SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK
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In the Matter of

COMMUNITY COALITION TO SAVE BETH ISRAEL HOSPITAL AND THE NEW YORK EYE AND EAR INFIRMARY, by its Co-Chair PENNY MINTZ; CENTER FOR INDEPENDENCE OF THE DISABLED, NEW YORK; the 504 DEMOCRATIC CLUB; SAVE NYEE, INC.; MICHAEL SCHWEINSBURG; ARTHUR Z. SCHWARTZ; ANDREA GORDILLO; SARAH BATCHU; RHODA LYMAN: and AIXA TORRES, as President of the Alfred E. Smith Houses Residents Association ,

Index No.

VERIFIED PETITION/ COMPLAINT

Plaintiffs-Petitioners,

v.

MOUNT SINAI BETH ISRAEL HOSPITAL; NEW YORK EYE AND EAR INFIRMARY OF MOUNT SINAI; MOUNT SINAI HEALTH SYSTEM; NEW YORK STATE DEPARTMENT OF HEALTH; and JAMES V. MCDONALD, as Commissioner of the New York State Department of Health,

Defendants-Respondents,

For an Order and Judgment Pursuant to Sections 2802-b and 2801-c of the Public Health Law; 10 NYCRR § 400.26, § 401.3, and § 710.1 *et seq.*; § 8–0101 of the Environmental Conservation Law (the N.Y. State Environmental Quality Review Act); 6 NYCRR § 617.1 *et seq.*; Section 296 of the NY State Executive Law; § 8-107 of the Administrative Code of the City of New York; Article VII of the New York State Constitution; and Article 78 of the Civil Practice Law and Rules.
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Plaintiff-Petitioners, as and for their /Complaint/Petition, restate the caption as set forth above, and allege, by their undersigned attorneys, as follows:

INTRODUCTION

1. This Petition/Complaint is filed as an update to litigation which has been proceeding since February 2024 (the Predecessor Action), addressed to the proposed closure of Mount Sinai Beth Israel Medical Center ("Beth Israel," "Beth Israel Hospital," "the Hospital," or "MSBI") ,because MSBI is "losing money." This proposal has now been approved by Respondent New York State Department of Health ("DOH"). We allege in this Petition/Complaint that the DOH approval is not only arbitrary and capricious, reflecting an ongoing lack of concern for the healthcare of the residents of Lower Manhattan, it violates the rights of Lower Manhattan residents under the New York State Constitution, under the NYS Public Health Law, under the DOH's own regulations, under the State Environmental Quality Review Act (SEQRA), and for residents with disabilities, under the NY State and NY City Human Rights Laws.

2. Beth Israel, in 2022 had 495 active inpatient beds; patients spend 141,514 days as inpatients in those beds (**see Exhibit AAAA**); it had 55,282 visits to its Emergency Room (see **Exhibit BBBB**); and those patients generated $$3,845,637,44 in revenue (see Exhibit AAAA). Even in 2023, where in November saw a massive shutdown of hospital services, over 50,000 patients used the Emergency Room (see **Exhibit CCCC** ; the hospital had 139,562 In-patient days, all with an income of $4,040,519,774 (see **Exhibit DDDD**), and, according to the American Hospital Directory, to a net PROFIT of $107,776,000. That is a lot of patient days, and health care, and nether the MSBI, its parent, the Mount Sinai Health System (MSHS), or the Department of Health has provided an answer, or at least an answer which addresses the catastrophic loss of health care of the patients who used Beth Israel in 2022 and 2023. Even now, with all of the efforts to close down, and all of the publicity about closure, and with all of the efforts to diminish ambulance services, which we discuss below and in the affidavits accompanying this Petition/Complaint, 100

patients per day have been arriving at the Beth Israel Emergency Room since MSBI acknowledged that it was not closing on July 12, 2024.

3. The underlying motivation for the closure, we contend, is the billion dollar plus worth of real estate which sits under Beth Israel, which we discuss in the Affidavit of Jeanine Keilly, submitted with this Petition/Complaint, which is incorporated herein. This is not a grounds for closure which the DOH should be countenancing.

4. In late October 2023, the Mount Sinai Health System ("MSHS"), after 10 years of stripping the Mount Sinai Beth Israel Medical Center of critical revenue producing services, and after a post 2020 COVID Pandemic announcement that it appreciated the importance of the Hospital to the population of Lower Manhattan, and that it would rebuild the Hospital, submitted a closure plan for MSBI to the New York State Department of Health . Under a Regulatory Directive issued in August 2023, modeled after related New York Law, DOH must approve any hospital closure plan, or any plan to reduce hospital services, before it occurs.

5. The closure of MSBI will have a devastating impact on the residents of Lower Manhattan, who already suffer from insufficient hospital services.

6. MSHS's closure plan, which was amended in May 2024,which DOH has now approved, is grossly deficient and fails to meet the basic requirements of the NY State Constitution, applicable laws and procedures. Furthermore, despite failing to obtain the necessary approval under DOH regulations, and the Certificate of Need process, and then in direct violation of a cease and desist letter from DOH and a Temporary Restraining Order issued in the Predecessor Action, MSHS terminated the contracts of all or most of its staff physicians, continued to reduce services at MSBI and at the New York Eye and Ear Infirmary ("NYEE") hosted job fairs for employees to encourage them to leave or transfer out of the facilities, prematurely announced closure dates so

that most professional staff, including physicians who hadn't been terminated, resigned so that they could find other employment. *See* Affidavit of PCA Doe and the Letter from "Concerned Employees," dated January 18, 2024, attached as **Exhibit S**, and the DOH Statement of Deficiencies, annexed as **Exhibit Z**.

7. On December 21, 2023 DOH issued a Cease & Desist Order **Exhibit M**, ordering MSHS to cease closing services without permission. MSHS ignored this order. As a result, on February 7, 2024 Plaintiffs-Petitioners filed a lawsuit closely related to this one, alleging that MSHS's actions to close MSBI were illegal and that DOH was required as a matter of law to reject the proposed closure plan. On February 14, 2024 Justice Nicholas Moyne issued a Temporary Restraining Order (**Exhibit FFFF**), ordering MSHS not to close services without permission of both DOH and the court. On March 14, 2024 the Federal Centers for Medicare & Medicaid Services issued a Statement of Deficiencies validating Plaintiffs-Petitioners' allegations that MSHS was endangering patient welfare by diverting unstable patients to other facilities.(See Exhibit) On March 21, 2024 DOH issued a Statement of Deficiencies to MSHS further substantiating Plaintiffs-Petitioners' allegations that MSHS was breaking the law by closing services without DOH permission and without going through the Certificate of Need Process.. On March 22, 2024 Justice Nicholas Moyne expanded the February 14, 2024 Temporary Restraining Order, re-stating that MSHS was not permitted to close services and ordering MSHS to make best efforts to restore services closed since the December 21, 2023 Cease & Desist Order (**see Exhibit GGGG).**

8. On or about April 2, 2024 the DOH issued a letter returning the Closure Plan to Beth Israel as "incomplete." On May 23, 2024, Mount Sinai Beth Israel submitted an amended Closure Plan, which is inadequate as a matter of law, and on its merits (see discussion below, and

in the accompanying affidavit of Kim Murdaugh, MD, submitted herewith and incorporated herein.. On July 26, 2024, DOH approved the inadequate amended closure plan.

9. This Petition-Complaint is, essentially, an update of the Previous Petition-Complaint, addressed, i to this unlawful determination of the DOH. The Previous Petition/Complaint was dismissed by Judge Moyne as moot, with leave to refile as a Petition addressed to a decision of the DOH.

A Brief History

10. MSBI is located on 1st Avenue between East 16th and East 17th Streets in Manhattan, directly across the street from the Stuyvesant Town residential complex. MSBI (previously known simply as Beth Israel Hospital) has historically served the greater Lower East Side area of Manhattan (the east side of Manhattan below 23rd Street) since 1889 and has been known for providing high-quality, culturally competent care for observant Jewish communities (such as by providing kosher cuisine), the Black and Hispanic residents of several NYC Housing Authority developments south of 14th Street, residents of Chinatown, and thousands of moderate and low income residents of Stuyvesant Town, a Mitchell Lama development across the street from the hospital, between 23rd Street and 14th Street.

11. Since 2010, when St. Vincent's Hospital on 7th Avenue and 11th Street was suddenly shut down pursuant to a bankruptcy filing, MSBI has served as the principal hospital for residents of the Lower East Side, residents of Stuyvesant Town, all parts of Greenwich Village and Chelsea, especially lower income residents who rely on Medicaid, including residents in the NYCHA developments south of 14th Street on the Lower East Side, and NYCHA residents in Chelsea in developments known as Fulton Houses and Elliot-Chelsea Houses, a largely Black and Hispanic community. The principal service area of the hospital, Zip Codes 10002 and 10009, also

has one of the highest, if not the highest concentration of people with disabilities and residents over 65 of any community in NYC.

12. MSBI is the only full-service hospital south of 30th Street in Manhattan that accepts Medicaid and exchange-procured insurance plans for most services.

Purpose of the Petition-Complaint

13. This is a hybrid Petition and Action brought pursuant to the New York State Constitution; the State Environmental Quality Review Act ("SEQRA"); the Public Health Law, specifically the DOH adopted regulatory requirements for closure plans, and its consequent Certificates of Need ("CONs") regulations, , as detailed in 10 NYCRR 400.26 *et seq.* and 10 NYCRR 710.1 *et seq.*, the New York New York City Human Rights Laws, and Article 78 of the Civil Practice Law and Rules, brought:

1) to challenge the July 26, 2024 DOH closure approval as both arbitrary and capricious and in violation of the law and to compel the DOH to
    a) revoke its approval of the closure plan and instead reject it;
    b) order the restoration of all services closed or reduced at MSBI since October 2023;
    c) revoke its conditional approval for the closure of NYEE granted in around June 2023;
    d) review the 2017 CON permitting the closure of the MSBI Cardiac Surgery unit, as this Court ordered in March 2020, and revoke it;
2) to compel MSHS and Beth Israel to
    a) cease reducing any further services at MSBI,

b) restore all services it has eliminated since its last substantive CON application, in July 2017, was approved;

c) restore the Cardiac Surgery unit, which was unlawfully closed without a proper CON application in 2017, as this Court found in March 2020;

d) commence appropriate review under SEQRA of any subsequent Beth Israel application to close Beth Israel;

e) commence a genuine public engagement process regarding the future of MSBI; and

3) to compel MSHS and NYEE to cease reducing any services at NYEE and restore those services which have been reduced or eliminated since 2017.

PARTIES

14. Plaintiff-Petitioner Community Coalition to Save Beth Israel Hospital and the New York Eye and Ear Infirmary is an unincorporated association comprised of residents of Lower Manhattan, healthcare advocates and medical staff at Beth Israel Hospital and NYEE.. It sues by its Co-Chairperson Penny Mintz.

15. Plaintiff-Petitioner Center for the Independence of the Disabled, New York (CIDNY) is a New York City based not-for profit corporation and a public charity under Internal Revenue Code Section 501(c)(3) that assists and advocates for persons with disabilities. It serves over 30,000 people a year, assisting people with disabilities with, among other things, navigating the health care system.

16. Plaintiff-Petitioner 504 Democratic Club is a political organization which advocates for the rights of people with disabilities in the electoral arena and which has litigated extensively in support of the rights of disabled people.

17. Plaintiff-Petitioner Save NYEE, Inc., is a New York not for profit Corporation and a public charity under Internal Revenue Code Section 501(c)(3) created by physicians working at NYEE, in order take actions, including public relations actions and meeting with representatives of the NY State Department of Health to preserve the full array of services at NYEE.

18. Plaintiff-Petitioner Michael Schweinsburg is the President of the 504 Democratic Club and is an individual with multiple disabilities who resides on East 8th Street in Manhattan near Avenue C. Mr. Schweinsburg is a Medicaid recipient. Beth Israel is the closest hospital to his residence.

19. Plaintiff-Petitioner Arthur Z. Schwartz is a resident of West 12th Street in Greenwich Village, Manhattan. He is 71 years of age and suffers from cardiovascular disease. In January 2017, he was admitted to Beth Israel after suffering a heart attack. He was treated at Beth Israel and survived. Beth Israel is the closest hospital to his residence.

20. Plaintiff-Petitioner Andrea Gordillo is a resident of East 3rd Street. Beth Israel is the closest hospital to her home, which she has used as a patient.

21. Plaintiff-Petitioner Sarah Batchu is a resident of East 10th Street. Beth Israel is the closest hospital to her home, which she has used as a patient.

22. Plaintiff-Petitioner Rhoda Lyman is a 95-year-old resident of First Avenue at 18th Street who has used Beth Israel Hospital for emergency and out-patient care for many years and was most recently treated in the Beth Israel Emergency Room in late 2021.

23. Plaintiff-Petitioner Richard Cruz was employed at Beth Israel for 31 years as a Maintenance Mechanic. On or about January 1, 2024, he was told that as part of the shutdown of Beth Israel he was reassigned to NYEE. As a result of this shift, he has lost 31 years of seniority, and has to work weekends and holidays.

24. Plaintiff Aixa Torres is the President of the Alfred E. Smith Houses Residents Association. Governor Alfred E. Smith Houses, or the Alfred E. Smith Houses. is a public housing development built by the New York City Housing Authority in the Two Bridges neighborhood of the Lower East Side of Manhattan, between the Manhattan and Brooklyn Bridges. There are 12 buildings in the complex; all are 17 stories tall, making them densely populated. Beth Israel is the closest major hospital for the tenants.

25. Defendant-Respondent NY State Department of Health ("DOH:) is an Executive Department of the State of New York. Defendant-Respondent James V. McDonald is the Commissioner of the State of New York Department of Health, headquartered in Albany, New York. Defendant-Respondent James V. McDonald is sued in his official capacity only.

26. Defendant-Respondent Mount Sinai Beth Israel Hospital is a not-for-profit hospital corporation created after the purchase of Beth Israel by MSHS in 2013. Its principal facility is located at First Avenue and 16th Street in Manhattan. It serves the Lower Manhattan Community below 40th Street, from the East River to the Hudson River, as well as communities in Brooklyn, New York. In 2015, 25% of all hospital admissions in Lower Manhattan were at Beth Israel, and it had over 90,000 visits to its Emergency Room. At present, it is configured to have 800 inpatient beds. Its corporate office is located at First Avenue and 16th Street.

27. Defendant-Respondent New York Eye and Ear Infirmary of Mount Sinai is a not-for-profit hospital corporation created after the purchase of the New York Eye and Ear Infirmary

by MSHS in 2013. Its principal facility is located at Second Avenue and 14th Street in Manhattan. It serves the Lower Manhattan community below 40th Street, from the East River to the Hudson River, as well as communities in Brooklyn.

28. Defendant-Respondent Mount Sinai Health System is a not-for-profit hospital corporation with headquarters located at 1 Gustave L. Levy Place, New York, NY 10029. The Mount Sinai Health System began as a single hospital, founded in 1852 and opened in 1855 as the Jews' Hospital. In 1864, the hospital became formally nonsectarian and, in 1866, changed its name to The Mount Sinai Hospital. The hospital is one of the oldest and largest teaching hospitals in the U.S. The Hospital's main campus is located on the Upper East Side of Manhattan, beside Central Park. Since 2010 it has purchased multiple not-for-profit hospitals throughout the City of New York, including Beth Israel, Roosevelt Hospital, St Luke's Hospital, and Astoria General Hospital.

LEGAL FRAMEWORK

The New York State Constitution

29. The New York State Constitution, at Article VII states:

> The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine.

The NY Public Health Law

30. **Declaration of Policy** – Public Health Law § 2800 contains the "Declaration of policy and statement of purpose" in regard to this title, and states as follows:

> Hospital and related services including health-related service of the highest quality, efficiently provided and properly utilized at a reasonable cost, are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the state, pursuant to section three of the article seventeen of the constitution, the department of health shall have the central, comprehensive responsibility for the development and administration of the state's policy with respect to hospital and related services, and all

> public and private institutions, whether state, county, municipal, incorporated or not incorporated, serving principally as facilities for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition or for the rendering of health-related service shall be subject to the provisions of this article.

31. **Health Equity Impact Assessment** – Section 2802-b of the health law, amended in 2023, states in relevant part:

> **§ 2802-b. Health equity impact assessments**
>
> Definitions. As used in this section:
>
> 1. "Application" means an application under this article for the construction, establishment, change in the establishment, merger, acquisition, elimination or substantial reduction, expansion, or addition of a hospital service or health-related service of a hospital that requires review or approval by the council or the commissioner, where the application is filed or submitted to the council, the commissioner or the department after this section takes effect. Provided, however, that an application for the change in the establishment, merger or acquisition of a hospital shall not be included in this definition if the application would not result in the elimination, or substantial reduction, expansion, addition or change in location of a hospital service or health related service of the hospital.
>
> 2. "Project" means the construction, establishment, change in the establishment, merger, acquisition, elimination, or substantial reduction, expansion, or addition of a hospital service or health-related service of a hospital that is the subject of an application.
>
> 3. "Health equity impact assessment" or "impact assessment" means an assessment of whether, and if so how, a project will improve access to hospital services and health care, health equity and reduction of health disparities, with particular reference to members of medically underserved groups, in the applicant's service area.
>
> 4. "Medically underserved group" means: low-income people; racial and ethnic minorities; immigrants; women; lesbian, gay, bisexual, transgender, or other-than-cisgender people; people with disabilities; older adults; persons living with a prevalent infectious disease or condition; persons living in rural areas; people who are eligible for or receive public health benefits; people who do not have third-party health coverage or have inadequate third-party health coverage; and other people who are unable to obtain health care.

2. (a)(i) Every application shall include a health equity impact assessment of the project. The health equity impact assessment shall be filed together with the application, and the application shall not be complete without the impact statement. The applicant shall promptly amend or modify the impact statement as necessary.

(b) In considering whether and on what terms to approve an application, the commissioner and the council, as the case may be, shall consider the health equity impact statement.

3**.** Scope and contents of a health equity impact assessment. A health equity impact assessment shall include:

a. A demonstration of whether, and if so how, the proposed project will improve access to hospital services and health care, health equity and reduction of health disparities, with particular reference to members of medically underserved groups, in the applicant's service area.

b. The extent to which medically underserved groups in the applicant's service area use the applicant's hospital or health related services or similar services at the time of the application and the extent to which they are expected to if the project is implemented.

c. The performance of the applicant in meeting its obligations, if any, under section twenty-eight hundred seven-k of this article and federal regulations requiring providing uncompensated care, community services, and access by minorities and people with disabilities to programs receiving federal financial assistance, including the existence of any civil rights access complaints against the applicant, and how the applicant's meeting of these obligations will be affected by implementation of the project.

d. How and to what extent the applicant will provide hospital and health-related services to the medically indigent, Medicare recipients, Medicaid recipients and members of medically underserved groups if the project is implemented.

e. The amount of indigent care, both free and below cost, that will be provided by the applicant if the project is approved.

f. Access by public or private transportation, including applicant-sponsored transportation services, to the applicant's hospital or health-related services if the project is implemented.

g. The means of assuring effective communication between the applicant's hospital and health-related service staff and people

of limited English-speaking ability and those with speech, hearing or visual impairments handicaps if the project is implemented.

h. The extent to which implementation of the project will reduce architectural barriers for people with mobility impairments.

i. A review of how the applicant will maintain or improve the quality of hospital and health-related services including a review of:

   i. demographics of the applicant's service area;

   ii. economic status of the population of the applicant's service area;

   iii. physician and professional staffing issues related to the project;

   iv. availability of similar services at other institutions in or near the applicant's service area; and

   v. historical and projected market shares of hospital and health care service providers in the applicant's service area.

j. The extent to which the availability and provision of reproductive health services and maternal health care in the applicant's service area will be affected if the project is implemented. Applicants shall demonstrate how the project will impact the delivery of statutorily protected reproductive health care, pursuant to section twenty-five hundred ninety-nine-aa of this chapter, and maternity services.

4. The health equity impact assessment shall be prepared for the applicant by an independent entity and include the meaningful engagement of public health experts, organizations representing employees of the applicant, stakeholders, and community leaders and residents of the applicant's service area.

5. The department shall publicly post the application and the health equity impact assessment on its website within one week of the filing with the department, including any filing with the council. The applicant shall publicly post the application and the health equity impact assessment on its website within one week of acknowledgement by the department.

32. Section 2801-c of the Public Health Law states:

> The supreme court may enjoin violations or threatened violations of any provisions of this article; and it may enjoin violations of the regulations of the department adopted thereunder. Upon request of the public health council or the commissioner, the attorney general shall maintain an action in the supreme court in the name of the people of the state to enjoin any such violation. Notwithstanding any limitation of the civil practice law and rules, such court may, on motion and affidavit, and upon proof that such violation is one which reasonably may result in injury to any person, whether or not such person is a party to such action, grant a temporary injunction upon such terms as may be just, pending the determination of the action.

33. Although the Health Equity Impact Assessment statute was not made applicable to the closure of a hospital when it was enacted in 2023, it was made applicable by a regulatory Guideline issued by the DOH in August 2023, guidelines which have not been challenged as applicable or improperly imposed by the Defendant/Respondents here before their Statute of Limitations expired. See **Exhibit E.** Additionally, the Health Equity Impact Requirements were and are applicable by Section 2802-b(2) which makes the requirement applicable to "elimination, or substantial reduction, expansion, or addition of a hospital service or health-related service of a hospital," events which occurred many time after the submission of the Closure Plan.

The Certificate of Need Process

34. Defendant-Respondent DOH's supervisory authority over hospital operations derive from Section 2800 of the Public Health Law. See Paragraph 35, above.

35. The Certificate of Need (CON) process is included in 10 NYCRR 710.1, which commences with the pronouncement, "Medical facilities shall be planned to achieve efficiency and economy of operation and care of high quality." See 10 NYCRR 710.1(a).

