical role in communities, not just as providers of a broad range of health care and social services, but as employers and economic anchors. Like the communities they serve, they are always changing and must have the flexibility to do so. They do not take these responsibilities lightly, especially the very difficult decisions that must be made about facility and program closures.

We have grave concerns about the additional burdens that this legislation will create for distressed hospitals and therefore the impact on patient care and the financial state of New York's healthcare system. For all these reasons, we urge Governor Hochul to veto this legislation.

Sincerely,

/s/ Wendy D. Darwell

Wendy D. Darwell
President and CEO