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Access Denied: Hospital Closures and Emergency Care Deserts in New York State

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Introduction

Adequate access to healthcare is essential for longevity and quality of life. Yet, healthcare personnel and facility shortages are common across the country, and often disproportionately in rural areas (RHI Hub, 2026a). Healthcare deserts- areas with insufficient availability of or access to medical care- are prevalent across the U.S. and are a common concern for researchers, policymakers, and the public alike. With the passage of the One Big Beautiful Bill Act (OBBA), now Public Law 119-21, the implementation of cuts and restrictions to federal funding and programs are underway and states are bracing under increased financial pressure. These changes, particularly to Medicaid, have led to concerns about the ability for hospitals to remain open- especially those in financial distress or with high volumes of Medicaid patients. Last year, the Fiscal Policy Institute released a report (Eisner & Kinnucan, 2025) identifying hospitals in New York at risk of closure, with 70 being most at risk- 59 of which were located upstate (counties north of Rockland and Westchester). The loss of a hospital can be devastating for access to medical care and can drive populations previously served by those hospitals into care deserts. Therefore, we endeavored to estimate the impacts of these predicted closures on the population living in care deserts in New York State. While the loss of any medical facility or service is cause for concern, since the time between the onslaught of a medical emergency and receiving care is often critical we chose to focus specifically on emergency care deserts (considered living over 15 miles away from a hospital with an emergency room, or 5 miles in an urban area). This paper aims to quantify the current and potential population in emergency care deserts by addressing the following questions:

- In which areas of the state are people farthest away from a hospital? Where is access to emergency care most precarious in the event of hospital closure?
- What is the population in New York State currently living in emergency care deserts? How many additional people would live in emergency care deserts under two broad closure scenarios?

2025 budget reconciliation bill (PL 119-21)

The One Big Beautiful Bill Act (OBBA) became public law in July of 2025 and contains policy changes aimed at reducing federal spending. This includes new restrictions on Medicaid, the nation's joint state-funded and federally funded health program for people with low incomes and disabilities (Rao et al., 2026). Analysis of the state-level impacts of these implementations by RAND (2026) outlined the main Medicaid provisions and their corresponding sections in Pub. L. 119-21 [2025]:

- Address verification [Sec.71103]
- Good faith waiver [Sec. 71106]
- Redetermination [Sec. 71107]
- Eligibility restrictions for immigrants [Sec. 71109]
- Emergency Medicaid [Sec. 71110]

- Provider Taxes [Secs. 71115 and 71117]
- State-directed payments (SDPs) [Sec. 71116]
- Work Requirements [Sec. 71119]
- Cost-sharing [Sec. 71120]
- Home-and community-based services (HCBS) [Sec. 71121]
- Rural Health Transformation Program (RHTP) [Sec. 71401]

In sum, these changes impose minimum work requirements (80 hours a month of work or other eligible activities for non “medically frail” individuals), increase the frequency and strictness of eligibility determinations and redeterminations (evaluation of eligibility every 6 months in expansion states instead of every year), limit Medicaid eligibility to citizens/nationals and lawful permanent residents (with a few exceptions), reduce federal matching assistance percentage (FMAP) contributions for emergency care (which helps pay for Medicaid-ineligible immigrants seeking emergency care), and limits state use of provider taxes. The provisions do also include some new spending, most notably the \$50 billion Rural Health Transformation Program (RHTP), but the provisions overall are expected to result in an estimated \$709 billion reduction in federal spending (Congressional Budget Office, 2025b). These changes are expected to have variable impacts on state budgets, but the total estimated effect is a state Medicaid budget reduction of \$664 billion and a state general fund reduction of \$87 billion (Rao et al., 2026). The Congressional Budget Office (CBO) also estimated that up to 10 million people could lose insurance coverage due to these Medicaid provisions in addition to changes to the Affordable Care Act’s (ACA) Marketplace (CBO, 2025c).