36. The CON program is a review process for the establishment, ownership, construction, and modification of health care services. In general, a CON must be filed before new facilities are built, existing facilities are renovated, major medical equipment is acquired, services are added or deleted, or facility ownership is transferred. The importance of the CON process in

the era of hospital closures and consolidation is explored in *Empowering New York Consumers in An Era of Hospital Consolidation* (*see* **Exhibit A**)*,* published in May 2018, which discusses the importance of the CON process, and its misuse during an earlier attempt by Mount Sinai to close Beth Israel in the 2017-2018 period, discussed *infra.*

37. Hospitals are required to submit a CON application and obtain approval prior to:

- Establishing or constructing new facilities, programs or hospices
- Renovating existing facilities, programs or hospices
- Acquiring major medical equipment
- **Adding or deleting services**
- Changing ownership of facilities, programs or hospices
- Modifying service areas for agencies of hospices

See 10 NYCRR 710.1(c)(1). Emphasis added.

38. Any reduction of hospital services requires the filing and approval of a CON.

39. There are three types of CON application reviews: full review, administrative review, and limited review. The type of review depends on the cost of the project, service, and type (change in ownership, new construction, renovation, etc.). 10 NYCRR 710.1, in relevant part, describes the following as proposals requiring a "full review":

> (2) Proposals requiring a full review, including a recommendation of the State Hospital Review and Planning Council.
>
> i. Any proposal involving any of the activities set forth in paragraph (1) of this subdivision that falls within any of the following categories shall require a full review pursuant to the requirements of this Part and article 28 of the Public Health Law:
>
> a) the addition of beds, other than beds designated for patients with acquired immune deficiency syndrome (AIDS) which are eligible for administrative review under paragraph (3) of this subdivision**, or the conversion of beds which establish a different level of care**, regardless of cost;
>
> b) any proposal for the addition, **modification or change in the method of delivery of the following services**, including the initial acquisition of any equipment relating thereto, regardless of cost;

1. therapeutic radiology …
2. **adult or pediatric cardiac surgery**;
3. **cardiac catheterization, including the relocation of any Cardiac Catheterization Laboratory Center service within a network or to another site in a multi-site facility** …

c) **any proposal involving total project cost in excess of $30,000,000 for a general hospital** or $15,000,000 for all other facilities, except as otherwise provided under paragraph (3) of this subdivision.

(Emphasis added.)

<u>**Health Equity Impact Assessment Regulations**</u>

40. As a result of the Health Equity Impact Assessment amendment to the Public Health Law, which applied to all the service eliminations at MSBI since October 2023, and which the DOH made applicable to Hospital Closures in its August 2023 Guidance, the Department of Health enacted the following regulations:

Section 400.26. Health Equity Impact Assessments.

(a) In accordance with Public Health Law § 2802-b, applications under Article 28, meeting the criteria set forth in this section, shall include a health equity impact assessment. The purpose of the health equity impact assessment is to demonstrate how a proposed project affects the accessibility and delivery of health care services to enhance health equity and contribute to mitigating health disparities in the facility's service area, specifically for medically underserved groups.

(b) Definitions. For the purposes of this section the following terms shall have the following meaning:

(1) "Independent entity" means individual or organization with demonstrated expertise and experience in the study of health equity, antiracism, and community and stakeholder engagement, and with preferred expertise and experience in the study of health care access or delivery of health care services, able to produce an objective written assessment using a standard format of whether, and, if so, how, the facility's proposed project will impact access to and delivery of health care services, particularly for members of medically underserved groups.

(2) "Conflict of Interest" means having a financial interest in the approval of an application or assisting in drafting any part of the application on behalf of the facility, other than the health equity assessment.

(3) "Stakeholders" shall include individuals or organizations currently or anticipated to be served by the facility, employees of the facility including facility boards or committees, public health experts including local health departments, residents of the facility's service area and organizations representing those residents, patients of the facility, community-based organizations, and community leaders.

(4) "Meaningful engagement" shall mean providing advance notice to stakeholders and an opportunity for stakeholders to provide feedback concerning the facility's proposed project, including phone calls, community forums, surveys, and written statements. Meaningful engagement must be reasonable and culturally competent based on the type of stakeholder being engaged (for example, people with disabilities should be offered a range of audiovisual modalities to complete an electronic online survey).

(c) In accordance with Public Health Law 2802-b, applications for the construction, establishment, change in establishment, merger, acquisition, elimination or substantial reduction, expansion or addition of a hospital service or health-related service of a hospital that require review or approval by the public health and health planning council or the commissioner, shall include a health equity impact assessment…

(d) A health equity impact assessment shall be performed by an independent entity without a conflict of interest, using a standard format provided by the Department, and shall include:

(1) meaningful engagement of stakeholders commensurate to the size, scope and complexity of the facility's proposed project and conducted throughout the process of developing the health equity impact assessment, to incorporate and reflect community voices;

(2) a description of the mechanisms used to conduct meaningful engagement;

(3) a documented summary of statements received from stakeholders through meaningful engagement as submitted to, or prepared by, the facility or independent entity. The Department

reserves the right to request and review individual statements as submitted, or prepared by the facility or independent entity, while reviewing the health equity impact assessment;

(4) documentation of the contractual agreement between the independent entity and the facility;

(5) a signed attestation from the independent entity that there is no conflict of interest; and

(6) a description of the independent entity's qualifications.

(e) When submitting an application to the Department requiring a health equity impact assessment, the application must include:

(1) a full version of the application and a version with proposed redactions, if any, to be shared publicly; and

(2) a signed written acknowledgment that the health equity impact assessment was reviewed by the facility, including a narrative explaining how the facility has or will mitigate potential negative impacts to medically underserved groups identified in the health equity impact assessment. The narrative must also be made available to the public and posted conspicuously on the facility's website until a decision on the application is rendered by the public health and health planning council or the commissioner.

Section 600.1 Applications for establishment.

* * *

(b) Applications to the council shall contain information and data with reference to:

* * *

(5) the following documents shall be filed:

* * *

(iii) a health equity impact assessment, if applicable, pursuant to section 2802-b of the Public Health Law and section 400.26 of this Title;

(iv) such additional pertinent information or documents necessary for the council's consideration, as requested.

Section 710.2 Application; project scope and concept.

* * *

(b) The application setting forth the scope and concept of the project shall include the following if applicable:

* * *

(11) a health equity impact assessment, if applicable, pursuant to section 2802-b of the Public Health Law and section 400.26 of this Title.

41. According to the DOH, the statutory authority and the legislative objectives for creating Section 400.26 of the regulations was as follows:

Statutory Authority:
Public Health Law (PHL) § 2803(2)(a) authorizes the Public Health and Health Planning Council (PHHPC) to adopt and amend rules and regulations, subject to the approval of the Commissioner of Health (Commissioner), to effectuate the provisions and purposes of Article 28 of the PHL. Chapter 766 of the Laws of 2021 and Chapter 137 of the Laws of 2022 amended Article 28 of the PHL by adding a new Section 2802-b, requiring health equity impact assessments to be submitted to the Department of Health (Department) for certain applications requiring review or approval by PHHPC or the Commissioner.

Legislative Objectives:
The legislative objective of PHL § 2802-b is to ensure the establishment, ownership, construction, renovation, and change in service of health care facilities defined in Article 28 into their decision making and planning processes to promote the maximum utilization of resources and ensure that medically underserved groups are not negatively impacted by proposed establishment, ownership, construction, renovation, and/or change in service applications. Requiring a demonstration of meaningful engagement with stakeholders will ensure that the people whom the health care facilities serve have a voice in proposed projects. This assessment is critical for Article 28 facilities to consider when making changes to their services, facilities and ownership. The regulations ensure that a facility reviews the findings of the health equity impact assessment and develops a narrative statement for how it will mitigate potential for exacerbating health inequities in underserved communities.

Department of Health Guidance on Hospital Closures

42. In August 2023, the DOH, following enactment of the Health Equity Assessment Act, and the adoption of the attendant regulations (both set forth above), issued guidelines to address hospital closures. *See* **Exhibit E.** These Guidelines went way beyond the prior regulations addressed to hospital closures, which only required 90 days' notice. The Guidelines stated in relevant part:

> Effective June 22, 2023, a Health Equity Impact Assessment (HEIA) is required as part of Certificate of Need (CON) applications submitted to the Department. For additional information, please visit the Department's HEIA website at https://www.health.ny.gov/community/health_equity/impact_assessment.htm.
>
> Any cessation, pause or limitation of a service is a closure that requires a closure plan and requires written approval from the New York State Department of Health ("Department"). Even if the closure is intended to be temporary, a closure plan is nevertheless required, and the closure is not permitted unless it is approved by the Department. The Department reserves the right to utilize all potential sanctions in a case where this guidance is not followed.
>
> **Prior to the submission of a closure plan to the Department for review, the provider** must notify their Federal, State and local-level elected officials (county, city, town, and village, as applicable) and the community about the proposed closure. They **must also hold a public meeting,** where the Chief Executive Officer or the Chief Operating Officer attends and answers questions, **that allows for advance notice to stakeholders and allows for public comments regarding the closure**. They must also notify any organization that represents people who work at their facilities. If the proposal is to close psychiatric or substance use disorder beds or services, the proposed closure must also be discussed with the New York State Office of Mental Health (OMH) and the New York State Office of Addiction Services and Supports (OASAS)…
>
> - The closure plan is not approved until you receive written notification of the closure plan's approval from the Department. Acknowledgment of the closure plan submission nor a verbal comment from an individual who works for the Department cannot be considered an approval.

- Pursuant to Department regulations, the following requirements regarding closures must be met:

- 90 days prior notice of the intent to close must be provided to the Department.

- prior written approval of the closure plan must be obtained from the Department before the facility is approved to close.

- **no actions related to the proposed closure, such as discontinuing a service, may be taken prior to receiving approval of the closure plan.**

- notification must be provided to patients, contracted services, staff, other agencies, and managed care programs immediately upon receipt of the Department's approval of the closure plan….

The information below must be included (in sequential order) in the facility closure plan submitted for the Department's approval. …

1. Target closure date, whether the entire facility is closing or, if the entire facility is not closing, what service(s) will be closing and what service(s) will be remaining at the facility.

2. Reason(s) for closure. Please provide detailed information, data, financials, etc. relevant to the reason(s) for closure…

5. The closure plan must include very specific reference as to how the facility will establish and maintain ongoing communication with the Department throughout each milestone of the closure process.

6. The number of patient visits to the facility for the previous three years …

7. Number of staff affected by the closure.

* * *

9. A narrative description of the proposed plan to notify patients, staff, physicians, and other staff of the closure plan. This must include written notification and meetings including those with elected officials and the community. Include dates and times of meetings, if available at the time of submission of the proposed plan, so that Department staff may attend if desired. A copy of the written communication must be provided with the closure plan. The letter must include a contact name and phone number

in the event questions should arise. Please indicate who will be signing these letters.

10. All Required reports e.g., Financial Reports and Census Reports have been submitted to the Department. All required Health Commerce System (HCS) information must be up to date.

* * *

12. The plan to discontinue admissions, including the date new admissions will stop. Include a plan to notify all referring institutions/providers.

13. A summary of the facility's current financial condition and description of the assets available to the operator to maintain appropriate services during the closure period.

14. A description of the population served by the facility and how current patients will continue to obtain access to care. Number of patients affected by the closure. Identify the zip codes where at least 80% of patients originate. The process must include assessing the needs of the patients.

15. **Identify and confirm availability of services at other area facilities including obtaining information to ensure that the provider can accept new patients, identifying where Medicaid patients can obtain care if the closing provider provides services to Medicaid patients; providing information about other facilities to patients and families, ensuring language access (i.e. that information about the closure and continuing care with another provider is communicated in the patient's preferred language) and that the wishes of current patients/families are respected; and ensuring that concerns such as geographic location, public transportation, type of facility/provider, medical care, etc., are addressed in identifying future placement options and ensuring continuity of care for patients. Please note, as always, it is the responsibility of hospitals to ensure that individual patients are offered choices and that the patients accept the transfer prior to any movement taking place**.

16. The plan to ensure that patient belongings will be secured if a hospital is closing, and the patient is being transferred to another hospital.

* * *

20. The plan to ensure adequate staffing throughout the closure process, and to ensure that staff have information regarding other employment opportunities.

21. The operator of the facility closing shall indicate what the building will be used for once the facility is closed and the disposition of the building's contents.

State Environmental Quality Review Act

43. To ensure the "laudable goal" of placing environmental concerns alongside economic interests in the land use decision-making process, the "Legislature created an elaborate procedural framework, called the State Environmental Quality Review Act or SEQRA, requiring parties to consider the environmental ramifications of their actions as early as possible." *Matter of King v. Saratoga Bd. of Supervisors*, 89 NY2d 341, 347 (1996).

44. SEQRA requires government agencies to consider the environmental impacts of proposed actions.[1] Rules and regulations promulgated as a result of the law distinguish between Type I, Type II, and Unlisted Actions.[2] Type I Actions are enumerated and considered more likely to require an Environmental Impact Statement ("EIS").[3] Type II Actions, also enumerated, generally do not require environmental review.[4] All other actions are Unlisted Actions and thus, like Type I Actions, may require environmental review.[5] Among Type I Actions are actions involving facilities with more than 240,000 square feet of gross floor area, and actions contiguous to publicly owned or operated parkland. 6 NYCRR 614.4(b)(6) and (b)(10).

[1] *See* N.Y. Envir. Conser. Law § 8-0109

[2] *See* 6 NYCRR § 6I7.3

[3] *See* 6 NYCRR § 6I7.4(b)(1)–(11).

[4] *See* 6 NYCRR § 6I7.5(c)(1)–(37).

[5] *See* 6 NYCRR § 6I7.3(c).

45. Agencies can designate additional actions as Type I or Type II. When an agency designates an action that would otherwise be unlisted and thus potentially require an environmental review, other agencies involved in the review process must adhere to that designation.[6] However, other agencies are not bound by an agency's Type II designation.[7]

46. Proposed Type I and Unlisted Actions require the lead agency (which here, upon information and belief, either is or should be the DOH) to either issue a negative declaration as to environmental impact or draft an EIS. A negative declaration is legally sufficient if the lead agency has identified all relevant environmental impacts, thoroughly analyzed such impacts, and provided a written explanation of the reasoning that supports the negative declaration.[8] Thus, a negative declaration is improper and legally insufficient if the agency fails to identify a relevant environmental impact, thoroughly analyze the impacts identified, or explain the reasoning behind its negative declaration.[9]

47. In order to assess whether a proposed action will have a significant environmental impact, agencies must take a "hard look" at the proposed action and its effects.[10] A "hard look" involves a level of granularity that includes, for example, a discussion of alternatives "sufficient to permit a comparative assessment of the alternative discussed."[11] Actions also must be evaluated in

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[6] *See* 6 NYCRR §§ 617.4(a)(2) and 617.5(b).

[7] *See* 6 NYCRR §§ 6I7.4(a)(2) and 617.5(b).

[8] *Dunk v. City of Watertown*, 11 A.D.3d 1024, 784 N.Y.S.2d (App. Div. 4th Dep't 2004); *See also* New York State Dep't of Environmental Conservation, *The SEQRA Handbook* 80 (3rd Ed. 20I0), http://www.dec.ny.gov/docs/permits_ ej_operations_pdf/seqrhandbook.pdf.

[9] *Defreetsville Area Neighborhood Ass 'n, Inc. v. Town of North Greenbrush*, 299 A.D.2d 631, 750 N.Y.S.2d 164 (App. Div. 3d Dep't 2002) (finding environmental review improper when town adopted resolution issuing negative declaration of environmental significance regarding rezoning plans but failed to consider that rezoning would lead to the construction of retail shopping center).

[10] *MYC New York Marina v. Town Board of East Hampton*, 17 Misc.3d 751 (Sup. Ct. Erie County 2007) (citing *Aldrich v. Pattison*, 107 A.D.2d 258, 266, 486 N.Y.S.2d 23 (App. Div. 2d Dep't 1985).

[11] *MYC New York Marina v. Town Board of East Hampton*, 17 Misc.3d 751 (Sup. Ct. Erie County 2007)

terms of their "reasonably related" long-term, short-term, direct, indirect and cumulative impacts,[12] and must be analyzed with other actions that are part of a long-range plan, likely to be subsequently undertaken, or dependent on approval of the initial action.[13] Significance is also evaluated in connection with the proposed action's setting, probable occurrence, duration, irreversibility, geographic scope, magnitude, and the number of people affected.[14]

48. The New York Court of Appeals has held that the "[t]hreshold at which an environmental impact statement must be prepared is relatively low."[15] If an action is determined to have a significant impact, the EIS must provide a description of: short-term and long-term effects; unavoidable effects; possible alternatives, including the effects of taking no action at all;[16] public resource commitments; possible mitigation measures; the action's growth-inducing characteristics; use of energy; solid waste implications; affects groundwater protection; and any other information consistent with the Commissioner's guidelines.[17]

49. The New York Court of Appeals has weighed "population patterns" and "existing community character" as relevant when evaluating an agency's EIS.[18] Indeed, agencies must consider an action's secondary and long-term effects on "population patterns, community goals, and neighborhood character," including any "potential acceleration of the displacement of local

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[12] *Chinese Staff Workers Ass'n v. City of New York*, 68 N.Y.2d 359, 367 (1986).

[13] *See* 6 NYCRR § 617.7(c)(2).

[14] *See* 6 NYCRR §§ 617.7(c)(3).

[15] *Chinese Staff Workers Ass 'n v. City of New York*, 68 N.Y.2d 359 (1986).

[16] *MYC New York Marina v. Town Board of East Hampton*, 17 Misc.3d 751 (Sup. Ct. Erie County 2007) (rejecting board's environmental review where it did not consider "no action" alternative and therefore failed to take a requisite "hard look" at the environmental impact of rezoning as required under SEQRA).

[17] 6 NYCRR § 617.9

[18] *Chinese Staff Workers Ass 'n v. City of New York*, 68 N.Y.2d 359, 365 (1986) (reversing appellate court's grant of summary judgment to Defendants-Respondents and granting petitioner's cross-motion for same, finding that lead agencies did not take requisite hard look because they failed to include project's secondary, long-term, and social effects on population patterns and community character in EIS).

residents and businesses."[19] Such considerations are analogous to public health, which, again, is a factor identified in regulations and agency guidance. *See also Teich v. Bucheit,* 221 A.D.2d 452 (2d Dep't 1995); *Hand v. Hospital for Special Surgery*, 943 N.Y.S.2d 792 (Sup. Ct. N.Y. County 2012).

50. While SEQRA does not specifically include health in its broad definition of "environment,"[20] state regulations clearly do—for example, 6 NYCRR § 617.2 lists "human health" in its definition of "environment."[21] Consistent with this is the Commissioner of Environmental Conservation's *SEQRA Manual*, which instructs agencies to consider "community health,"[22] and The Mayor's Office of Environmental Coordination's *CEQR [City Environmental Quality Review] Manual*, which dedicates an entire chapter to "public health."[23] Additionally, agencies must consider whether the action will create "a hazard to human health" or cause a "material conflict with a community's current plans or goals as officially approved or adopted. "[24] Thus, agencies must consider whether the proposed action will affect health, and if so, whether that impact would be significant.

51. Most NY State agencies have their own responsibility-specific SEQRA regulations. The DOH has such regulations set forth at 10 NYCRR 97.6 *et seq.*

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[19] *Chinese Staff Workers Ass'n v. City of New York*, 68 N.Y.2d 359, 367 (1986); N.Y. Envir. Conser. Law § 8-0105(6)

[20] N.Y. Envir. Conser. Law § 8-0105(6)

[21] 6 NYCCR § 617.2(1)

[22] New York State Department of Environmental Conservation, *The SEQRA Handbook* 83 (3rd Ed. 2010), http://www.dec.ny.gov/docs/permits_ej_operations_pdf/seqrhandbook.pdf.

[23] New York City Mayor's Office of Environmental Coordination, *CEQR – City Environmental Quality Review: Technical Manual* (March 2014) (*see* Chapter 20),http://www.nyc.gov/htmVoec/downloads/pdf/2014_ceqr_tm/2014_ceqr_technical_manual.pdf

[24] *See* 6 NYCRR § 617.7(c)(1)(iv), (vii).

52. 10 NYCRR 97.6 requires an initial review of an action, including completion of an Environmental Assessment Form ("EAF"), to determine whether it is subject to SEQR.

53. Once such a determination is made, Section 97.7 sets forth a series of mandatory actions by DOH. At 10 NYCRR 97.7(b) and (c) the regulations state:

> (b) An EAF shall be completed for every type I action which is directly undertaken, funded or approved by the department unless an acceptable draft EIS has already been or will be prepared on the action. No EAF shall be considered complete unless it contains a list prepared by the applicant of all other involved agencies which the applicant has been able to ascertain, exercising all due diligence.
>
> (c) Actions involving only the department. When the department proposes to directly undertake an action which does not require funding or approval from any other agency, or receives an application to fund or approve an action over which no other agencies have approval authority, it shall be the lead agency, and shall determine the significance of the action in accordance with sections 97.13 and 97.14 of this Part within the following time periods:
>
> (1) If the department is directly undertaking the action, it shall determine the significance of the action as early as possible in the design or formulation of the action.
>
> (2) If the department has received an application for funding or approval of the action, it shall determine the significance of the action within 15 calendar days of its receipt of the complete application, an EAF, and any additional information it deems necessary to make that determination.

54. The DOH regulations refine the criteria for determining what actions may have a significant effect on the environment. *See* 10 NYCRR 97.13. Those regulations, in part, state:

> (a) An action may have a significant effect on the environment if it can reasonably be expected to lead to one of the following consequences:
>
> * * *
>
> (3) the encouraging or attracting of a large number of people to a place or places for more than a few days relative to the number of people who would come to such place absent the action;

> (4) the creation of material conflict with a community's existing plans or goals as officially approved or adopted;
>
> (5) the impairment of the character or quality of important historical, archeological, architectural or aesthetic resources or of existing community or neighborhood character;
>
> (6) a major change in the use of either the quantity or type of energy;
>
> (7) the creation of a hazard to human health or safety;
>
> (8) a substantial change in the use, or intensity of use of land or other natural resources or in their capacity to support existing uses except where such a change has been included, referred to, or implicit, in a broad statement prepared pursuant to section 97.17 of this Part;
>
> (9) the creation of a material demand for other actions which would result in one of the above consequences;
>
> (10) changes in two or more elements of the environment, no one of which is substantial, but when taken together result in a material change in the environment; or
>
> (11) two or more related actions no one of which has or would have a significant effect on the environment, but which cumulatively meet one or more of the criteria in this section.
>
> (b) For the purpose of determining whether an action will cause one of the foregoing consequences, the action shall be deemed to include other contemporaneous or subsequent actions (1) which are included in any long-range comprehensive integrated plan of which the action under consideration is a part, (2) which are likely to be undertaken as a result thereof, or (3) which are dependent thereon…

55. 10 NYCRR 97.10(c) requires that DOH shall not make a decision to approve an action that has been the subject of a final SEQRA EIS until it has:

> (1) given consideration to the final EIS;
>
> (2) made a written finding that the requirements of this Part have been met; and
>
> (i) consistent with social, economic and other essential considerations from among the reasonable alternatives thereto, the action to be carried out or approved is one which minimizes

or avoids adverse environmental effects to the maximum extent practicable, including the effects disclosed in the relevant environmental impact statement; and

(ii) consistent with social, economic and other essential considerations, to the maximum extent practicable, adverse environmental effects revealed in the environmental impact statement process will be minimized or avoided by incorporating as conditions to the decision those mitigative measures which were identified as practicable;

(3) prepared a written statement of facts and conclusions relied upon in the EIS, supporting its decision and indicating the social, economic and other factors and standards which formed the basis of its decision.

NY State Human Rights Law

56. Section 269 of the NY State Human Rights Law, Article 15 of the Executive Law, states:

> 2. (a) It shall be an unlawful discriminatory practice for any person, being the owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation, resort or amusement, because of the race, creed, color, national origin, citizenship or immigration status, sexual orientation, gender identity or expression, military status, sex, disability, marital status, or status as a victim of domestic violence, of any person, directly or indirectly, to refuse, withhold from or deny to such person any of the accommodations, advantages, facilities or privileges thereof, including the extension of credit, or, directly or indirectly, to publish, circulate, issue, display, post or mail any written or printed communication, notice or advertisement, to the effect that any of the accommodations, advantages, facilities and privileges of any such place shall be refused, withheld from or denied to any person on account of race, creed, color, national origin, citizenship or immigration status, sexual orientation, gender identity or expression, military status, sex, disability or marital status, or that the patronage or custom thereat of any person of or purporting to be of any particular race, creed, color, national origin, citizenship or immigration status, sexual orientation, gender identity or expression, military status, sex or marital status, or having a disability is unwelcome, objectionable or not acceptable, desired or solicited.

> (c) For the purposes of paragraph (a) of this subdivision, "discriminatory practice" includes:
>
> (i) a refusal to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford facilities, privileges, advantages or accommodations to individuals with disabilities, unless such person can demonstrate that making such modifications would fundamentally alter the nature of such facilities, privileges, advantages or accommodations;
>
> (ii) a refusal to take such steps as may be necessary to ensure that no individual with a disability is excluded or denied services because of the absence of auxiliary aids and services, unless such person can demonstrate that taking such steps would fundamentally alter the nature of the facility, privilege, advantage or accommodation being offered or would result in an undue burden;

57. "The scope of the disability discrimination provisions of the New York State Human Rights Law, N.Y. Exec. Law § 291 *et seq.*, are similar to, but broader than, the Federal Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act, a precursor to the ADA." *Wilson v. Phoenix House*, 42 Misc.3d 677, 699, 978 N.Y.S.2d 748, 765 (Sup. Ct. 2013).

<u>NYC Human Rights Law</u>

58. A. Section 8-107(4) of the NYC Human Rights Law states:

> 4. Public accommodation. a. It shall be an unlawful discriminatory practice for any person who is the owner, franchisor, franchisee, lessor, lessee, proprietor, manager, superintendent, agent or employee of any place or provider of public accommodation:
>
> 1. Because of any person's actual or perceived race, creed, color, national origin, age, gender, disability, marital status, partnership status, sexual orientation, uniformed service or immigration or citizenship status, directly or indirectly:
>
> (a) To refuse, withhold from or deny to such person the full and equal enjoyment, on equal terms and conditions, of any of the accommodations, advantages, services, facilities or privileges of the place or provider of public accommodation.

59. Section 8-107(15) of the NYC Human Rights Law states:

> 15. Applicability; persons with disabilities. (a) Requirement to make reasonable accommodation to the needs of persons with disabilities. Except as provided in paragraph (b), it is an unlawful discriminatory practice for any person prohibited by the provisions of this section from discriminating on the basis of disability not to provide a reasonable accommodation to enable a person with a disability to satisfy the essential requisites of a job or enjoy the right or rights in question provided that the disability is known or should have been known by the covered entity.

60. Section 8-107(17) of the NYC Human Rights Law states:

> 17. Disparate impact.
>
> a. An unlawful discriminatory practice based upon disparate impact is established when:
>
> (1) The commission or a person who may bring an action under chapter 4 or 5 of this title demonstrates that a policy or practice of a covered entity or a group of policies or practices of a covered entity results in a disparate impact to the detriment of any group protected by the provisions of this chapter;

61. "The State HRL provides protections broader than the ADA; and the City HRL is broader still." *Phillips v. City of N.Y.*, 66 A.D.3d 170, 176. 884 N.Y.S.2d 369 (1st Dept.2009). "Both the City HRL and State HRL protect certain groups from policies or practices that discriminate against them in areas such as employment, public accommodations, and housing. The City's HRL is more expansive than that of the State. It was amended in 2005 to broaden its protection against discrimination." *Doe v. City of New York*, 42 Misc. 3d 502, 505, 976 N.Y.S.2d 360,363 (Sup. Ct. 2013) (citations omitted).

62. "The New York City Human Rights Law, like the State Human Rights Law, protects certain groups from policies or practices that discriminate against them in areas such as employment, public accommodations, and housing … . The City's Human Rights Law goes the additional step of prohibiting policies or practices which, though neutral on their face and neutral

in intent, have an unjustified disparate impact upon one or more of the covered groups." *Levin v. Yeshiva Univ.*, 96 N.Y.2d 484, 489, 754 N.E.2d 1099, 1100-01 (200l) (internal citations omitted).

63. "[D]isparate impact claims involve policies or practices that are facially neutral but disproportionately or more harshly impact one group … . An unlawful discriminatory practice based upon disparate impact is established when: (1) [the Plaintiff! demonstrates that a policy or practice of a covered entity . . . results in a disparate impact to the detriment of any group protected by the provisions of this chapter; and (2) the covered entity fails to plead and prove as an affirmative defense that . . . such policy or practice does not contribute to the disparate impact[.]" *Roberman v. Alamo Drafthouse Cinemas Holdings, LLC*, 67 Misc. 3d 182. 187-88, 120 N.Y.S.3d 709, 714 (N.Y. Sup. Ct. 2020) (quotations omitted).

CPLR Article 78

64. Article 78 of the Civil Practice Law and Rules creates a legal framework for enjoining an administrative agency's administrative decision in court.

65. An Article 78 proceeding may lie in the absence of a final determination by an administrative agency or body where the relief sought is by way of prohibition or by way of mandamus to compel performance by an administrative agency of a duty enjoined by law. Mandamus for such purpose, however, lies where the right to relief is "clear" and the duty sought to be enjoined is performance of an act commanded to be performed bylaw and involving no exercise of discretion. *Hamptons Hospital & Medical Center, Inc. v. Moore*, 52 N.Y.2d 88 (1981).

66. Furthermore, a Plenary Action may be brought to enjoin violations, or threatened violations, of the Public Health Law. Section 2801(c) specifically states:

> The Supreme Court may enjoin violations or threatened violations of any provisions of this article; and it may enjoin violations of the regulations of the department adopted thereunder. Upon request of the public health council or the commissioner, the attorney general shall maintain an action in the supreme

> court in the name of the people of the state to enjoin any such violation. Notwithstanding any limitation of the civil practice law and rules, such court may, on motion and affidavit, and upon proof that such violation is one which reasonably may result in injury to any person, whether or not such person is a party to such action, grant a temporary injunction upon such terms as may be just, pending the determination of the action.

See, Matter of Hamptons Hosp. & Med. Ctr. v. Moore, 52 N.Y.2d 88, 96–98, 436 N.Y.S.2d 239 (N.Y1981); *O'Reilly v. Grumet*, 126 N.E.2d 275, 278–79 (N.Y. 1955).

STATEMENT OF FACTS

MSHS Buys MSBI, Claiming It Will Increase Quality of Service

67. The Mount Sinai Health System, since it purchased Beth Israel Hospital in 2013, has systematically stripped Beth Israel both of services, and of significant sources of income, putting the hospital today in the situation of claiming that it has insufficient income to continue operating.

68. The hospital which is now MSBI was originally incorporated as Beth Israel Hospital on May 28, 1890, by a group of 40 Orthodox Jews on the Lower East Side of Manhattan, each of whom paid 25 cents to set up a hospital dedicated to serving immigrant Jews living in the tenement slums of the Lower East Side of Manhattan. At the time, most of New York's hospitals would not treat Jewish patients. The hospital initially opened a dispensary at 206 Broadway in 1891, and moved to Jefferson and Cherry Street in 1895. In 1902, the hospital established its nursing school, today known as Mount Sinai Phillips School of Nursing (PSON). On March 12, 1929, it moved to First Avenue and 16th Street, facing Stuyvesant Square. It purchased its neighbor Manhattan General Hospital in 1964 and was renamed Beth Israel Medical Center on March 10, 1965.

69. By then it had extended beyond its Jewish base and served the entire population of Lower Manhattan including Manhattan's Lower East Side, Chinatown, Gramercy, the West

Village, and Chelsea. In 1988 it had the largest network of heroin-treatment clinics in the United States with 7,500 patients and 23 facilities.

70. The merger of St. Luke's-Roosevelt and Beth Israel Hospitals in 1997 resulted in the creation of a new holding company. The holding company, Continuum Health Partners, Inc., was established to govern both hospitals.

71. Mount Sinai Health System merged with Continuum Health Partners in September of 2013, creating a large hospital network stretching across Manhattan. Through the merger, MSBI, Roosevelt Hospital on West 59th Street, St. Luke's Hospital in Morningside Heights and NYEE in the East Village all joined MSHS. MSHS officials touted the merger as having the potential to improve quality of care. MSHS stated that they pursued the merger to help them establish and build out their own citywide network, in order for MSHS to compete for market share with other large and growing regional hospital networks such as NYU, New York-Presbyterian, Montefiore, and Northwell.

Services at Beth Israel Medical Center (as of January 21, 2013)

72. According to Beth Israel Hospital's own archives the following services were available at Beth Israel Hospital at the time of the Mount Sinai-Continuum merger were as follows (source: https://web.archive.org/web/20130121141315/http://chpnyc.org/patients/BI_home/BI_ProgramsServices.html):

1. AIDS Services: Inpatient and outpatient services for HIV/AIDS
2. Allergy and Immunology (Div., Medicine): provides diagnostic and treatment capabilities for patients with allergic diseases
3. Anesthesiology: Services and treatments to make patients comfortable before, during and after surgery.
4. Appel-Venet Comprehensive Breast Service: State-of-the-art diagnosis and treatment of breast cancer with a multidisciplinary focus and a supportive environment
5. Asian Services: Services designed for Asian communities
6. Bereavement: Web based television channel devoted to assisting those who have lost loved ones

7. Beth Israel ALS Center: Provides quality care that is geared towards helping patients live more productively and independently
8. Beth Israel Hernia Center: Specially trained surgeons offer the latest in minimally invasive techniques to treat various hernia types.
9. Beth Israel Medical Group: 24-hour walk-in medical services in New York with conveniently located medical offices in Manhattan and Westchester
10. Betty & Morton Yarmon Stroke Center: Neurologists are available 24-hours a day to provide comprehensive consultation, supervise diagnostic evaluations and make treatment decisions.
11. Brief Psychotherapy Research Program: Our program provides low-cost, specialized treatment for various emotional and interpersonal difficulties of a longstanding nature, including problems with anxiety and depression.
12. Bronchial Thermoplasty: A non-drug procedure for severe, persistent asthma in patients 18 years and older, whose asthma is not well controlled with inhaled corticosteroids and long-acting beta-agonists.
13. Business Health Program: Expertise in treating work-related injuries and illnesses
14. Cancer Center: High-quality, comprehensive medical care
15. Cardiac Surgery: State-of-the-art surgery for a vast array of vascular conditions
16. Cardiology: The Heart Institute allows patients to obtain access to a comprehensive range of cardiovascular services and lifesaving resources easily and promptly
17. Center for Blood Management and Bloodless Medicine and Surgery: a specialized program committed to the appropriate provision and use of blood, its components and derivatives, and to strategies to reduce or avoid the need for a blood transfusion.
18. Center for Endovascular Surgery: Specially trained doctors are able to treat a variety of medical disorders without traditional surgery
19. Center for Health and Healing: The Center provides comprehensive outpatient integrative services for adults and children. Physicians and practitioners of diverse healing traditions and modalities focus on patient-centered primary and specialist care to optimize health, prevent illness and treat acute and chronic conditions.
20. Chemical Dependency Services, Stuyvesant Square: A hospital-based program treating men and women 18 years of age and older
21. Child Psychiatry: A multidisciplinary outpatient clinic committed to providing the highest quality care for children, adolescents and families
22. Colorectal Surgery: The Division of Colorectal Surgery offers a comprehensive range of services including a breadth of minimally invasive and traditional surgical interventions for benign and cancerous conditions of the colon, rectum and anal region, including leading-edge expertise in robotic surgery.
23. Craniofacial and Cleft Palate Center: The team treats patients with a wide range of reconstructive needs from craniosynostosis and clefts of the lip and palate, to traumatic craniofacial injuries
24. Cystic Fibrosis Center: Patients and their families rely on our accurate diagnostic capabilities, state-of-the-art treatment approach, and the comprehensive supportive services we provide.
25. Dermatology: Comprehensive dermatology services for all skin types.
26. Digestive Diseases (Dept. of Med): The physicians of the Division of Digestive Diseases at Beth Israel treat diseases of the esophagus, stomach, pancreas, biliary system, liver, colon and rectum.
27. Endocrine Surgery: We off expertise in the treatment of benign and malignant disorders of the thyroid, parathyroid, and adrenal glands, and pancreatic and gastrointestinal neuroendocrine tumors.

28. Endocrinology and Metabolism (Div., Medicine): Provides comprehensive evaluation, treatment and care of patients with endocrine and metabolic disorders
29. Epilepsy - Adults: The team at The Mirken Department of Neurology provides comprehensive care for people with epilepsy
30. Epilepsy - Pediatrics: Pediatric neurologists and neurosurgeons are physicians whose expertise lies in the areas of the brain, spinal cord and peripheral nerves
31. Executive Health Program: Health coverage for today's executives
32. Foot and Ankle Surgery: Our fellowship-trained foot and ankle surgeons add an important clinical addition to the head-to-toe delivery of sports medicine
33. Friedman Diabetes Institute: Nutritional counseling, educational initiatives, exercise and wellness programs
34. General Medical Associates (Primary Care) (Div., Medicine): General Medical Associates represents the Adult Primary Care Division of the Department of Medicine at the Beth Israel Medical Center.
35. Genetics (Dept. of Pediatrics): We provide genetic counseling and medical genetics consultations for a wide range of prenatal and postnatal conditions
36. Geriatrics (Dept. of Medicine): Beth Israel Senior Health is a geriatrics practice affiliated with Beth Israel Medical Center. Staffed by specialists trained in the care of older adults, we offer primary medical care, consultations with other physicians, and a wide range of support services, including house calls to the homebound and caregiver support services.
37. Hand Surgery: Our nationally renowned hand surgeons treat professional and amateur athletes as well as individuals from all walks of life
38. Head and Neck Surgery: We promote the most up-to-date methods of diagnosing, treating and rehabilitating patients with diseases of the head and neck
39. Heart Institute: Expert diagnosis and treatment of cardiovascular disease
40. Heart Surgery: offers state-of-the-art surgical techniques to treat the vast array of vascular conditions in the heart
41. Hematology and Oncology (Div. Medicine): High-quality, comprehensive medical care from Continuum Cancer Centers of New York.
42. Heritage Initiative: Services designed for Jewish communities
43. Hospice: Provides the best in specialized care for people in the final stage of life
44. The Hospitalist Program: Beth Israel's hospitalists are a group of highly trained physicians who spend their day strictly on inpatient care
45. Hyman Newman Institute for Neurology and Neurosurgery (INN): The Institute houses internationally recognized adult services with specialty treatments (medical and surgical) for illness of the nervous system
46. The Chris and Morton P. Hyman Patient Care Unit: a special wing featuring large, luxurious private patient suites
47. Hyperhidrosis Program: Hyperhidrosis is a medical condition that causes perspiration far greater than the physiological needs of the body
48. Incontinence: Physicians specialize in the diagnosis and management of pelvic floor disorders in women
49. Integrative Medicine: Integrative Medicine combines conventional medical practices with other indigenous and western healing approaches
50. Interventional Neuroradiology: Our multidisciplinary approach includes micro-surgical and endovascular procedures
51. Israeli Health Program: Access to Hebrew-speaking physicians
52. Karpas Health Information Center: The center reaches into the community and sponsors screenings, wellness workshops and classes throughout the city

53. Latino Health Institute: Services designed for Latino communities
54. Live Well New York: The Big Apple's New Hometown Health Information and Wellness Initiative
55. Louis Armstrong Center for Music and Medicine: Integrative care using music to complement medical treatment
56. Lung Nodule Center: The Beth Israel Lung Nodule Center offers the most advanced techniques and treatment options to diagnose and manage lung nodules—whether they are benign (non-cancerous) or malignant (cancerous).
57. Maternity Services
58. Medicine (Dept.): Offers primary care and specialized care in over ten different medical disciplines.
59. Methadone Maintenance Treatment Program: an invaluable tool for the effective treatment and rehabilitation of opioid-addicted individuals
60. Midwifery: Offers obstetrical and gynecological services to women who prefer care from a midwife
61. Nephrology (Div., Medicine): Expert care for kidney disease and high blood pressure
62. Neurology, Alan and Barbara Mirken Department of Neurology: a leader in the treatment of brain disorders and diseases of the nervous system
63. Neurosurgery: Patient-centered, advanced neurosurgical treatments for neurological disease and disorders
64. OB-GYN: Comprehensive obstetrics and gynecology services
65. Orthopedic Surgery: "Best in Manhattan for Overall Orthopedic Services" by HealthGrades
66. Ostomy Program: Patients who are considering elective ostomy surgery or need support after having ostomy surgery can take advantage of the comprehensive *inpatient* and *outpatient* services available at the Beth Israel Ostomy Program. Our specialized and caring Wound, Ostomy and Continence Nurses (WOCN) provide pre-operative stoma site selection, ongoing education and training for patients and family in caring for your ostomy as well as emotional counseling on lifestyle adjustments.
67. Pain Medicine and Palliative Care: Offers a broad array of therapies for chronic pain of all types
68. Parent and Family Education: Offers a variety of educational programs and services to help you meet the challenges of pregnancy, birth and starting a new family
69. Patient Care Representative: We can assist you in your medical progress and guide you toward a speedy recovery and discharge
70. Pediatric Orthopedics: Treat congenital defects, growth abnormalities, neurological conditions and fractures
71. Peripheral Nerve Center: Relieving pain and restoring function
72. Phillips Beth Israel School of Nursing: We offer students an outstanding academic program with the opportunity for hands-on clinical experience at a full-service teaching hospital
73. Plastic and Reconstructive Surgery: Complex reconstructions following breast surgery, head and neck surgery and trauma
74. Primary Care: Beth Israel offers many primary care locations with extended hours and convenient locations.
75. Psychiatry: The Department features many programs, centers, and services tailored to serve specific needs
76. Pulmonary and Critical Care Medicine (Div., Medicine): High-quality, comprehensive medical care
77. Radiation Oncology: Our world-renowned, highly skilled specialists and innovative technology attracts patients from around the world

78. Radiology: Combine acclaimed professionals, caring medical personnel, and state-of-the-art equipment in eight convenient locations
79. Rheumatology: Specialize in all rheumatic diseases, including gout, fibromyalgia, osteoarthritis and Lyme Disease, and have extensive experience in a variety of other conditions.
80. Senior Health and House Calls (Dept. of Medicine): Beth Israel Senior Health is a geriatrics practice affiliated with Beth Israel Medical Center. Staffed by specialists trained in the care of older adults, we offer primary medical care, consultations with other physicians, and a wide range of support services, including house calls to the homebound and caregiver support services.
81. Shoulder and Elbow Surgery: Our surgeons handle the depth and breadth of this specialty including the most complex shoulder replacements for patients
82. Sleep Health: Diagnosis, evaluation and treatment of all types of sleep disorders
83. Speech-Language and Learning Center: Certified speech-language pathologists who provide assessment and treatment to infants, children, adults and their families.
84. Spine Institute: Full range of diagnostic and treatment services for back pain and spinal disorders
85. Sports Medicine: Our Sports Medicine division is in a unique position to take care of both the weekend warrior and the elite player.
86. Stroke Centers: We staff and equip our stroke centers and emergency departments to provide rapid diagnosis, expert treatment and rehabilitation for stroke victims
87. Stuyvesant Square Chemical Dependency Services: A hospital-based program treating men and women 18 years of age and older
88. Surgery: The department consists of nearly 110 full-time and voluntary surgeons representing general surgery and all the major surgical subspecialties
89. Surgical Oncology: The Surgical Oncology Division at Beth Israel Medical Center provides surgical diagnostic and treatment approaches to solid, cancer tumors throughout the body.
90. Thoracic Surgery: Expertise in pulmonary, esophageal, chest wall, central thorax and upper digestive system surgeries
91. Thoracic Oncology: Provides patients with a comprehensive approach in the prevention, screening, detection, treatment and support of all aspects of thoracic malignancies.
92. Urology: Offers comprehensive care to men and women for all urologic conditions
93. Vascular and Birthmarks Institute of New York: Treatment options for birthmarks, including port-wine stains, hemangiomas and vascular malformations in children and adults
94. Vascular and Endovascular Surgery: The Vascular and Endovascular Surgery Division offers a full range of regionally recognized expertise in the latest therapies for the treatment of arterial and venous disorders. Our vascular surgeons are able to perform many procedures with minimally invasive techniques.
95. Volunteer Program: Become a part of the Beth Israel family by participating in one of our volunteer programs
96. Women's Heart NY: is a multi-site comprehensive heart program designed specifically for women who are at risk for, or have a history of heart disease.
97. The Advanced Wound Healing Center: The Advanced Wound Healing Center at Beth Israel Medical Center offers comprehensive wound care treatment and care for patients suffering from chronic or non-healing wounds that have not healed after six weeks.