As previously noted, these changes to Medicaid are not unilaterally applicable across states, and some aspects are left to state judgement. For example, who is defined as “medically frail” and exempt from the work requirements is up to states to determine (Musumeci et al., 2025). Additionally, many of the provisions apply differently to expansion and non-expansion states. Expansion states are those that adopted the ACA Medicaid expansion (beginning in 2014), extending coverage to adults with incomes up to 138% of the Federal Poverty Level, and non-expansion representing the 10 which have not adopted this change. Many of the outlined provisions contain greater restrictions for expansion states- for example, the imposed work requirements, scheduled to begin in January of 2027, only apply in expansion states (Liss & Whitehead, 2025; Coleman & Federman, 2025). The new limits to provider taxes (which help pay facilities back for services to Medicaid patients) also disproportionately impact states that adopted the Medicaid ACA expansion. While no states are allowed to enact new provider taxes or raise existing ones, beginning in 2028 the “hold harmless threshold” (the limit that can be reached before an investigation is triggered) for expansion states will be gradually lowered by 0.5% annually until it reaches 3.5% in (Burns et al., 2025).

Because of these differences, expansion states, states with State Directed Payments (SDPs), and states using Provider Taxes are expected to experience the largest impacts on their Medicaid budgets. The state-level impact analysis by RAND (Rao et al, 2026) estimated that California (-\$112.3 billion), New York (-\$62.6 billion), and Arizona (-\$42.2 billion) will experience the largest numerical reductions in their Medicaid funds by 2034, while Arizona (-18.7%), Iowa (-

15.8%) and Nevada (-15.5%) would have the largest relative losses. In terms of state general funds, California (\$102.1 billion; -6.1%) would experience the greatest losses in both dollars and percentage by 2034, followed by Illinois (-\$10.9 billion; -2.7%) and Michigan (-\$8.3 billion; -2.7%). According to this analysis, three of the bill's provisions are expected to have the largest impact on New York State's Medicaid fund by 2034: Work Requirements (-3.44%; -\$41.4 billion), Provider Taxes (-0.88%; -\$10.6 billion), and Redeterminations (-0.87%; -\$10.5 billion) (Rao et al. 2026). Though the estimated overall reduction in the state's Medicaid fund appears small at -5.2%, it amounts to a loss of -\$62.6 billion, which could put the most economically precarious hospitals at risk- especially with losses due to Provider Taxes impacting hospitals with large Medicaid populations. Though the Rural Health Transformation Program (RHTP) is intended to cushion the impact of Medicaid budget losses in rural areas, it is only estimated to contribute a 0.08% increase (+\$981.9 million) in New York State's Medicaid fund by 2034, still resulting in a sizeable net negative effect.

Hospitals in New York State

Across the U.S., hospital closures are already a persistent problem, with 148 hospitals closed between 2017 and 2023 (Levinson et al. 2025). Closures have outpaced openings, especially in rural areas, with 61 hospitals closed and only 11 opened from 2017 to 2023 in rural areas compared with 87 hospitals closed and 74 opened in urban areas (Levinson et al. 2025). In New York State, an estimated 25 hospitals have closed between 2005 and 2020, 5 of them in rural areas (Cecil G. Sheps Center for Health Services Research 2026; NYSDOH 2026). As of May 2026, there are 260 hospitals in New York State and the counties in other states directly adjacent to it. Over a third (102) of these hospitals are in "Upstate" New York, which we define as north of Rockland and Westchester counties, and 58 are within the five boroughs of New York City (NYC). In response to the proposal of the OBBBA in 2025, the Fiscal Policy Institute (FPI) published a brief on hospitals in New York State at risk of closure due to proposed Medicaid cuts (Eisner & Kinnucan, 2025). Their brief highlighted 70 hospitals in the state "at risk" of closure under severe cuts to Medicaid, and an additional 23 hospitals potentially at risk. They calculated the share of net patient revenue (NPR) for each hospital coming from Medicaid and government appropriations. They then defined "most at risk" hospitals as those with over 25% of their NPR coming from Medicaid/govt. appropriations, and marginal risk as more than 20% but less than 25% NPR from Medicaid (Eisner & Kinnucan, 2025). This brief spurred many questions about what these hospital closures would look like in practice, and the resulting impacts on access to care.