Source: https://web.archive.org/web/20130121141315/http://chpnyc.org/patients/BI_home/BI_ProgramsServices.html.

73. MSBI and NYEE had been profitable and financially viable up to that time. See data at Paragraph 75. MSHS represented that it was committed to maintaining MSBI as the "community hospital" for Lower Manhattan, and that MSBI would be the anchor facility for its new "Downtown Network," comprised of stand-alone medical practice offices and MSBI's already-existing ambulatory care center on Union Square.

74. During the merger, both MSBI's and NYEE's heretofore existing individual governing boards were dissolved, and decision-making shifted upward to the MSHS board acting as a "mirror board" for both facilities. A Community Advisory Board was created for MSBI that met intermittently up until 2020, when the COVID-19 pandemic arrived. Most of its meetings were simply briefings by MSHS and/or MSBI administrators, but it was not used for any meaningful advisement or decision making.

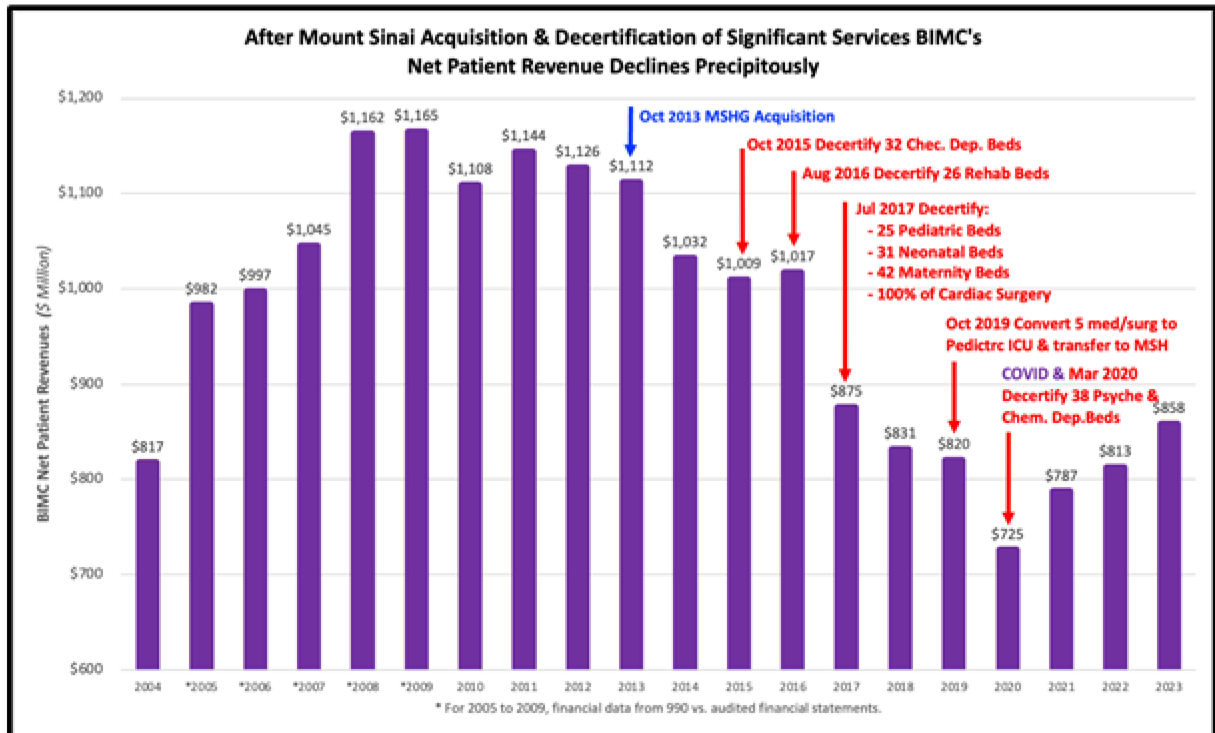
Almost Immediately After Taking Ownership of MSBI and NYEE, MSHS Planned to Liquidate Its Assets and Sell Its Real Estate

75. As of 2010, Beth Israel had residency training programs in nearly every major field of medicine including Emergency Medicine, Internal Medicine, Surgery, Otolaryngology, Oral and Maxillofacial Surgery, Radiology, Family Medicine, Dermatology, Obstetrics and Gynecology, Neurology, Ophthalmology, Pathology, Psychiatry, Podiatry, and Urology. Mount Sinai Beth Israel also had a Department of Chiropractic, Music Therapy, and Acupuncture.

76. Soon after MSHS took over MSBI and NYEE, they began to shift services away from both facilities to other parts of its network, particularly to its flagship hospital, Mount Sinai Hospital, located uptown in East Harlem. MSHS closed many of MSBI's most profitable units, including labor and delivery, neo-natal intensive care, pediatric surgery, and cardiac surgery. At NYEE, MSHS closed almost all ENT (ear, nose, and throat) services, a core part of its very mission since its founding in 1820. While NYEE has remained profitable despite MSHS' service

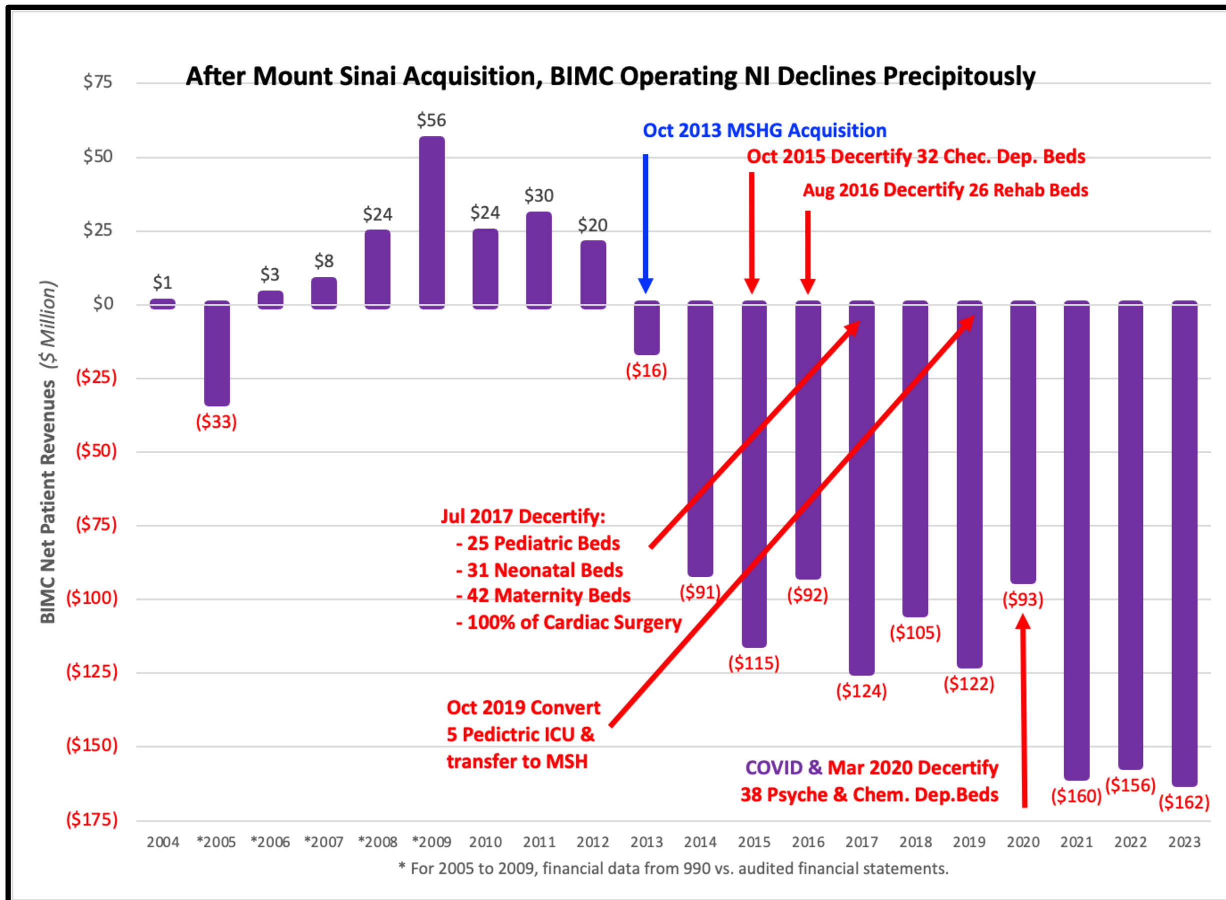
manipulation, MSBI immediately turned significantly unprofitable and has remained so to the present.

77. As this chart below demonstrates, over the same time period, net patient revenue at MSBI immediately began to suffer, dropping precipitously from 2013 to 2020 and is only just beginning a modest recovery.



78. Also removed from MSBI, its Faculty Practice Plan ("FPP") was merged into MSHS' Icahn School of Medicine ("ISMMS") between 2014 and 2015. In 2013, MSBI's FPP had generated $174 million in other revenue, and physician billing provided $19 million in other revenue. In addition, MSHS sold the Clinical Outreach Lab of MSBI, MSH, and St. Luke's-Roosevelt, which generated a one-time gain for MSBI, but subsequently resulted in a loss of more than $30 million a year in "other operating revenue" from MSBI's books. New pharmacy practice revenue has grown somewhat, but not enough to make up for the loss of those other sources of revenue.

79. With all of these changes instituted at MSBI by MSHS, MSBI's operating net income declined precipitously, as shown below.



80. When it submitted its original Closure Plan in October 2023, and now, even more fervently, in connection with its Amended Closure Plan of May 2024, MSHS has argued, and continues to argue, that MSBI is in such bad shape that it is dragging down the rest of the MSHS network and therefore must be closed as soon as possible. If the Court does not revoke DOH's approval of MSBI's Amended Closure Plan, MSHS could then also benefit from the sale of the valuable MSBI property, just to the east of Stuyvesant Park, over to First Avenue. The Affidavit of Jeannine Keilly, submitted herewith, demonstrates that that property is worth over $1 billion. MSHS has prepared its own valuation, assessing the property value at one half billion dollars. Lower Manhattan will then be left with a collection of ambulatory facilities associated with Mount

Sinai Health System, but no emergency department or inpatient facility as an anchor and hub in the area. Lower Manhattan residents will be forced to either travel uptown when seeking hospital care within the Mount Sinai system, or utilize already overcrowded hospitals, Bellevue and NYU Langone, further uptown which will only become more overcrowded.

The 2016 Closure Effort

81. Less than three years after the merger, in May 2016, MSHS announced plans to close what was then an 800-bed Beth Israel Hospital and sell off a substantial portion of its real estate. Hospital officials said the facility was to be replaced with a new 70-bed Mount Sinai Downtown Beth Israel Hospital and emergency room and with a network of outpatient centers and doctors' offices.

82. MSHS officials insisted that the new 70-bed hospital would be sufficient to serve the needs of Lower Manhattan residents. However, community residents and public officials representing them voiced concerns and protested. "The downsizing of Beth Israel hospital to a 70-bed medical/surgical center may be inadequate and will cause significant harm to health care services in Lower Manhattan," the Village Independent Democrats stated in a resolution adopted in December 2017.[25]

83. In the last 20 years, Lower Manhattan has witnessed a significant decrease in medical services, specifically hospital beds, specialty clinics and emergency centers attached to full-service hospitals. Residents have already been affected by the sudden closure of St. Vincent's Hospital in 2010. Needs assessments performed after that closure demonstrated that residents of Lower Manhattan, east and west, below 23rd Street, were relying on Beth Israel for a significant

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[25] Village Independent Democrats, *Resolution by the Village Independent Democrats Concerning the Drastic Downsizing of Mt. Sinai/Beth Israel Hospital* (December 2017), https://assets.nationbuilder.com/alisonshumanmedia/pages/49925/attachments/original/1692617106/Beth-Israel-Hospital-Final.pdf?1692617106.

portion of their care. In fact, Beth Israel's inpatient admissions increased 16 percent after the closure of St. Vincent's and its emergency room visits increased 12 percent, with Beth Israel absorbing over half of St. Vincent's emergency room patients.[26]

84. Dr. Jeremy Boal, the President of Mount Sinai Downtown between 2013 and 2023, had promised the community that as officials work to build their new facility, MSBI "will remain open" and "will continue to welcome patients throughout the transformation."[27] The new facility was to be constructed at the site of the former residents' building for NYEE, which was to be torn down by May 2018. The new facility was not slated to open until 2021. Boal has also pointed to the creation of a new urgent care walk-in center at the existing Beth Israel ambulatory care facility in Union Square, as well as renovated extension clinics, mammography and ultrasound services and other facilities. An article from Fierce Healthcare, published in 2019, featured on Mount Sinai Hospital's website, is annexed as **Exhibit B1.** In the article Dr. Boals is quoted as saying:

> "Today marks an important step forward in Mount Sinai's $1 billion commitment to rebuild, renew and revitalize health care for the downtown community," said Jeremy Boal, M.D., president of Mount Sinai Downtown and the executive vice president and chief clinical officer of the Mount Sinai Health System, in a statement. "From the new Mount Sinai Beth Israel Hospital and enhanced New York Eye and Ear Infirmary of Mount Sinai, to an expanded and enhanced ambulatory network and a new Mount Sinai Comprehensive Behavioral Health Center, we are transforming how health care services are delivered to New Yorkers."

And see **Exhibit B2**, with drawings released by MSBI showing a new 10 story hospital building.

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[26] "Post Closure Review of Service Area Access to and Utilization of Inpatient and Emergency Services" (West Side Community Health Needs Assessment, February 3, 2011), http://www.nyc.gov/html/mancb2/downloads/pdf/community_health/steeringcommittee_discussion4.pdf

[27] Jeremy Boal, "The Transformation of Mount Sinai Beth Israel" (PHHPC's Establishment and Project Review Committee, New York, NY, June 8, 2017), http://www.totalwebcasting.com/view/index.php?func=VIEW&id=nysdoh&date=2017-06-08&seq=1

85. In addressing CON requirements, Mount Sinai officials, in 2017, packaged the closing of hospital services at the existing Beth Israel facility into multiple narrowly framed applications addressed to the closing of or reductions in service that were deemed to meet the current CON qualifications for what is called "limited review" by DOH staff. This is instead of "full review," which would be conducted at public meetings of the Public Health and Health Planning Council. (PHHPC).

86. In 2017 Mount Sinai filed, received approval for and completed six separate limited review CON applications to decertify or close services at Beth Israel or to add services at its satellite locations, including:

a. In November 2016, MSBI applied to close its 20-bed pediatric unit. *See* **Exhibit AA,** Application, and **Exhibit BB**, DOH Website Information. These were closed on January 24, 2017. According to the Executive Summary (**Exhibit AA**), during the first nine months of 2016, these 20 beds "were filled by 761 patients for a total of 1709 patient days." MSBI proposed that the beds be replaced by a "dedicated pediatric observation unit" and that patients could also use the Mt. Sinai Hospital, 80 blocks to the north.

b. In November 2016 Mt. Sinai applied to convert five (5) medical surgery beds to five (5) pediatric intensive care beds and "transfer" them to Mt. Sinai hospital. *See* **Exhibit CC,** the Application, and **Exhibit DD**, DOH Website Information.

c. In January 2017, Beth Israel applied to decertify its cardiac surgery program. *See* **Exhibit EE**, Application, and **Exhibit FF**, DOH Website Information. Though filed on January 4, 2017, the unit closed almost immediately. According to the application (Exhibit EE), between 2012 and 2015, MSBI performed between 287 and 324 cardiac surgeries per year. These

patients "would now be seen at other Mount Sinai facilities within Manhattan." The annual revenue loss was pegged at $17,184,370.

d. In February 2017, MSBI applied to decertify the maternity unit, including 42 maternity beds, 14 neonatal continuing care beds and 17 neonatal intermediate care beds. *See* **Exhibit GG**, Application, and **Exhibit HH**, DOH Website Information. On average, during 2013 there were 10.5 deliveries per day. Even in 2016, after rumors of a shutdown began to circulate, there were 5.7 deliveries per day, 3,302 for the year. In 2016 the neonatal unit had 208 patients, for a total of 2,431 patient days (about half of the 2013 numbers). MSBI asserted that patients could perform deliveries elsewhere in Manhattan and Brooklyn, and half of the delivery mothers were from Brooklyn. Although the annual revenue loss was stated as $39,429,713 per year, MSBI stated that the "Total Project Cost" was $500.

e. The hospital also filed and completed multiple limited review CON applications to convert existing MSBI beds to other purposes and then move those beds to other facilities within the Mount Sinai system. In March 2017, Beth Israel applied to convert four medical beds to intensive care beds (*see* **Exhibit II**) and then to transfer those four beds to Mount Sinai uptown facilities.

f. In July 2016 MSBI applied to decertify 26 inpatient Physical Medicine and Rehabilitation beds (**Exhibits LL and MM**). "Through this project, patients who would typically be seen at MSBI will now be seen at other Mount Sinai facilities within Manhattan."

87. In addition to closures, MSBI also applied for permission to expand its Union Square outpatient facility and to begin building its 70-bed hospital on 14th Street and First Avenue.

a. Expansion of the 10 Union Square facility to create an urgent care/walk-in center was estimated to cost $3,974,002. The renovation involved 3,700 square feet of space. (*See* **Exhibit NN**.)

b. The addition of a second MRI unit at 10 Union Square, which was estimated to cost $5,563,000. (*See* **Exhibit OO**.)

c. Demolition of 321 E. 13th Street (s*ee* **Exhibit PP**), which was estimated to cost $10,736,000. This building was to be part of the new hospital building MSBI planned to build on that location and at the location of NYEE, at 310 W. 14th Street. That plan was not approved by NYC under its zoning regulations, and upon information and belief, it was withdrawn in 2020.

88. While these limited review applications (other than the East 13th Street demolition) were still under review by the DOH, MSHS began reducing or eliminating services without approval. In mid-June 2017, the maternity unit stopped taking elective deliveries. According to the NYSE-CON website, however, the application to decertify the maternity beds was not approved until July 28, 2017. Mount Sinai officials said that pregnant women would be able to deliver babies at Mount Sinai West (the former Roosevelt Hospital on 59th Street) or Mount Sinai Hospital in East Harlem, which are each located several miles away from the current MSBI facility. Hospital officials further represented that patients could also have heart surgery at Mount Sinai in East Harlem, Manhattan. Traffic jams and subway delays would undoubtedly complicate transportation to either of these uptown facilities; in fact, there is no direct subway line to either one.

89. By segmenting the "transformation" of Beth Israel into multiple pieces, and stating that the "cost" of each application was $500, Mount Sinai officials were able to submit CON applications with total cost projections that fell within the eligibility limits for "limited review" by the DOH. At the time most of the Beth Israel CONs were submitted, the total cost of a project had

to be $6 million or less to qualify for limited review. Mount Sinai's CON applications to close the Beth Israel maternity unit, pediatric unit and the 31 chemical dependency beds, to downgrade the neonatal intensive care beds, to decertify cardiac surgery and to convert and transfer beds to other locations each declared the same predicted cost of $500, which is simply the fee for filing the CON application. The applications showed otherwise. For example, the "cost" of moving or ending maternity services caused MSBI to lose over $30 million per year, and it is implausible that there were no administrative costs associated with the change aside from the CON filing fee. In short, MSHS lied to DOH in their CON applications.

90. MSHS refuted the suggestion that it was "gaming" the CON process. In an April 25, 2017, letter to then-State Assemblymember Brian Kavanagh, who had complained, Mount Sinai Downtown President Boal wrote that the hospital's "transformation will span four years, impacting multiple sites and clinical services and include significant upgrades to physical plants. To combine all of these changes into one CON application would require us to halt the work currently being done and, more significantly, create a massive delay in the process and a logistical nightmare for DOH." Because Beth Israel "has sustained losses of over $350 million over the last four years," Boal said, the hospital transformation needs to "be able to move with requisite diligence and speed." In any case, he wrote, "We have reviewed with outside counsel our approach to the CON submissions. We are confident that our process is consistent with current DOH policy."

91. On June 14, 2017, then City Council Member Rosie Mendez wrote to the DOH Commissioner Zucker expressing concern about the multiple "limited review" CON applications and called on the submission of a more comprehensive plan. (*See* Exhibit **RR**). She did not receive a response.

92. On July 28, 2017, Plaintiff-Petitioner Schwartz wrote to State Health Commissioner Zucker complaining about the lack of SEQRA Review and the segmented manner in which MSHS was proceeding with its downsizing plan (*see* **Exhibit SS**). He did not receive a response. His letter addressed the need to classify the Beth Israel project as a Type I Action under 6 CRR NY 617.4(b)(6) and (b)(10) since it involved a facility with more than 240,000 square feet of gross floor area and because it is contiguous to publicly owned or operated parkland (Stuyvesant Park).

93. On August 9, 2017, then Public Advocate Letitia James wrote to Commissioner Zucker, also about the lack of SEQRA review (*see* **Exhibit TT**), addressing conflict with a community plan (10 NYCRR 97.13(a)(4) (the plan for perinatal care)) and because it would create a substantial change in use; *i.e.*, the existing hospital building would likely become a residential property. *See* 10 NYCRR 97.13(a)(8). She too did not get a response.

94. In late October/early November 2017, the DOH website changed the status of the various CONs (other than the East 13th Street demolition) to “approved” with a July 28, 2017, date.

95. Since October 2017 MSBI has not filed another CON application to eliminate any substantive service at the MSBI campus, even after it submitted its Closure Plan in October 2023, and resumed eliminating and reducing services.

96. While a closure impact study has not been performed, MSBI, on December 31, 2017, released a Community Health Needs Assessment (“CHNA”) as it was required to do under federal law. The assessment (**Exhibit UU**), which was conducted by a private firm, Verite Healthcare Consulting, included interviews with 104 “key informants,” a community survey conducted online during the summer of 2017, and a community poll conducted in September 2017.

One of the findings from this engagement process was “dissatisfaction and fear” generated by changes in the health delivery system, including the ongoing transformation of Beth Israel, following the closure of St. Vincent’s Hospital, and the longer travel times necessary for residents of Lower Manhattan to reach Mount Sinai “Centers of Excellence” uptown for services that were previously provided at Beth Israel.

97. The community survey found that the top two issues identified by responders as the most important in their neighborhoods were “access to physician, specialist, physician assistant and/or nurse practitioner services” (identified by 340 people or 47 percent of all responders) and “hospital accessibility” (identified by 296 people or 41.4 percent of all responders). When asked which issues have been improving, staying the same or getting worse over the past two to three years, the top response was “hospital access – getting worse,” listed by 160 people or 27.4 percent of responders.

98. While the CHNA reported that in Manhattan, “there are numerous locations for community residents to receive hospital services,” its list of 15 Manhattan hospitals included a number of uptown facilities, including specialty hospitals, such as the Hospital for Special Surgery and the N.Y. Presbyterian facilities in Washington Heights, north of 168th Street, which are not convenient for Lower Manhattan residents, and certainly not for residents facing time sensitive emergencies. Only Beth Israel and N.Y. Presbyterian’s Downtown Hospital (which is located over 2.5 miles away and largely does not accept Medicaid or exchanged-purchased health plans) are located in downtown, while NYU Tisch-Langone and Bellevue are in the East 30s, on First Avenue. In its review of available government data on health access, the 2017 CNHA included a map of Manhattan and Brooklyn areas designated by HSRA as “medically underserved.” Two of the areas so denoted were the Lower East Side and Chelsea/Clinton.

99. Demographic data for Lower Manhattan that were included in the CNHA show a growing and diverse population, with 30 percent of the residents being foreign born (largely Asian and Latino). In the Lower East Side, 21.7 percent of the population is "linguistically isolated," and 11.9 percent of Lower East Side residents live with a disability, one of the most, if not the greatest concentration of people with disabilities in the City of New York. Nearly a third of residents (29.8 percent) lived in households with incomes below $25,000 a year—a substantially higher percentage than the rest of Manhattan below 96th Street. Navigating a decentralized health delivery system where patients need to go to one of multiple outpatient locations, or to Mount Sinai's uptown hospitals, instead of to one downtown hospital facility for all care, would be a challenge for such residents. In short, closing Beth Israel would have a negative disparate impact on several protected groups, including disabled New Yorkers.

2017-2020 – No Meaningful Public Input or Environmental Review

100. By artificially piecemealing its CON applications, MSHS, with the clear concurrence of the Health Department, sidestepped all public processes, even the limited public process that the Department provides through the PHHPC. And DOH staff, without any meaningful study or public input, have openly already adopted a position that the impact of Beth Israel's closure would have no negative impact on Lower Manhattan, even though in the past year more than 25 percent of all Lower Manhattan admissions were at Beth Israel and 90,000 people visited the Beth Israel Emergency Room during that year.

101. The DOH, by allowing Beth Israel to close in the manner it was preparing to do in 2017-2018, and Beth Israel itself, had violated the State Environmental Quality Review Act, the Certificate of Need process, the New York State Constitution, the Americans with Disabilities Act, and the New York State and New York City Human Rights Laws. The closure of Beth Israel was then, and would be now, a Type I action under 6 CRR-NY 617.4(b)(6)(v) and (b)(10), and 10

NYCRR 97.13 (a)(4) and (a)(8); *i.e.*, it involves a facility with more than 240,000 square feet of gross floor area, and it is contiguous to publicly owned or operated parkland (Stuyvesant Park), conflicts with an existing plan, and will result in a substantial change of use.

102. In 2017 MSBI tried to circumvent SEQRA and the full CON review process by submitting the CONs piecemeal, attempting segmented review. But segmented review is not permitted to get around SEQRA. *See Teich v. Buchheit*, 221 A.D.2d 452 (2d Dept. 1995) and case law *supra*.

103. Despite the law, DOH, which designated itself a "lead agency" under SEQRA, permitted MSHS's evasion of SEQRA and the CON process back in 2017-2018, and released an "analysis" without any formal study or public input and has asserted that all of the services provided at Beth Israel pre-shutdown will be absorbed, without a problem, by the new 70-bed mini-hospital or other facilities in Manhattan.

104. In making this "analysis," the DOH used none of the metrics required by SEQRA, nor did they do the review required under the CON process. To the extent analysis was done, DOH entirely ignored, or made up data concerning the potential impact of the closure of the Beth Israel Hospital as it currently existed (an approach which appears to be occurring again).

Litigation Filed and COVID Hits

105. In December 2017 a lawsuit was filed in NY State Supreme Court, titled *Progressive Action of Lower Manhattan v. Zucker*, NY County Index No. 160480/2017, alleging that the department-by-department closures, which understated costs to the Hospital, had violated the CON process (which should have addressed what was really a hospital closure and downsizing of services), that the hospital closure underlying the piecemeal process required an Environmental Impact Statement under SEQRA, and that the approval of the closures by the DOH violated the right to health care under the State Constitution.

106. Although no injunction was issued, the lawsuit caused Mount Sinai to freeze its plans, and engage in additional discussion with community leaders and elected officials.

107. While the lawsuit was pending, then Manhattan Borough President Gale Brewer convened a task force of public officials, MSBI officials, and community activists to try to forge a consensus plan, which never came to fruition.

108. On around March 7, 2020 Supreme Court Justice Hagler issued a decision in the *Progressive Action* case, finding that in all cases other than that involving the closure of the heart surgery unit, the use of the CON process had been lawful, that "closures are not environmental hazards for the purposes of SEQRA," and that "this case does not present the types of 'unusual circumstances' in which 'potential public health consequences' are not addressed under a specific category but nonetheless mandates further analysis [such] as [for] example[], the potential impact of pesticide application to control the spread of West Nile Virus and the potential spread of gastrointestinal illness resulting from the installation of devices that aerosolize water." The Court did find that "*DOH erred in conducting a limited review for the closing of the cardiac surgery unit without providing a rational explanation for its decision. Under 10 NYCRR § 710.1 (c) (2) (i) (b) (2), proposals that involve the addition, modification, or change in the delivery method of adult or pediatric cardiac surgery require a full review*," 2020 WL 1065940, at *13, and remanded the closure of the cardiac surgery unit to DOH for further review. That review never occurred despite the court order. DOH has not complied with this court order, nor has MSBI restored the service.

109. Petitioners filed an appeal. However, one week later, exactly the type of pandemic that the Court held might require a different outcome struck New York and the rest of the world. On March 12, 2020, New York State shut down due to the COVID pandemic, and nearly 1000 people were dying each day. Beth Israel at the time was warehousing 600 beds. Under public

pressure (including a press conference by Petitioner-Plaintiffs Schwartz and Mintz outside the hospital), and after two weeks during which time 10,000–15,000 people died, MSBI reopened all sections of Beth Israel so that all beds could be used for COVID cases. MSHS was quickly able to convert Beth Israel from a nearly-empty facility to a fully functioning, fully-staffed hospital, with all beds full, within a very short time. The feat is all the more striking given the strain on hospital resources as a result of the Pandemic. Beth Israel operated at full capacity for most of 2020 and 2021. Counsel for MSBI advised the *Progressive Action* petitioners that the closure plan was on an indefinite hold; as a result, the appeal was not pursued.

2021 – MSBI Announces that It Will not Close Due to Community Needs

110. On around June 15, 2021, after continued community pressure to keep MSBI open given the need for more care demonstrated by the COVID pandemic, MSHS announced that it had cancelled its plan to downsize MSBI, citing the need for additional hospital beds.

111. Jeremy Boal, Mount Sinai Health System's chief medical officer and president of Mount Sinai Downtown, stated to the press, and to Beth Israel staff, that the dramatic reduction of beds no longer made sense after grappling to treat a surge of patients during the COVID-19 outbreak over the past year. He stated, in a note to employees, "The pandemic has taught us many lessons. It is with these lessons in mind that we have taken a careful look at our original plan for the new hospital. This analysis has led us to a different conclusion with regard to the best approach to caring for the communities that depend on MSBI [Mount Sinai-Beth Israel]." *See* articles annexed as **Exhibits C1** and **C2.**

112. Boal stated that instead of building a new facility at 13th Street, MSBI would upgrade portions of its existing Beth Israel campus.

2023 – MSHS Proposal to Close NYEE, Gets Conditional Approval

113. In early 2023, MSHS announced that it had submitted a CON to the DOH to close NYEE and merge its services into the Beth Israel campus. According to Mount Sinai, revenue had dropped significantly at NYEE; in fact, it had illegally reduced services without utilizing the CON process and caused many of its most experienced physicians to leave.

114. NYEE offered patients specialty services which included eye, ear, nose, and throat specialty surgery. Their services have been especially important to New Yorkers with hearing loss, who have been treated at NYEE's renowned Ear Infirmary. After 2016 Mount Sinai upped NYEE's inpatient census by performing gender-affirmation surgeries at the facility. They also served as a key resource to those with sight disabilities; the NYEE's own website states "New York Eye and Ear Infirmary of Mount Sinai (NYEE) offers patients the most advanced and comprehensive treatments for all eye conditions. Our highly skilled physicians are experts in managing the full range of eye problems, including cataracts, corneal disease, eye trauma, glaucoma, low vision, uveitis, and retina conditions such as age-related macular degeneration, and many other ophthalmologic disorders. With extensive experience handling the most complex cases, as well as a high volume of common procedures, our teams specialize in cornea and refractive surgery, neuro-ophthalmology, ocular immunology, ocular oncology, oculoplastic and orbital surgery, ophthalmologic pathology, and pediatric ophthalmology."

115. A substantial number of doctors, public officials and community residents opposed the closure of NYEE. In February 2023, the PHHPC held a public meeting, after which the PHHPC voted against approval of the closure. They sent a recommendation to the Health Commissioner to reject the plan.

116. On June 13, 2023, Defendant-Respondent McDonald granted "conditional approval" of the NYEE closure plan despite the vote of the PHHPC. The conditional approval

(**Exhibit D**) required that after an extensive community engagement process, all NYEE programs would be transferred to the Beth Israel facility, and that there be no loss of any beds, without DOH approval. It further required that the transfer occur before June 23, 2024.

117. To date MSHS has not met the requirements of the contingent approval. Nevertheless, upon information and belief, it has adopted a path of terminating the contracts of physicians, cutting staff, and reducing services without any notice to or approval from the DOH. In other words, MSHS has commenced shutting down NYEE without any permission from the DOH. Until late December 2023, DOH took no action to stop the reduction of services or the closures, even though complaints from staff were being made in public.

Services at Mount Sinai Beth Israel On the Date the Plan to Close Was Announced (October 25, 2023)

118. On October 25, 2023, the following services remained available at MSBI:

Coronary Care Beds: 8
Intensive Care Beds: 8
Medical/Surgical Beds: 499
Total beds: 543

- Ambulatory Surgery – Multi Specialty
- Cardiac Catheterization – Adult Diagnostic
- Cardiac Catheterization – Electrophysiology
- Cardiac Catheterization – Percutaneous Coronary Intervention
- Clinic Part Time Services
- Comprehensive Psychiatric Emergency Program
- Dental O/P
- Emergency Department
- Lithotripsy
- Magnetic Resonance Imaging
- Medical Services – Other Medical Specialties
- Medical Services – Primary Care
- Methadone Maintenance O/P
- Radiology Therapeutic
- Renal Dialysis – Acute

Source : *https://www.mountsinai.org/files/MSHealth/Assets/MSBI/MSBI-Closure-Plan-PFI1439-with-Cover-Letter.pdf*

MSHS Announces Total Closure of Beth Israel – Submits Application

119. In June 2023, the State enacted the Health Equity Impact Assessment amendment to the Public Health Law, the relevant portions of which are set forth above in Paragraph 27.

120. In August 2023, subsequent to the Health Assessment amendment, and the regulations put in place by the DOH to implement that statute, the DOH published regulations (see paragraphs 38 and 39, supra) and then Guidelines, set forth above in Paragraph 39 (and **Exhibit F**). These Guidelines addressed the new procedures that hospitals had to follow when they wanted to close a hospital: DOH was not only requiring notice, it was requiring permission to proceed with a partial or full hospital closure, and a set of submissions almost the same as the Health Assessment amendment and the implementing DOH regulations. Furthermore, hospitals were directed not to reduce services while the Closure Plan was being considered unless they engaged in the CON process.

121. MSHS and MSBI, despite the fact that they were preparing to close MSBI, did not file suit pursuant to CPLR Article 78 to declare that the DOH did not have the authority to issue mandatory guidelines, which were regulatory in nature. Having not done that, Defendant-Respondents waived the right to challenge the binding nature of the August 2023 Guideline.

122. Despite those Guidelines, which require a thorough and rigorous assessment of a proposed closure, including public meetings and public comment **in advance** of an application, on around September 13, 2023, MSHS, eschewing its 2021 statements expressing the dire need for beds in Lower Manhattan, announced that it was closing Beth Israel. There were no public meetings, no CON, and no Health Equity Assessment. According to press reports "The spokesperson clarified that the closure of the 696-bed teaching hospital would be gradual, and that they would work hand-in-glove with regulators in the process. Mount Sinai said it will "remain

open with a smaller bed count" and "continue to evaluate various options for a smaller hospital nearby." See **Exhibit F**.

123. MSHS's principal argument for closing Beth Israel was and still is that it is suffering financial losses. But the publicly available statistics for 2023, published in the American Hospital Directory, show enormous revenues for Mount Sinai's operations in Manhattan, and "losses" in every one of those facilities. Revenue is demonstrated by this chart:

Mount Sinai Upper East Side	$12,046,488,070
Mt Sinai Roosevelt & St Lukes	$ 5,544,120,782
Mt. Sinai Beth Israel	$ 3,943,522,673
NY Eye and Ear	$ 431,288,946

That is over $23 billion in revenue just in Manhattan. According to statistics published by the American Hospital Directory, Beth Israel lost $172 million in 2023. But the MSHS main campus on the Upper East Side lost $195,716,997 in 2023, Mt. Sinai Roosevelt/St. Lukes lost $122,118,882 in 2023, and NYEE lost $24,795,998 in 2023. So why choose Beth Israel and blame the closure on losses? Because the real estate on the south end of the Gramercy Park-Stuyvesant Park area is very, very valuable. The decision, contrary to the hospital's mission, and the reason it has a license, has nothing to do with health care.

124. On October 25, 2023, MSHS, still having not held a public meeting, and without having performed even a rudimentary assessment of the impact of a closure, or the ability of the two nearby hospitals to absorb the patients it was presently serving, submitted a closure plan for Beth Israel Hospital to the DOH. A copy is annexed as **Exhibit G**. There was no indication that the assessment was prepared by a third party with no conflict of interest.

125. Subsequent to the submission, on or about November 21, 2023, MSBI announced that it would be holding a Public Forum on November 28, 2023, at Baruch College, at 25th Street

and Lexington Avenue, about one mile from Beth Israel, and far from the population centers serviced by the hospital. No notices were posted in the hospital. *See* **Exhibit H.**

126. On November 22, 2023 Susan Steinberg, the President of the Stuyvesant Town Peter Cooper Village Tenants Association, which represents over 30,000 residents of Stuyvesant Town and Peter Cooper Village, which face Beth Israel across First Avenue, asked that MSBI move the meeting to a more accessible location, within the area below East 20th Street, where 42% of MSBI discharges live. MSBI ignored her letter, annexed as **Exhibit I**.

127. On November 17, 2023, MSBI submitted an Addendum to their Closure Plan to the DOH. *See* **Exhibit J.** Instead of a closure timed to occur in summer 2024, this Addendum described a closure beginning in January 2024 and completed, for the most part, by the end of March 2024.

128. Within days, and prior to the Public Meeting, staff at Beth Israel leaked an internal memo, **Exhibit K**, which set forth a definitive schedule, beginning in December 2023, for a closure which would proceed, one service at a time, though the end of March 2024, when very little would be left. This included elimination of 'elective" cardiac catheterization in December 2023, interventional radiology in January 2024, General Surgery in February 2024, and the Intensive Care Unit in March 2024. Even before the public meeting, much less any approval of the closure plan, staff were informed that they should begin looking for jobs elsewhere in the Mount Sinai system and were given dates for departure. This plan was in direct violation of the DOH Guidelines (**Exhibit E**), which state: "**no actions related to the proposed closure, such as discontinuing a service, may be taken prior to receiving approval of the closure plan." This Plan also spurred a mass exodus of professionals from the hospital.**

129. At the November 28, 2023 Public Forum, MSBI President and COO Elizabeth Sellman, when confronted about this violation of the Guidelines, first by staff who discussed closures already taking place, and reductions which has already occurred, and then by Petitioner-Plaintiff Schwartz, who read the language highlighted in Paragraph 125 to Sellman, stated: “There is nothing we can do. We just don’t have the personnel to operate safely.” In fact, MSBI was itself creating those unsafe conditions, by shifting unionized employees to other locations and forcing doctors (who do not have a union) to find new hospitals to work in given the upcoming termination of services at Beth Israel. In short, MSBI has been intentionally creating ongoing, dangerous conditions at its hospital in an effort to bolster its ability to sell off the hospital’s real estate portfolio. The court must order MSBI to restore services to safe and legally required levels.

130. Although DOH, as required by law, was present at the forum, and heard specific allegations about closures occurring, it took no immediate action.

131. On December 18, 2023, the NYC Fire Department issued a bulletin which stated: “Effective **Sunday, December 31, 2023**, Mount Sinai Beth Israel Hospital (H03), located in the borough of Manhattan, will be on **Permanent Diversion** for the CCC code, **LVO**.” (Emphasis in the original.) *See* **Exhibit L.** This meant that no more stroke patients would be transported to the Beth Israel Emergency Room. The FDNY notice was publicized in the news media. MSBI had not received permission from DOH to close, or de-staff, its Emergency Room, and affiliated services; but clearly it had.

132. With this public announcement by FDNY, the DOH, on December 21, 2023, issued a Cease and Desist Order (annexed as **Exhibit M**) to Mount Sinai, which stated in relevant part:

> “No closure of beds or services can be implemented without approval from the Department of Health under 10 NYCRR § 401.3(g), as specified in the Division of Hospitals and Diagnostic & Treatment Centers’ DAL#: 23-06. In addition, to the extent Mount Sinai Beth

> Israel is decertifying beds or licensed services prior to its full closure, a certificate of need (CON) application is required pursuant to 10 NYCRR § 710.1(c)(1).
>
> Please provide a written response confirming that no changes in operation will occur and that Mount Sinai Beth Israel will desist from any closure of beds or services until approval has been received from the Department."

What the Department did not do, however, was order the restoration of all services which had been ended or curtailed since the Summer of 2023. And, in fact, DOH waited another three months to say anything about the continued closures and reductions in services, even as they were being made known by Plaintiffs in this lawsuit.

Mount Sinai's Initial Closure Plan Was Inadequate and Unlawful

133. MSHS/MSBI's October 25 Closure Plan (**Exhibits G and J**) failed to conform to the DOH's requirements imposed, and not challenged, after passage of the Health Equity Assessment Law, and its attendant regulations, reflected in DOH's August 2023 Facility Closure Plan Guidelines. *See* **Exhibit E.**

134. Specifically, the closure plan ran afoul of the substantial requirements under item 15 (*see* infra, Paragraph 39) to "[i]dentify and confirm availability of services at other *area facilities* including obtaining information to *ensure that the provider can accept new patients*." (emphasis added).

135. There is no factual dispute that there are three "area facilities," that would be most convenient for patients in lower Manhattan to reach if MSBI closes: Bellevue Hospital Center located .6 miles north of MSBI; NYU Tisch-Langone located .8 miles north of MSBI; and New York Presbyterian/Lower Manhattan Hospital located 2.3 miles south of MSBI. MSHS lists these same hospitals as the top three facilities located closest to MSBI. *See* **Exhibit G** at 10-11. Of these

hospitals, upon information and belief, only Bellevue and MSBI accept Medicaid and exchange-purchased insurance for most services.

136. Studies have demonstrated that proximity to a hospital is directly correlated with mortality from emergent conditions such as heart attacks. Thomas C. Buchmueller, *How Far to the Hospital? The Effect of Hospital Closures on Access to Care*, J. Health Econ. 25, 740-761 (2006). *See* **Exhibit V**.

137. In its initial Closure Plan, the hospital stated that those three facilities "**will** be contacted by MSHS to determine if they have capacity to accept new patients." *See* **Exhibit G** at 13. This means that before submitting its application, MSHS had not contacted the other three hospitals, and had flatly neglected to provide *any* material information about whether the three remaining area hospitals serving downtown Manhattan have the capacity to accept MSBI patients. This omission alone should have resulted in an immediate rejection of the Closure Plan for falling far short of the DOH's requirement that MSHS "ensure" such facilities can adapt to an influx of new patients.

138. Upon information and belief, to this date, MSHS has consulted only with Bellevue Hospital to gauge their ability to absorb additional patients or plan a procedure for closure to mitigate the impact to those hospitals, and finding Bellevue already overwhelmed, it has offered to donate $20 million to an expanded Emergency Room, which could take years to build, and will have to squeeze more patients into a hospital with insufficient capacity.

139. In late January 2024, after and in violation of the DOH Cease and Desist Order, MSBI began diverting ambulances to NYU and Bellevue without consulting NYU, Bellevue, or the DOH. Upon information and belief, NYU and Bellevue were unable to absorb the new patients and complained to the DOH about MSBI's illegal and dangerous conduct. Upon information and

belief, for a period in late January 2024, DOH had officials present at MSBI to prevent MSBI from engaging in such illegal and dangerous conduct and overburdening nearby emergency rooms. But as soon as DOH left, almost all ambulance service to MSBI stopped.

140. Public data demonstrates that the three area hospitals, in fact, do not have sufficient capacity to provide healthcare services to the roughly 400,000 people MSBI currently serves.

141. The Federal Centers for Medicare and Medicaid Services ("CMS"), which records provider-level data reflecting quality of hospital care, reports that MSBI,[28] Bellevue[29] and NYU Tisch-Langone[30] receive "very high" emergency department patient volume (meaning they receive more than 60,000 patients a year). This designation represents the highest emergency department volume that the agency records. The agency further reports that patients wait well over three hours in each hospital's emergency department before leaving the facility. While CMS does not collect data on New York Presbyterian/Lower Manhattan, it is inconceivable that a 170-bed facility could shoulder the burden of servicing patients displaced by MSBI's closure.

142. Further, Lower Manhattan currently has 5 hospital beds for every 1,000 residents *including* MSBI, already the lowest bed-to-resident ratio in Manhattan. The Upper East Side has double the capacity, boasting 10 beds for every 1,000 residents, and Upper Manhattan maintains

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[28] Medicare.gov, *Find & Compare Providers Near You* (search by "Hospital" then insert hospital name "Mount Sinai Beth Israel" then select "Timely & effective care"), https://www.medicare.gov/care-compare/details/hospital/330169?city=New%20York&state=NY&zipcode=10003&measure=hospital-timely-and-effective-care.

[29] Medicare.gov, *Find & Compare Providers Near You* (search by "Hospital" then insert hospital name "Bellevue Hospital Center" then select "Timely & effective care"), https://www.medicare.gov/care-compare/details/hospital/330204?id=c8365c2e-6339-4d29-bafb-8ceca8539d61&city=New%20York&state=NY&zipcode=10003&measure=hospital-timely-and-effective-care#ProviderdetailsQualityIndicatorsContainer.

[30] Medicare.gov, *Find & Compare Providers Near You* (search by "Hospital" then insert hospital name "NYU Langone Hospitals" then select "Timely & effective care"), https://www.medicare.gov/care-compare/details/hospital/330214?id=3523a5ad-4232-44c5-8c33-f856789dbc66&city=New%20York&state=NY&zipcode=10003&measure=hospital-timely-and-effective-care#ProviderdetailsQualityIndicatorsContainer.

6 beds for every 1,000 residents. MSHS's Beth Israel Closure plan, and the amended plan, which we discuss below, wholly fails to account for how the remaining downtown hospitals, with already strained bed capacity, "can accept [any] new patients," much less carry the burden of the entire population Beth Israel serves.

143. Public data reveals much about the area being served by the existing Beth Israel Hospital and NYEE. **Exhibit N**, a survey of Individual Hospital Statistics for New York at the end of 2023, shows the following:

Hospital	Staffed Beds	Total Discharges	Patient Days	Revenue
MSBI	495	20,028	123,619	$3,845,637,000
Tisch-NYU	1728	70,850	457,041	$37,285,025,000
Bellevue	912	22,389	141,864	$2,927,119,000
NYP Dntn	132	8,655	45,964	$272,967,000
NYEE	15	342	812	$418,292,000

144. The American Hospital Directory also published greater detail about all of MSBI's operations (including its small Brooklyn affiliate) in 2023 by Medicare recipients. See **Exhibit O**. The full range of Clinical Services offered, which MSHS is looking to obliterate, is shown on pages 3 and 4. Most importantly, the data presented includes utilization statistics by Medical Service. Despite the elimination of Cardiac Surgery, and the deliberate downsizing of the Cath Lab, Beth Israel had 859 Medicare cardiology inpatients and 178 requiring Cardiovascular Surgery. In total, 5,578 of its 20,028 discharges were patients with Medicare insurance.

145. **Exhibit O** shows inpatient origin by Zip Code. In 2023, 45.6% of the population requiring inpatient treatment in Zip Code 10009 (the hospital's home Zip Code) used Beth Israel. For Zip Code 10002, just to the South, 23% of those requiring inpatient treatment used Beth Israel.

146. **Exhibit P** is the Census Data for Zip Code 10009. That data shows that despite the relatively high income in part of the area, 22.6% of the population lives below the Poverty Line, which translates to a high percentage of the population relying on Medicaid. Many of these

residents live in various NYC Housing Authority Projects below 14th Street, to the east of Avenue D. Beth Israel Hospital is the closest hospital for these NYCHA residents.

147. **Exhibit Q** is the Census Data for Zip Code 10002, which starts below Houston Street and includes much of Chinatown. That data shows a markedly lower average income than in 10009, with 26.1% of the residents living below the Poverty Line. Only 26% of this community is White; 37% is Asian, and 26% is Hispanic. This area also has a large NYC Housing Authority project, and a large percentage of Section 8 Housing. Beth Israel is the closest Hospital to all of the NYCHA residents. Again, with 26.1% of the population living below the Poverty Line, there is a higher percentage of residents using Medicaid than in most of Manhattan.

148. A study done by Madison Healthcare Advisors in 2023 is also illustrative. It contains data for calendar year 2022. **Exhibit R** shows “Hospital Beds By Area” and correlates it with population. Greenwich Village and Soho have zero (0) hospital beds for a population of 84,271. The Lower East Side, with a population of 164,160, shows 1 hospital sited in the area (NYEE) and 69 hospital beds. Stuyvesant Town and Turtle Bay, with a population of 132,940, shows 2,421 beds at Beth Israel, NYU Tisch-Langone and Bellevue. Clearly the Lower East Side, Greenwich Village and Soho are hospital bed deserts. The closest hospital (other than NYEE) is Beth Israel.

149. The Closure Plan submitted by Mount Sinai to DOH is a rather cursory document (as is its Amended Plan). All but 16 pages are either notices to elected officials or Census Data from every Zip Code in New York where 28 or more patients were admitted to Beth Israel. There is no indication that the “Assessment” was done by a third party. On page 8 it states that 83% of its patients were covered with Medicare or Medicaid. It tells us that 50,256 patients used the hospital’s services in 2022, (Page 8), and that there were 70,252 Emergency Department (ED)

visits in 2022 (Page 9). It tells us that 23% of the ED visits were "life-threatening." (Page 9). **That is over 16,700 people whose life-threatening problems will be forced to crowd into other facilities**. It talks about the other hospitals in the nearby area, Bellevue (1 mile away), NYU Langone (Tisch) (1.3 miles away), and NY Presbyterian Downtown (2.3 miles away) and simply lists the services they provide (See Pages 10 and 11). It also lists the other MSHS affiliates (from 5 to 12 miles away) and then blithely states: "All of these hospitals accept Medicaid. In addition, all of the facilities are accessible by public transportation." While it is true that all of the hospitals accept Medicaid for at least some services, the sentence is deceptive, as upon information and belief only Bellevue, like Beth Israel, accepts Medicaid for most services. The report then has this passage in an attempt to assure the reader:

> The Mount Sinai Health System facilities listed above have the capacity to accept patients. Bellevue Hospital Center, NYU Langone, and NYP Lower Manhattan **will be contacted** by Mount Sinai to determine if they have the capacity to accept new patients." (*See* Page 13, emphasis added.)

That is the sum total of the analysis.

150. Of importance is the statistical data for Zip Codes 10009 and 10002 attached to the Assessment. The data shows that in Zip Code 10002, 12.4% of the population is categorized as "disabled." For Zip Code 10009 the number is 13.1%. For Zip Code 10002 28.9% of the population is over 65. For Zip Code 10009 that percentage is 20.7%.

151. If both the original and amended closure plans and health equity impact assessment are measured against the statute, DOH Regulations, and DOH Guidelines, they are clearly deficient, so much so that granting permission to close violates Sections 2800 and 2802-b of the Public Health Law, made applicable to the Beth Israel closure by DOH's August 25, 2023 Guideline.

a. The regulations at Section 400.26(a) require that the Assessment "shall include a health equity impact assessment. The purpose of the health equity impact assessment is to demonstrate how a proposed project affects the accessibility and delivery of health care services to enhance health equity and contributes to mitigating health disparities in the facility's service area, specifically for medically underserved groups." The MSHS Application does not do that.

b. The regulations at 400.26 (d), as per Public Health Law Section 2802-b(4), require that "[a]health equity impact assessment shall be performed by an independent entity without a conflict of interest." 400.26(b) defines "independent entity" and "conflict of interest," in case the plain meaning is unclear. MSHS did not do this.

c. Section 2802-b(3)(b) of the Public Health Law requires that the Assessment demonstrate "*[t]he extent to which medically underserved groups in the applicant's service area use the applicant's hospital or health related services or similar services at the time of the application and the extent to which they are expected to if the project is implemented*." There is discussion of the extent of use of Mt. Sinai facilities by medically underserved groups, except a statement that "public transportation is available."

d. Section 2802-b(3)(d) of the Public Health Law requires a discussion of *"[h]ow and to what extent the applicant will provide hospital and health-related services to the medically indigent, Medicare recipients, Medicaid recipients and members of medically underserved groups if the project is implemented."* There is no discussion of this question, even though the hospital's own statistics show that more than 50% of its users utilize Medicaid and Medicare to pay for health services.

e. Section 2802-b(3)(i) of the Public Health Law requires that an applicant present "*A review of how the applicant will maintain or improve the quality of hospital and health-related services including a review of: i) demographics of the applicant's service area; ii)economic status of the population of the applicant's service area; iii) physician and professional staffing issues related to the project; iv) availability of similar services at other institutions in or near the applicant's service area.*" There is no discussion about how Mount Sinai's proposal will maintain or improve the quality of hospital and health-related services because the closure of Beth Israel Hospital **will not do that.**

f. The DOH Guidelines issued in August 2023 require that the Assessment "***Identify and confirm availability of services at other area facilities including obtaining information to ensure that the provider can accept new patients, identifying where Medicaid patients can obtain care if the closing provider provides services to Medicaid patients; providing information about other facilities to patients and families, ensuring language access (i.e. that information about the closure and continuing care with another provider is communicated in the patient's preferred language) and that the wishes of current patients/families are respected; and ensuring that concerns such as geographic location, public transportation, type of facility/ provider, medical care, etc., are addressed in identifying future placement options and ensuring continuity of care for patients. Please note, as always, it is the responsibility of hospitals to ensure that individual patients are offered choices and that the patients accept the transfer prior to any movement taking place***." The October 2023 Closure Plan submitted by MSHS utterly fails to present a discussion of this key requirement. The Application was no more than an exercise in filling in the blanks.

g. Section 400.26(d) requires that the application demonstrate "meaningful engagement of stakeholders commensurate to the size, scope and complexity of the facility's proposed project and conducted throughout the process of developing the health equity impact assessment, to incorporate and reflect community voices." MSHS engaged in no "meaningful engagement with stakeholders" prior to its application; and its sole meeting, a mile from its campus, with little publicity, which it has not reported to the DOH about, does not come close to meeting the "meaningful engagement" requirement with stakeholders. (In its Amended Closure Plan MSBI argues that it did; see discussion below). Section 400.26(b) defines "meaningful engagement" as "providing advance notice to stakeholders and an opportunity for stakeholders to provide feedback concerning the facility's proposed project, including phone calls, community forums, surveys, and written statements. Meaningful engagement must be reasonable and culturally competent based on the type of stakeholder being engaged." MSHS and MSBI have not done that.

h. Section 400.26(b) requires that the Assessment include "a documented summary of statements received from stakeholders through meaningful engagement." There is no summary of statements included in the October 2023 Closure Plan (or in the Amended Plan).

152. The DOH Regulations make it clear that the Legislative purpose for enacting the Health Care Equity Assessment was not just to force hospitals to fill in another form. The Regulations describe the Legislative Intent as follows:

> "[T]o ensure the establishment, ownership, construction, renovation, and change in service of health care facilities defined in Article 28 into their decision making and planning processes to promote the maximum utilization of resources and ensure that medically underserved groups are not negatively impacted by proposed establishment, ownership, construction, renovation, and/or change in service applications. Requiring a demonstration of meaningful engagement with stakeholders will ensure that the people whom the health care facilities serve have a

> voice in proposed projects. This assessment is critical for Article 28 facilities to consider when making changes to their services, facilities and ownership. The regulations ensure that a facility reviews the findings of the health equity impact assessment and develops a narrative statement for how it will mitigate potential for exacerbating health inequities in underserved communities."

See Paragraph 38 above.

153. The goal of the law, the regulation, and the Guideline is to ensure that "medically underserved groups are not negatively impacted," and that health inequities for underserved communities are mitigated. As a matter of fact, and law, there is no way for the closure of Beth Israel to mitigate the health inequities in the areas it principally serves, Zip Codes 10002 and 10009. In those areas, more than 20% of the population lives below the poverty line, a majority of residents are Black, Hispanic, or Asian, and nearly 15% are people with disabilities. In fact, MSHS's closure of MSBI and attempted diversion of Lower East Side residents to distant hospitals will have an unjustified negative disparate impact on those protected groups in violation of the New York State and New York City Human Rights Laws. There is no way to mitigate the loss of a hospital for that population, which is why MSHS does not even try to demonstrate that Bellevue and NYU-Tisch-Langone, much less the tiny NY Presbyterian Downtown, can absorb any of the services offered at Beth Israel, from the 70,000 person-per-year ER visits to the thousands of surgeries performed, to the lifesaving services performed by its cardiac catheterization unit.

154. The closure, as a matter of law and equity, is unlawful.

<u>MSHS Implements Service Reduction, Elimination and Relocation Without DOH Approval and in Defiance of the Cease and Desist Order.</u>

155. Before DOH rendered a decision either approving or denying the closure application, MSHS unilaterally embarked on a campaign to reduce, shift, or eliminate services absent requisite approval from the DOH and in patent abrogation of state rules and regulations.

156. As of December 31, 2023, MSBI no longer receives emergency stroke patients.[31]

157. MSBI has also reduced nursing staff across multiple departments, has scheduled nurses, Physicians Assistants and other professionals, technicians, and other staff to leave Beth Israel as early as February 1, 2024, despite the Cease and Desist Order, has issued termination letters to attending physicians and surgeons, and has used the subterfuge of "not renewing licenses which have expired" as the basis for such terminations. *See* **Exhibit J**.

158. On information and belief, MSHS has put significant pressure on all employees at MSBI to move to alternative MSHS facilities, including having them attend internal job fairs and making it clear their positions at MSBI will be terminated if they do not relocate. Those employees are terrified to speak out even as they produce elaborate descriptions of the deliberate, unlawful downsizing. See, for example, the letter/email from Concerned Employees of Beth Israel annexed as **Exhibit S.** As a result, MSHS has further reduced staffing at MSBI without filing a CON.

159. Beth Israel has further reduced funding to its Family Medicine Residency Program, which stands separate from the Hospital (see **Exhibit T**), depriving its 16th Street facility of residents who can provide family medicine, "exacerbating existing patient access challenges, primary care physician shortages, and [lead to] negative health impacts for the New York City community served by this vital program."[32]

160. MSBI has reduced language services without a CON. Upon information and belief, when MSHS purchased Beth Israel, there was an Asian Services Unit staffed by physicians who

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[31] *See* Carl Campanile and Craig McCarthy, *FDNY EMS no longer sending stroke patients to Beth Israel in phase-out,* New York Post (December 19, 2023), https://nypost.com/2023/12/19/metro/fdny-ems-no-longer-sending-stroke-patients-to-beth-israel-in-phase-out/?fbclid=IwAR0BathgsUj2VXqRqoM9kpTxu2JaAsc2xb1M347-TxPnNAi27iqVu6J2LP8, and see **Exhibit L**.

[32] New York State Academy of Family Physicians (@NYSAFP), Twitter (Dec. 15, 2023, 1:27 PM), https://twitter.com/NYSAFP/status/1735728408632426836. And see **Exhibit T**,

spoke Mandarin, Cantonese, and other Chinese dialects. After MSHS's purchase, Beth Israel turned the service into a "non-geographic" group of doctors performing the same services throughout the hospital. MSHS then used this shift to non-geographic services to disguise a service cut, when, after 2020, all of these physicians left Beth Israel and were not replaced. Similarly, numerous Spanish-speaking physicians, many of whom had decades-long relationships with patients in the neighborhood, have left Beth Israel without being replaced, resulting in a dramatic effective service reduction for Spanish-speaking patients, without a CON being filed.

161. On or about December 2023, MSBI internally charted a six-month timeline tracking which departments and services it planned to eliminate from its 16th Street location, as noted below. See **Exhibits J and K.**

a. In December 2023, MSBI planned to relocate its elective cardiac catheterization procedures to Mount Sinai Morningside and to The Mount Sinai Hospital and will close "10 Silver," a 30-bed medical surgical unit.

b. In January 2024, MSBI planned to "transition" large vessel occlusion stroke services or "LVO" services to an unspecified location; will shift interventional radiology to Mount Sinai West, and will close "7 Silver," a 31-bed medical surgical unit.

c. In February 2024, MSBI planned to relocate endoscopy and urology services to Mount Sinai West, will relocate vascular surgery to Mount Sinai Morningside and will terminate its electroconvulsive therapy service.

d. In March 2024, MSBI planned to "discontinue" "STEMI" services, which refers to ST-elevation myocardial infarction, a particularly severe type of heart attack with elevated risk of death. MSBI will also "discontinue" primary stroke services and close its intensive care unit.

See **Exhibit J**.

162. MSBI failed to file any CONs about any of these planned changes (other than its wholly deficient Closure Plan and its Addendum) in order to receive approval from the DOH for these profound alterations to the hospital's operation.[33]

163. Despite the Cease and Desist Order, and several Temporary Restraining Orders barring further reductions in service, and best efforts to restore service, and proceeding with an inadequate Closure Plan which did not even attempt to meet DOH regulations, MSHS and MSBI have continued planned closures and staffing reductions at Beth Israel. Among other actions, it began diverting ambulances bringing patients to its Emergency Room to Bellevue Hospital and NYU Tisch Langone, and now gets a very small number every day, has cut half of the staffing in the Intensive Care Unit, and has shipped vital supplies out of that ICU. It is also acting, intentionally, in a manner which has caused large numbers of nurses and doctors to quit, and not replace them, undercutting its ability to continue services.

164. MSBI pursued these unapproved service alterations and reductions in plain sight, clearly believing that the DOH would approve its unlawful Plan, or believing that it is too powerful to be tethered by State Law and Regulations. Such brazen conduct undermined the letter and spirit of the law and plainly jeopardizes the health of 400,000 New Yorkers. DOH's failure to insist on adherence to the law in a meaningful way and approval of the Amended Closure Plan, has only exacerbated the situation.

165. With respect to the CATH Lab, which deals with patients needing stents during heart attacks, or to prevent imminent heart attacks, Mount Sinai sent notice to the FDNY in early December (see Affidavit of Cath Lab nurse M.C., submitted herewith), stating that on March 10,

[33] *See* New York State Department of Health, *Certificate of Need (CON) Search Application*, (search by "Mount Sinai Beth Israel" as "facility name"), https://apps.health.ny.gov/facilities/cons/nysecon/projectSearch.

2024 it would stop its services in STEMI cases. After the Cease and Desist Order Mount Sinai did not advise the FDNY otherwise. During the first week of January, 2024, Mount Sinai cut its staff in the CATH Lab, and advised staff that only patients who were in-patient or who were brought to Beth Israel by ambulance would be treated. There were to be no more “outpatient procedures,” procedures scheduled a week or two in advance for patients with less emergency needs. This was a violation of the Cease and Desist Order, as was the failure to withdraw the Notice to FDNY.

166. On February 7, 2024 Plaintiff/Petitioners filed this lawsuit to both stop the plan and address the continuing reduction in services.

167. On or about February 14, 2024 Supreme Court, New York County entered a Temporary Restraining Order staying the implementation of closure of beds or services, offered at Mount Sinai Beth Israel Hospital or New York Eye and Ear Infirmary of Mount Sinai, without approval from the Court and the Department of Health under 10 NYCRR §401.3(g), as specified in the Division of Hospitals and Diagnostic & Treatment centers’ DAL#:23-06.

168. Despite this Order and without any application to the Court, Mount Sinai did not withdraw its notice about STEMI cases that had been sent to the FDNY. They did this even though there had been no reduction in staff through March 10, 2024—2 on-call nurses and 4 technicians were available as were the needed physicians. On March 5, 2024, the FDNY notified its ambulances not to bring STEMI patients to Beth Israel anymore.

169. On or about March 14, 2024 the US Department of Health and Human Services issued a report, the cover letter of which (**Exhibit Y**) commenced as follows:

> On January 31, 2024, the New York State Department of Health, Hospitals and Diagnostic & Treatment Centers Program (State survey agency) completed a survey at Mount Sinai Beth Israel to investigate an allegation of noncompliance with the requirements of 42 CFR §489.20 and 42 CFR §489.24. After a careful review of the findings, we have determined that your hospital violated the requirements of §489.20,

> which are as follows and detailed on the enclosed form CMS-2567, Statement of Deficiencies: 42 CFR §489.20(l) Compliance with 489.24 42 CFR §489.24(e) Appropriate Transfer These deficiencies have been determined to be of such character as to substantially limit the hospital's capacity to furnish adequate care and/or as to adversely affect the health and safety of patients. The finding that Mount Sinai Beth Israel is not in compliance with the above EMTALA requirements does not affect the hospital's accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. However, under 42 CFR §489.53, a hospital that violates the provisions of 42 CFR §489.24 is subject to termination of its provider agreement. You are advised that failure to achieve compliance with the EMTALA requirements, in accordance with the time frames set forth in an acceptable plan of correction (PoC), may result in the initiation of action to terminate Mount Sinai Beth Israel from the Medicare program on or around June 12, 2024. This preliminary determination letter serves to notify you of the violation. A final notice will be sent to you concurrently with notice to the public in accordance with regulations at 42 CFR 489.53 on or around May 28, 2024, should the hospital fail to regain substantial compliance with these requirements.

170. That letter has appended to it a full report (Exhibit Y). That Report, after discussing the appropriate standard of care asserted that

> This STANDARD is not met as evidenced by: Based on medical record (MR) review, document review, and interview, in six (6) of six (6) medical records MRs reviewed, the hospital failed to ensure that The "Physician Certification Consent To Transfer" form, documented the benefits and/or risks associated with the patient's transfer and were specific to the patient's medical condition.

The Report then discussed six cases where improper, and life-risking transfers took place.

171. Mount Sinai and its Beth Israel affiliate had made it clear in their November 5, 2023 Addendum that they intended to largely close Beth Israel by March 31, 2024, and discouraged any hope among staff that this would not occur. As a result, there was a massive resignation of physicians effective March 31, 2024, which Mount Sinai and MSBI did not seek to head off. In fact, they relied on those resignations as the reason why they had to close services.

172. On March 21, 2024, the Respondent/ Defendant DOH issued a Statement of Deficiencies addressed to MSBI President Elisabeth Sellman. The Cover Letter and the list of

specific service closures, which required a response and a plan for corrective action within 10 days, is annexed as **Exhibit Z**. The Statement listed every service closure which had unlawfully happened at Beth Israel since the beginning of November 2023. Among them were the following:

> During a tour of 5 Dazian Unit on 1/25/24 at approximately 11:40AM, it was identified that the number of registered nurses assigned to the unit was not in accordance with the unit Clinical Staffing Plan. The Staffing Plan states: 11-15 patients with 3 RNs 16-20 patients with 4 RNs 21-24 patients with 5 RNs There were 3 RNs on the unit with a patient census of 22.
>
> Based on observation, document review, medical record review and interview, the facility failed to comply with: 4 NYCRR, Title 10, Part 401: Section 401.3 Changes in existing medical facilities. (a) Proposed changes in physical plant, bed capacity and the extent and kind of services provided shall be submitted to the department in writing, pursuant to the provisions of section 710.1(b) of this Title. Such changes shall not be made until receipt of the appropriate department approval as set forth in section 710.1(b) of this title. The commissioner may grant administrative approval to such proposed changes in accordance with the provisions and criteria set forth in section 710.1(c) of this Title. Specifically, the facility failed to, (a) ensure there were no changes in bed capacity and services without the Department of Health (DOH) written approval of the facility's closure plan, dated 10/25/2023, (b) compliance with the New York State Department of Health (NYSDOH) CEASE and DESIST order, dated 12/21/23, and (c) ensure appropriate resources for delivery of patient care were maintained. This failure places all patients at risk for delay in treatment and services.
>
> Findings: A. During a tour of the facility on 1/25/2024, the following changes in bed capacity and services were identified: -Intensive Care- On 11/2023 the ICU beds were decreased to a 16-bed unit. -Medical/Surgical - On 11/11/2023, 8 Silver, a 32-bed medical telemetry unit was closed. On 12/3/2023, 10 Silver, a 30-bed medical surgical unit, was closed. Currently the hospital has a capacity of 88 medical surgical beds. The Mount Sinai Beth Israel Operating Certificate dated 11/14/2023, states: Certified Beds Total: 543 Intensive Care: 36 Medical/Surgical: 499 -Cardiac Catheterization - Percutaneous Coronary Intervention (PCI)- As of 12/15/2023 only emergent procedures will be performed. No elective procedures will be performed. - Cardiac Catheterization -Adult Diagnostic - As of 12/15/2023 only emergent procedures will be performed. No elective procedures will be performed. - Cardiac Catheterization - Electrophysiology (EP) - As of 12/15/2023 only emergent procedures will be performed. No elective procedures will be performed Per interview with Staff Q ( ) on 1/25/2024 at 3:45 P.M, Staff Q stated cardiac catheterizations are currently at 1-4 cases per day; prior there were as many as 15-20 per day. Staffing is currently for emergencies.

Electrophysiology, they're only doing implantable cardioverter defibrillator (ICD) placements (a small battery-powered device placed in the chest. It detects and stops irregular heartbeats, also called arrhythmias). This procedure is done only in house with urgent pacemakers. Staff Q also stated, that 12/18/2023 was the last time they had ambulatory surgeries. They're only doing inpatients.
During interview on 1/31/2024 at 10:05AM, Staff MM, stated: prior to November 2023 they had two ICU units, with a total 24 beds. In November of 2023, they could not staff 24 beds and the census was not there. Currently, the ICU is a 16-bed unit. Staff MM, also stated, the Operating Certificate documents 499 medical/surgical beds. They have not had that census in years. On 11/11/2023, 8 Silver, a 32-bed medical telemetry unit was closed. On 12/3/2023, 10 Silver, a 30-bed medical surgical unit, was closed. The beds were closed due to a decrease in staff and census. Staff MM confirmed the hospital medical surgical bed capacity of 88. B. Review of the letter from the NYSDOH to Mount Sinai Beth Israel, dated 12/21/2023, stated the following: "Mount Sinai Beth Israel is hereby directed to CEASE and DESIST from closing beds and services without approval of the Department of Health ("Department"). Continuing to close beds or services without approval is unlawful and may result in civil penalties ...No closure of beds or services can be implemented without approval from the Department of Health ...**In addition, to extent Mount Sinai Beth Israel is decertifying beds or licensed services prior to its full closure, a certificate of need (CON) application is required ..."**
During a tour of the facility on 1/25/2024, the following changes in services were identified: -Thrombectomy Capable Stroke Center - After 12/31/2023 the Emergency Department (ED) no longer accepts categories 4 and 5 stroke patients.

-Radiology-Diagnostic - After 12/31/23 the MRI on call service 12:00AM - 8:00AM, seven (7) days a week was cancelled. CAT scans will be performed in the ED for inpatients and ED patients. Outpatient CAT scans will no longer be performed. -Clinical Laboratory Services - As of 1/24/2024, thyroid panel tests will be sent to Mount Sinai Hospital. -Ambulatory Surgery-Multi Specialty- As of 1/26/2024, outpatient elective surgeries were stopped. Only emergent surgeries would be performed. Continuing with electroconvulsive therapy (ECT). During interview on 1/26/2024 at 1:20PM, Staff R, verified that elective surgeries at the MSBI facility were ending today, 1/26/2024. (Perioperative services are provided through Ambulatory Surgery/Multi Specialty). The plan is that on Monday 29th, we'll have one (1) Operating Room (OR) available with capacity for three (3), with on call coverage, remaining the same. During a tour the facility's Radiology Department, on 1/25/2024 at 12:00 PM, the procedure rooms and patient waiting areas were empty. There were no patients or staff. Staff A, , confirmed the Radiology Department changes occurred after the hospital received the "Cease and Desist Order" letter from the DOH. C. Review of

the facility "Safety Net Incident SEA/RCA/Safety Solution," dated 1/13/2024, stated the following "received as notification for stroke code. EMS was directed to bring patient here even though we are no longer receiving Large Vessel Occlusion (LVO), stroke level 4 and 5. Also, there was a delay in the stroke team responding. First activation of Stroke code at 8:14 AM, but no one from stroke team came. Activated stroke team again at 8:23 AM, stroke attending came. Patient to be transferred to MSW." (Patient #44) During interview with Staff L, , on 1/25/2024 at 12:00PM, Staff L stated, after 12/31/2023, the MRI on-call service 12:00AM - 8:00 AM, seven (7) days a week has been cancelled. The surveyor asked Staff L how this would impact patient care. Staff L stated not having MRI on call affects patients in critical condition that would require an emergent MRI. The surveyor asked Staff L to explain patients in critical condition that require an emergent MRI. Staff L stated patients with a spinal abscess, cord compression, neurological changes, vision loss, or orthopedic fractures. Patients who can't receive the MRI would have to be transferred to another Mt Sinai location with MRI services. The transfer delays the MRI. Finding was reviewed with Staff G, , on 1/29/2024 at 2:15PM. The surveyor asked why the stroke patient was transferred to another hospital when MSBI is a stroke center? Staff G stated, due to Interventional Radiology staffing, the hospital spoke with FDNY to take the hospital ED out of rotation for stroke patients requiring a potential thrombectomy. He was not sure when this occurred. Review of Patient #1's MR identified: On 12/28/2023, the patient was brought to the Emergency Department with a chief complaint of unresponsiveness. The patient was diagnosed with Intracerebral Hemorrhage and the physician determined that the patient needed to be transferred to another hospital. The physician's note on 12/28/2023 at 3:19PM documented "Cancel transfer to (Neurosurgery ICU) NSICU at this time and ICU to evaluate her at MSBI to determine disposition." At 3:52 PM the physician documented "Keep MSW neurosurgery ICU transfer now because MSBI ICU here full." Per interview of Staff M ( ) at on 1/25/2024 at 2:30 PM she confirmed that the patient was transferred to another hospital because an ICU bed was not available. Review of the "Physician Certification Consent to Transfer" form, dated 1/22/2024, stated the following: " ... informed patient representative that patient requires ICU level care and requires transfer due to space limitation and staff limitation at current hospital." (Patient #33). Review of Patient #33's MR identified: On 1/22/2024, the patient was brought to the Emergency Department with a chief complaint of unresponsiveness. The patient was diagnosed with Septic Shock secondary to Pneumonia and the physician determined that the patient needed to be transferred to another hospital. Per interview of Staff G ( ) at on 1/29/2024 at 1:29 PM he confirmed that the patient was transferred to another hospital because an ICU bed was not available.

Review of the facility's "Safety Net Incident SEA/RCA/Safety Solution" (form for documenting incidents) dated 01/01/2024 stated the following: "Patient being evaluated for cord compression/cauda equina, nursing via

> transfer center, recommended MRI Lumber; MRI technician was called in for emergency MRI, image performed and negative (6pm-9pm); when rediscussing with nursing via transfer center, then recommend MRI cervical/ thoracic spine emergently. Discuss with Radiology resident about recalling technician to the hospital. Concerns for resource management and completion of consult recs." (Patient #43) Review of Patient #43's MR identified: On 01/01/2024 at 9:51PM, the physician ordered a stat MRI of the cervical and thoracic spine. At 1/2/2024 at 5:27AM the physician note documented, "Spoke with neurosurgery around midnight-do not believe she has arachnoiditis, still recommend MRI cervical and thoracic spine be done while she is here-they are okay with her getting it in the AM, when the technician is here. The stat MRI was not performed until 1/2/2024 at 10:15AM, approximately 12 hours after it was ordered. Finding was reviewed with Staff M ( ) on 1/31/2024 at 11:08AM, Staff M stated, there was no radiologist on call to perform the emergent MRI. The physician called the neurologist to get permission to perform the MRI in the morning. Staff M confirmed that the stat MRI was not performed until 1/2/24 at 10:15AM, approximately 12 hours after it was ordered. Review of the facility "Safety Net Incident SEA/RCA/Safety Solution," dated 1/13/2024, stated the following "received as notification for stroke code. EMS was directed to bring patient here even though we are no longer receiving Large Vessel Occlusion (LVO), stroke level 4 and 5. Also, there was a delay in the stroke team responding. First activation of Stroke code at 8:14 AM, but no one from stroke team came. Activated stroke team again at 8:23 AM, stroke attending came. Patient to be transferred to MSW." (Patient #44). Per Interview with Staff C ( ), on 1/31/2024 at 10:00AM, Staff C stated, the neurointerventional radiology (NIR) attendings work for the system. Prior to 1/1/2024, the attendings would go to the patient's presenting ED and they would treat them there. This would eliminate the patients having to be transferred to another hospital. The attendings were directed to no longer come to the MSBI facility to treat the LVO patients after 12/31/2023. The patient would be transferred to another hospital in the system for treatment. Staff C confirmed the LVO patient had to be transferred to another facility for treatment because the hospital no longer provides this service.

173. Following this report, and a Second Motion for a Temporary Restraining Order, this Court issued an injunction which ordered the Mount Sinai Defendants to "maintain all beds, services, units, licenses, certifications, and designations which were in place at MSBI's 16th Street campus as of March 22, 2024 including, but not limited to all services in its Interventional Cardiology CATH Lab;" and further ORDERED the Mount Sinai Defendants "to make their best efforts to restore any and all beds, services, units, licenses, certifications, and designations which

were in place at the Hospital at the time the NY State Department of Health issued a Cease and Desist Order on December 21, 2023., and which have since been lost," and ordered the Mt. Sinai Defendants to "use their best efforts to enable the Hospital to appropriately send notice to the NYC Fire Department that it should resume the delivery of patients which FDNY stopped delivering by ambulance per the FDNY directive titled March 5, 2024 titled Permanent Diversions Mount Sinai Beth Israel Hospital."

174. On April 2, 2024 the DOH issued a Notice that the Closure Plan was incomplete. See **Exhibit AAA.** That letter asserted as follows**:**

> Please be reminded that pursuant to Title 10 of the New York Codes, Rules and Regulations (NYCRR) § 401.3(g), no medical facility shall discontinue operation or surrender its operating certificate unless 90 days' notice of its intention to do so is given to the commissioner and his written approval obtained. In order to obtain the commissioner's approval to close, DHDTC DAL 23-06 sets forth specific requirements that must be met. Specifically, DHDTC DAL 23-06 requires that:
>
> - Prior to the submission of a closure plan to the Department for review, the provider must notify their Federal, State and local-level elected officials (county, city, town, and village, as applicable) and the community about the proposed closure. The provider must also hold a public meeting, where the Chief Executive Officer or the Chief Operating Officer attends and answers questions, that allows for advance notice to stakeholders and allows for public comments regarding the closure.
>   - Please ensure the closure plan includes details related to the notification to Federal, State, and local-level elected officials and any organization that represents people who work at the hospital. This should include the notification means and some record of acknowledgment or attempts by Mount Sinai to gain acknowledgment of the notification and notes regarding feedback, if any was received. Additionally, please include documentation of written notification, with dates and times, of any public meeting(s) held with community stakeholders and notes regarding feedback, if any was received. (See page 1, paragraph 4 and item #9, page 3 in DHDTC DAL 23-06). DHDTC DAL 23-06 also requires that prior to the submission of the closure plan, the facility:

- Identify and confirm availability of services at other area facilities beyond the Mount Sinai Health System network, including information to ensure that the provider can accept new patients. In the closure plan, please provide detailed information about your discussions with other hospitals in the surrounding area including the date that these discussions occurred and the responses from these hospitals regarding their capability and capacity to accept additional inpatient, emergency department, and outpatient volume of patients for medical-surgical care and behavioral health care. If any facility is unwilling to meet with you, please include details of attempts to engage with that facility. (See DHDTC DAL 23-06, Page 3, #14 -15).
    - Specifically related to **emergency services,** Mount Sinai Beth Israel must work with other providers to identify, confirm, and explore possible partnerships or solutions to support the availability of **emergency services and the capacity** to respond to emergencies.

Additionally, the Department is requesting information on the following:

- The reason cited for Beth Israel's closure is a claimed financial loss over the last two years, but the closure plan did not provide independent evidence to support this claim. Please include the last three years of audited financials for Mount Sinai Beth Israel and the Mount Sinai Health System, to demonstrate how the Beth Israel Hospital is adversely impacting Mount Sinai Health System's financial stability. (See DHDTC DAL 23-06, Pages 2-3, #2, #13).

- The closure plan noted there have been declining volumes at Beth Israel Hospital over the last ten years. However, the response to item 6, "the number of patient visits for the previous three years…" shows increasing visits. Please clarify. (See DHDTC DAL 23-06, Page 3, #6).

- Please provide additional information on how any declining patient volume at Mount Sinai Beth Israel is impacting revenue and negatively affecting necessary investments in facilities, clinical programs, and technology for the Mount Sinai Health System, as stated in the October 25, 2023, closure plan. (See DHDTC DAL 23-06, Page 2, #2).

In summation, please submit a new, comprehensive closure plan that includes all required elements set forth in DHDTC DAL 23-06, including items 1-22 on pages 2 through 4, and relevant information from the November 2023 addendum to the closure plan, along with the missing elements set forth in this letter. We note that the proposed date of closure may need to be adjusted to reflect this new plan.

175. On May 23, 2024, Mount Sinai Defendants submitted a new closure plan for Beth Israel Hospital (Exhibit **BBB**) that was inadequate as a matter of law. As a result, approval of such closure plan is not within the discretion of the Department of Health. Additionally, MSBI asserts, throughout that submission, that all it has to do is give 90 days' notice of closure to DOH, that it did that in October 2023, and that it has a right to close the entire facility on July 12, 2024; or that its Amended Closure Plan starts the 90 day clock over, and that even without DOH's approval, it has an unfettered right to close MSBI effective August 23, 2024, blocked only by the Temporary Restraining Order in place. This position, which, of course, has made it impossible to retain staff or recruit staff, strangling the hospital from within, along with the reduction in services, and the attendant loss of income, has put the hospital close to its deathbed.

176. Specifically, the plan either wholly omitted required elements pursuant to DHDTC DAL 23-06 or provided information so misleading or inapplicable as to render the closure plan inoperative.

Deficiencies in the Amended Closure Plan

a. Failure to Provide Public Meeting

177. DHDTC DAL 23-06 requires that "Prior to the submission of a closure plan to the Department for review, the provider must [. . .] hold a public meeting, where the Chief Executive Officer or the Chief Operating Officer attends and answers questions, that allows for advance notice to stakeholders and allows for public comments regarding the closure."

178. Here, the Hospital indicated that it satisfied the public meeting requirement because it held a public meeting on November 28, 2023. NYSCEF Doc. No. 207 at 2. That meeting was held to notify the public and answer questions regarding the Hospital's first October 2023 plan. The Hospital cannot double count a public meeting intended to provide notice regarding one

closure plan as sufficient to provide the public with adequate notice regarding an entirely distinct, new closure plan filed seven months later.

179. Indeed, by the Hospital's own admission, the May 2024 closure plan is distinct from the October 2023 plan in order to account for "the significant passage of time and events." NYSCEF Doc. No. 206 at 2.

180. Further, the April 2, 2024 letter directed the Hospital to "submit a new, comprehensive closure plan that includes all required elements set forth in DHDTC DAL 23-06."

181. Allowing the Hospital to entirely evade a crucial public notice requirement would not only undermine the regulations set forth under DHDTC DAL 23-0 but would also deprive patients, stakeholders and the community of an opportunity to understand a life altering change to their healthcare system and would further exacerbate public confusion about the future of the hospital.

182. The court should therefore roundly reject the notion that the wholly inadequate November 2023 meeting, or the various meetings with elected officials which are listed in the May 23, 2022 submission, addressing only the October 2023 closure plan, satisfies the public meeting requirement for the May 2024 closure plan.

b. <u>Omission of Patient Visit Data</u>

183. Under item 6 of DHDTC DAL 23-06, the Department of Health requires data on the "[n]umber of patient visits to the facility." Such information is necessary to determine the effect of closure on surrounding facilities that will be absorbing the closing hospital's patient population, most urgently in medical emergencies. In its April 2 letter directing Beth Israel Hospital to submit a new closure plan, the Department of Health stressed as much, noting that "Mount Sinai Beth Israel must work with other providers to identify, confirm, and explore possible partnerships or

solutions to support the availability of emergency services and the capacity to respond to emergencies."

184. Rather than provide a complete patient count, the Hospital, by its own admission, provided "statistics [that] exclude patients who were admitted for behavioral health diagnoses because behavioral health patients will be treated at the Mount Sinai Behavioral Health Center, which will be unimpacted by the closure of the Hospital."

185. The Department of Health requires the production of "patient visits," without any qualifications on the kind of patients that visit the facility. Nowhere in either DHDTC DAL 23-06 or the Department of Health's multiple communications with Beth Israel does the agency authorize the Hospital to eliminate the count of behavioral patients that it assumes would be treated elsewhere.

186. Second, by necessity, *all* of Beth Israel's former patients would be treated at other facilities following its closure. The purpose of eliciting data on all patient visits to Beth Israel is to understand the impact of absorbing former Beth Israel patients on those other facilities and to facilitate sound deliberation by the Department of Health on whether to permit closure based on that data. Manipulated data, that arbitrarily excludes behavioral health patients, cannot facilitate such a process.

187. Finally, it is patently false that all behavioral health patients that would have been treated at Beth Israel will be treated by The Mount Sinai Behavioral Health Center. That facility does not accept emergency patients; its own website redirects patients to Beth Israel.

188. The closure plan must be rejected as a result of this flagrant omission of required patient data.

c. **Availability of Services**

189. Item 15 of DHDTC DAL 23-06 requires Mount Sinai Defendants to "Identify and confirm availability at the alternate providers, including obtaining information to ensure that the provider can accept new patients, identifying where Medicaid patients can obtain care; providing information about other facilities to patients and families, ensuring language access (*i.e.*, information is communicated in the patient's preferred language) and that the wishes of current patients/families are respected; and ensuring that concerns such as geographic location, public transportation, type of facility/provider, medical care, etc. are addressed in identifying future placement options and ensuring continuity of care."

190. In returning the initial closure plan as incomplete, the DOH noted that "Specifically related to emergency services, Mount Sinai Beth Israel must work with other providers to identify, confirm, and explore possible partnerships or solutions to support the availability of emergency services and the capacity to respond to emergencies."

191. Mount Sinai Defendants' updated closure plan fails to satisfy DHDTC DAL 23-06 as a matter of law for the following reasons:

1. The response lists a number of hospitals, including hospitals up to 12 miles away, as potential destinations for services. However, there is no analysis about the health effects of the additional distance traveled to get to these hospitals.

2. Furthermore, the response states, "All of the below-referenced hospitals accept Medicaid." While it is true that each hospital accepts Medicaid for *some* services, the closure plan does not specify which hospitals accept Medicaid for which services. As many of the hospitals listed do not accept Medicaid for many if not most services, the closure plan does not give the DOH information necessary to "identif[y] where Medicaid patients can obtain care."

3. Attachment 19 lists 9 conversations with the 5 different hospital entities. However, it does not have any description of these conversations. As a result, there is no basis for the DOH to determine that Mount Sinai has worked with these hospitals to ensure whether those "provider[s] can accept new patients" for each of the services proposed to be cut. It certainly does not establish any evidence that they have "work[ed] with other providers to identify, confirm,

and explore possible partnerships or solutions to support the availability of emergency services and the capacity to respond to emergencies."

4. Mount Sinai Defendants rely in data from three attachments to demonstrate that these other hospitals can absorb additional patients from Beth Israel's closure. However, these three attachments fail to provide the DOH with the information required:

   a. Attachments 20 and 21 are limited to emergency room absorption analysis. While this is responsive to DOH's follow-up request, it still fails to supply any evidence, pursuant to DHDTC DAL 23-06, of "availability at the alternate providers" for other services.

   b. Attachments 20 and 21 also fail to demonstrate the "availability of alternate providers" of emergency services, as requested in the DOH's rejection of the initial closure plan. Specifically, analysis in Attachments 20 and 21 are conducted for Beth Israel's February 2024 emergency data. This data is artificially lowered by the fact that Mount Sinai Defendants had illegally closed most services in the months prior. Most egregiously, Mount Sinai Defendants had ended the ambulance contract for the Beth Israel emergency room immediately prior to this data, meaning that the Beth Israel ER numbers exclude ambulances almost entirely. If Beth Israel had been operating at the capacity and providing the services legally required, the ER numbers would be substantially higher, resulting in much greater impacts on other hospitals' ER capacities. The extent of such impacts is entirely unknown, because Mount Sinai Defendants did not supply DOH with the data necessary to learn the impact of Mount Sinai's closure – from legally required levels down to zero – on other hospitals. As a result, the closure plan is legally insufficient.

   c. Attachment 22 purports to show an absorption analysis of Beth Israel's closure on inpatient beds more broadly. However, the analysis itself is entirely missing. Mount Sinai Defendants include only the conclusory table, which they claim is the product of such an analysis. However, the DOH is incapable of ascertaining the accuracy of the numbers in Attachment 22 absent the underlying analysis. As a result, again, Mount Sinai Defendants' submission is inadequate as a matter of law.

DOH, In Approval of the Inadequate Closure Plan, Acted Arbitrarily and Capriciously and Not in Accordance with Law.Approval of the MSBI Closure Plan Violates the NYS Constitution, the Public Health Law and DOH Regulations and Should Not Have Been Approved as a Matter of Law

192. On July 26, 2024, DOH approved MSBI's closure plan. See **Exhibit EEEE.** As we discuss above, not only is MSHS's Closure Plan and Amended Closure Plan unlawfully

constructed and submitted, there is no way under the New York State Constitution ("*The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine*"), the Public Health Law, or the DOH Regulations that the closure of Beth Israel and its services can be allowed. Additionally, the time has come to restore the Cardiac Surgery unit unlawfully closed in 2017.

193. The approval included several conditions, which at a hearing on Index 151136/2024 on August 8, 2024, both MSHS and DOH indicated had been met simply by MSHS agreeing to meet the conditions, not performing the underlying actions. MSHS's mere promise to comply with the conditions of approval ring hollow given the overwhelming volume of prior unresolved violations of DOH rules as noted in this Petition/Complaint. MSHS has, allegedly, promised (a) to ensure safe transfer of patients during closure, (b) to provide Bellevue Hospital with $20 million to expand its emergency department, (c) open an urgent care center at NYEE and keep it open for 3 months, (d) extend "hospital at home" services within the catchment area, (e) staff behavioral health beds at its Behavioral Health Center on Rivington Street, and (f) pay for an additional ambulance to service the catchment area.

194. None of these conditions address the inadequacies of the closure plan, which specifically relate to information that MSHS failed to provide to DOH. DOH is unable to determine whether $20 million is adequate to expand Bellevue's emergency department if it does not understand the patient increase that will result from MSBI's closure. And, in any case, $20 million is not only inadequate, but it will also come months or years too late, after MSBI has long closed. Similarly, an urgent care center open for three months is not only inadequate to compensate for the services lost due to the closure of MSBI, but it is impossible for DOH to

understand the community's needs, absent an adequate closure plan, such that DOH could negotiate such a condition in good faith. The same can be said about requiring MSHS to broaden its "hospital at home system" where "possible"; it is an entirely arbitrary condition given that MSHS failed to provide DOH with sufficient information in its amended closure plan to determine whether those services could even plausibly mitigate the effects of closing Beth Israel. DOH does not explain where the services would be extended, for how long, or what it would consider "possible." The condition is haphazard and devoid of any specific, workable boundaries

195. Further, it is inconceivable that the directive to increase staffing at the Behavioral Health Center on Rivington Street was based on anything short of an arbitrary and dangerously capricious deliberation. Under item 6 of the DHDTC DAL 23-06 guidelines governing hospital closure plans, the Department of Health requires data on the "[n]umber of patient visits to the facility." Yet in its amended closure plan MSHS, by its own admission, provided "statistics [that] exclude patients who were admitted for behavioral health diagnoses." NYSCEF Doc. No. 207 at 13. As discussed in paragraphs 180-185, MSS entirely omitted data concerning behavioral health patients that seek treatment at Beth Israel and there is no information concerning what proportion of those patients seek emergency care. Of particular importance: the Behavioral Health Center at Rivington Street does not treat emergency patients; its own website instead directs patients to Beth Israel Hospital. It is entirely unclear why DOH would require increased staffing for the Behavioral Health Center at Rivington Street when the closure plan does not have any of the information necessary to determine the utility of that condition.

196. Finally, the condition to coordinate access to emergency care with ambulance service providers is, as with the all the other conditions, untethered to operative information from the closure plan. As discussed in paragraphs 186-188, MSHS neglected to provide any workable

information in its amended closure plan for DOH to determine that remaining "provider[s] can accept new patients." To put it plainly: once the ambulances are loaded with patients downtown, where exactly should they go? DOH's approval of the closure plan has no answer, nor could it when MSHS failed to provide sufficient information on the emergency room capacity at the remaining area hospitals.

197. Given the inadequate closure plan, any approval would be arbitrary and capricious and not in accordance with law.

The Impact of an MSBI and NYEE Closure Would Be Devastating to the Health of the Affected Population, Which Is Poorer, Less White, and Less Able-Bodied than the Areas Where Other Mt Sinai Hospitals Are Located

198. There is no question that MSBI's and NYEE's closure would be devastating to the health of the affected population, which is poorer, less white, and less able-bodied than the areas where other MSHS hospitals are located.

199. Of critical importance here, as we discuss below, is the impact that the closure of Beth Israel and NYEE will have on the surrounding population which suffers from disabilities, including the 25% of the population which is over 65, as well as the total elimination of NYEE which by design is created to, and continues to serve hearing and vision disabled persons, and for which no substitute is offered, much less an accommodation as required by the New York State and New York City Human Rights Laws.

200. Plaintiffs-Petitioners have prepared, with the help of local elected officials, a proper Health Care Equity Assessment created by Health Professionals associated with Plaintiff Community Coalition (see **Exhibit U**) which demonstrates the devastating impact which the Beth Israel closure will have on affected communities. *See also* the Affidavit of Penny Mintz, submitted herewith.

PRIORITY LIST OF ESSENTIAL SERVICES TO RESTORE AT MOUNT SINAI BETH ISRAEL

201. This evolving list of essential hospital services is based on input from physicians, community members, the community-led Health Equity Impact Assessment, and the services that Mount Sinai described as critical for the community four years ago in their certificate of need (CON) application to build a replacement hospital for Mount Sinai Beth Israel.

202. Excerpt from "A Community-Led Health Equity Impact Assessment of the Proposed Closure of Mount Sinai Beth Israel Medical Center" (January 2024): *Only four years ago, Mount Sinai obtained approval from the New York State Department of Health for a certificate of need (CON) application to build a new replacement hospital for the aging Beth Israel facility. At that time, Mount Sinai's CON application called for a hospital on 14th Street with an emergency department, 70 inpatient beds (52 medical/surgical and 18 ICU), and a "procedural platform to include cardiac catheterization, electrophysiology and interventional radiology procedures." Mount Sinai said there was a need to accommodate 70,000 patients a year in the emergency department. In that CON application, Mount Sinai stated it had carefully studied the population, demographics and health care needs of the downtown community and had concluded that:*

> *"The community requires access to* ***critical emergency care, including cardiac and stroke emergency care, operating room facilities to respond to these emergencies and other surgical procedures, emergency mental health facilities and observation and inpatient beds****…The new MSBI facility will be a full-service hospital consisting of inpatient beds, an adult and* ***pediatric ED, radiology functions, operating rooms (OR) and IR suites, including neuro-IR and cardiac catheterization****. The new hospital building will serve as a neighborhood hub of critical care, treating patients in need for lifesaving treatment when suffering strokes, heart attacks, aneurysms and trauma."*

Essential Beds

Coronary Care Beds: Number a population-based decision
- *Had 8 as of closure plan announcement on 10/25/2023*

Intensive Care Beds: Number a population-based decision
- *Had 8 as of 10/25/2023*

Medical/Surgical Beds: Number a population-based decision
- *Had 499 as of 10/25/2023*

Total certified beds: Number a population-based decision
- Having surplus certified beds allows for the possibility for their use during critical periods, *i.e.* influenza season, COVID-19 surge, natural disaster, future pandemic
- *Had 543 total beds as of 10/25/2023*
- *Had 853 total beds as of 5/15/2014*

https://web.archive.org/web/20160321230626/http://www.bethisraelny.org/files/Implementation%20Strategy%20MSHS.pdf

Essential Services

Services denoted with (*) were present at announcement of closure on 10/25/2023
- Adult Emergency Department*
  - Including but not limited to cardiac and stroke emergency care
- Pediatric Emergency Department
- Comprehensive Psychiatric Emergency Program*
- Inpatient Psychiatry
- Primary Care Medicine / Hospitalist Service*
  - Asian Services
- Medical Services – Other Medical Specialties*
  - Internal Medicine (general internal medicine / Hospitalist service)
  - Neurology (including acute stroke service)
  - HIV/AIDS care
  - Palliative Care and Hospice
- Renal Dialysis (acute)*
- Observation Unit
- Telemetry Unit
- Surgery
  - Operating rooms to respond to emergencies
  - General Surgery service
  - Anesthesia service
- Intensive Care Units (ICUs)
  - Surgical ICU (SICU)
  - Medical ICU (MICU)*
  - Coronary Care Unit (CCU)*
- Cardiac Catheterization
  - Adult Diagnostic*

  - Electrophysiology*
  - Percutaneous Coronary Intervention*
- Radiology
  - 24/7 staff radiologists can read remotely
  - On-site technologists to perform MRI, CT, ultrasound
  - Magnetic Resonance Imaging (MRI)*
  - Ultrasound
  - Computed Tomography (CT)
- Neuro Interventional Radiology (Neuro IR)
  - Necessary to respond to certain types of strokes
- Physical Therapy / Occupational Therapy*
- Speech-Language Pathology*
- Addiction Medicine / Chemical Dependency
  - Acute Detox (Inpatient Unit)
- Social Work*
- Walk-In Clinic
  - Can be at NYEE or BI campus
  - Important to include ENT
  - *Essential for patients on public insurance, i.e. Medicare and Medicaid*

AS AND FOR A FIRST
CAUSE OF ACTION

203. Plaintiffs-Petitioners incorporate by reference all preceding paragraphs.

204. By acting as they have, the Defendants-Respondents have endangered the health of hundreds of thousands of residents on Lower Manhattan, and nearby Brooklyn, without any meaningful remediation for the services which have been lost.

205. By acting as afore described, Defendants-Respondents Mount Sinai Beth Israel Hospital, New York Eye and Ear Infirmary of Mount Sinai, and the Mount Sinai Hospital System, with the acquiescence of the DOH, have violated, and threaten to continue violating Section 2800 *et seq.* of the Public Health Law, most notably Section 2802-a, and the regulations issued thereunder including 10 NYCRR § 400.26. § 401.3, and § 710.1 et seq., DOH's August 2023 Closure Guidance and December 2023 Cease & Desist Order.

AS AND FOR A SECOND
CAUSE OF ACTION

206. Plaintiffs-Petitioners incorporate by reference all preceding paragraphs.

207. Despite its Cease and Desist Order, the Defendant-Respondent Department of Health has dragged its feet on its earlier supervision of the Defendants-Respondents Mount Sinai Beth Israel Hospital by allowing reduction is services to proceed, even after it issued its Cease and Desist Order, or its March 15, 2024 Statement of Deficiencies despite the fact that MSBI was openly violating the DOH regulations and its Closure Directive by closing or reducing the size of various departments, even openly defending its actions at the November 2023 Public Forum.

208. Furthermore Defendant-Respondent Department of Health has taken no action to stop the downsizing of services at NYEE, despite the fact that DOH, in its June 23, 2023, conditional approval of the NYEE Closure, conditioned that closure on the transfer of services to Beth Israel, which MSHS has not done or has plans to do.

209. Additionally, the DOH has failed to require MSBI to restore the services it shut down at MSBI since its last approved CON in 2017, or that it has shut down over the last 24 months at NYEE without any CON.

210. The DOH has failed to review the 2017 CON permitting MSBI to eliminate its cardiac surgery unit, as ordered by this court in *Progressive Action*.

211. DOH, which should have immediately rejected the Mount Sinai Closure Plan as inadequate, approved the closure of MSBI, despite its unlawful and inadequate closure plan, and plans to take no action to stop the closure of NYEE.

212. By acting as aforedescribed, the DOH and Commissioner McDonald have violated the health care guarantees of the N.Y. State Constitution, which states at §3, “The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision

therefor shall be made by the state," as well as Section 2800 *et seq.* of the Public Health Law, most notably Section 2802-a, and the regulations issued thereunder including 10 NYCRR § 400.26. § 401.3, and § 710.1 *et seq.*

AS AND FOR A THIRD
CAUSE OF ACTION

213. Plaintiffs-Petitioners incorporate by reference all preceding paragraphs.

214. By closing or reducing scores of services at MSBI and NYEE without filing a single Certificate of Need application, MSBI, NYEE and MSHS violated Public Health Law, and the regulations issued thereunder including 10 NYCRR § 400.26. § 401.3, and § 710.1 *et seq.*

AS AND FOR A FOURTH
CAUSE OF ACTION

215. Plaintiffs-Petitioners incorporate by reference all preceding paragraphs.

216. By acting as aforedescribed, Defendants-Respondents have violated the State Environmental Quality Review Act.

217. The closure of Beth Israel Hospital is a Type I Action under SEQRA. Upon information and belief, the DOH has not commenced any sort of Environmental Review of MSBI's and MSHS's plans.

218. In fact, given the needs for acute care hospitals shown by the COVID Pandemic, precisely the circumstances noted by Judge Hagler in *Progressive Action* as requiring SEQRA review of hospital closures, and acknowledged by Mount Sinai in the statement of Jeremey Boals in June 2021 as requiring MSBI's beds to stay open, *see* **Exhibits C1 and C2**, approval of the Beth Israel Hospital closure cannot proceed, even if the Public Health Law is not being violated, without a full Environmental Impact statement.

AS AND FOR A FIFTH
CAUSE OF ACTION

219. Plaintiffs-Petitioners incorporate by reference all preceding paragraphs.

220. The actions of Defendants-Respondents Mount Sinai Health System, Mount Sinai Beth Israel, and the New York Eye and Ear Infirmary of Mount Sinai amount to a refusal to take such steps as may be necessary to ensure that no individual with a disability is excluded or denied services and have had and will have an unjustified negative disparate impact on people with disabilities, Asian and Hispanic New Yorkers, New Yorkers facing language access barriers, and low-income New Yorkers.

221. By acting as aforedescribed, Defendants-Respondents Mount Sinai Health System, Mount Sinai Beth Israel, and the New York Eye and Ear Infirmary of Mount Sinai have violated and are threatening to further violate Section 296 the New York State Human Rights Law.

AS AND FOR A SIXTH
CAUSE OF ACTION

222. Plaintiffs-Petitioners incorporate by reference all preceding paragraphs.

223. The actions of Defendants-Respondents DOH, Mount Sinai Health System, Mount Sinai Beth Israel, and the New York Eye and Ear Infirmary of Mount Sinai amount to a refusal to take such steps as may be necessary to ensure that no individual with a disability is excluded or denied services, and have had and will have an unjustified negative disparate impact on people with disabilities, Asian and Hispanic New Yorkers, New Yorkers facing language access barriers, and low-income New Yorkers.

224. By acting as aforedescribed, Defendants-Respondents Mount Sinai Health System, Mount Sinai Beth Israel, and the New York Eye and Ear Infirmary of Mount Sinai have violated and are threatening to further violate Sections 8-107(4), (15) and (16) of the NYC Human Rights Law.

AS AND FOR A SEVENTH
CAUSE OF ACTION

225. Plaintiffs-Petitioners incorporate by reference all preceding paragraphs.

226. The actions of DOH in approving MSHS's inadequate closure plan, without adequate information on which to base a decision as to whether to close it, including information DOH itself requires in its August 2023 closure plan guidelines, and despite all evidence that such approval was unsafe, were arbitrary and capricious and not in accordance with law.

227. By acting as aforedescribed, the DOH and Commissioner McDonald have violated Section 2800 et seq. of the Public Health Law and DOH guidelines issued thereunder.

INJURY

228. The injury which has been suffered by Plaintiff/Petitioners as a result of the reduced services described herein, and which will be suffered by them should Beth Israel Hospital close has been, and will be irreparable. These actions have already caused death, and will put huge numbers of Lower Manhattan residents at risk for medical complications and death.

PRAYER FOR RELIEF

WHEREFORE, Petitioners-Defendants pray that the Court enter a Preliminary Injunction, and Judgment:

a. holding DOH's approval of the closure plan to be arbitrary and capricious and not in accordance with law and ordering DOH to revoke the approval of the closure plan and reject it;

b. compelling the DOH to review its 2017 approval of the closure of the MSBI cardiac surgery unit and to revoke the approval;

c. compelling DOH to order the restoration of all services at MSBI which have been reduced of closed since October 2023;

d. compelling the DOH to reverse its decision to approve the partial closure of NYEE;

e. compelling the DOH to conduct a review of proposed closures of MSBI and NYEE under SEQRA;

f. enjoining MSHS, MSBI, and NYEE from engaging in further action to close or reduce services in MSBI or NYEE until DOH has issued a decision on its closure application;

g. enjoining MSHS, MSBI, and NYEE from engaging in further action to close or reduce services at MSBI or NYEE until the Public Health Law requirements set forth at Section 2801-b, and the State Environmental Quality Review Act have been fully complied with;

h. compelling the reopening and the proper staffing of those portions of MSBI which have been closed since the last substantive CON application was approved in 2017;

i. compelling the reopening and the proper staffing of the cardiac surgery unit of MSBI;

j. compelling the reopening and the proper staffing of those portions of NYEE which have been closed without approval of the DOH;

k. granting such other and further relief as the Court deems just and proper, including an award of attorney’s fees and costs.

Dated: New York, New York
August 12, 2024

ADVOCATES FOR JUSTICE
Attorneys for Petitioners-Plaintiffs

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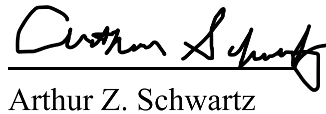
VERIFICATION

Arthur Z. Schwartz, Petitioner-Plaintiff, verifies, under penalty of perjury, that to his knowledge, information and belief, the allegations in the Petition/Complaint are true. My verification is based upon personal knowledge, review of source documents cited in the text, or base upon interviews with physicians, nurses and other health professionals at Beth Israel Hospital



Arthur Z. Schwartz

Sworn to before me this _12th___ day of
August, 2024.

Notary Public
Laine Alida Armstrong
Notary Public of the State of New York
No. 02AR6416573
Qualified in Kings County
My Commission Expires 04-19-2025