Types of Hospital Designations

Before considering the impact of hospital closures, it is important to understand different categories hospitals can fall into because this can influence the resulting impact. Urban and rural hospitals have different needs, and with lower patient volumes, fewer beds, and generally higher prevalence of Medicaid/Medicare patients, hospitals in or serving rural areas often struggle to stay financially stable based on revenue from patients alone. The federal government employs specific classifications in efforts to prevent financial distress and closures for rural hospitals.

“Rural” is a generic term that can vary in meaning, but federal rural classification is often required for hospitals to be eligible for various benefits. It is worth noting, however, that because of a 2016 policy change, geographically urban hospitals can be dually classified by becoming “administratively rural” which allows them to receive both Medicare benefits designated for rural hospitals (including potential eligibility as a Rural Referral Center or Sole Community Hospital) and those allocated to urban hospitals such as an urban wage index (used to adjust Medicare payments based on local labor costs). For example, Jamaica Hospital Medical Center in Queens is classified as a Rural Referral Center but located in a borough of NYC- the largest city in the United States. Despite this complication, federal hospital classifications are relevant to understanding the role hospitals play in various communities, and the potentially varying impacts of hospital closures.

One primary designation is the Critical Access Hospital (CAH), which was created by the Balanced Budget Act of 1997 (Public Law 105-33) following a large swath of rural hospital closures in the 1980s and 1990s to help sustain essential services in vulnerable areas (RHI hub, 2026b). CAHs receive certain benefits, such as cost-based reimbursement for Medicare and Medicaid services and more flexible staffing and service arrangements. To be eligible for this designation, a hospital must have 25 or fewer acute care inpatient beds, be over 35 miles from another hospital (with some exceptions based on geography and location type), provide 24-hour emergency care services, and have an annual average length of stay of 96 hours (4 days) or less (RHI hub, 2026b). There are currently 21 CAHs in NYS, and an additional 9 in bordering counties. A similar but more recent hospital designation, Rural Emergency Hospital (REH), was established by Congress in December of 2020 (Public Law 116-260) in response to losses of essential services in rural areas due to hospital closures and went into effect in January of 2023. The REH designation allows hospitals to receive enhanced Medicare payments for certain outpatient services and additional monthly facility payments. This serves as an added level of protection for communities that may not be able to support or sustain a small rural hospital or CAH. To qualify as an REH, a hospital must provide 24-hour emergency and observation services and cannot have inpatient beds except in a distinct skilled nursing unit (RHI hub, 2026b). Notably, converting into an REH-eligible hospital can incur its own costs, such as those needed for operational restructuring or state compliance. New York is the only state in the Northeast region with REHs, and contains three: Westfield Memorial Hospital, Ira Davenport Memorial Hospital, and Clifton-Fine Hospital.

Another related federal designation is the Sole Community Hospital (SCH), which applies to hospitals serving as the only of its kind within a 45-minute drive. Distance requirements for eligibility vary depending on whether a facility falls within a rural area, and how accessible it is based on several factors such as topography, speed limits, and typical weather conditions. The SCH designation has no bed limit, so these hospitals can range from small community hospitals to larger regional facilities. SCHs receive Medicare reimbursement based on their own historical costs rather than national average rates, along with "hold harmless" protections that prevent payments from falling below a base-year level even if patient volumes decline (RHI, 2026d). In New York State, SCHs also receive State Directed Payment (SDP) rate add-ons to their Medicaid Managed Care reimbursement rates, which provide additional payments above

standard managed care rates for certain services. As of Fiscal Year 2025, there are 16 SCHs in New York State receiving these add-ons (NYS DOH, 2025).

The last federal designation of interest is the Rural Referral Center (RRC), which are hospitals that function as regional hubs and receive many patient referrals from surrounding rural facilities. A hospital is classified as an RRC if it meets the following criteria: the hospital participates in Medicare, is located in a rural area (or is considered “administratively rural”), has 275 or more beds, 50% or more of its Medicare patients are referred from other hospitals or external physicians, over 60% of its Medicare patients live more than 25 miles from the hospital, and at least 60% of all Medicare-provided health care services are to those over 25 miles away. Hospitals designated as RRCs may also simultaneously hold another designation such as a CAH (RHI Hub, 2026d.). When smaller rural hospitals close or convert to an REH and lose their inpatient capacity, RRCs can absorb a disproportionate share of that burden. There are 49 RRCs in New York State as of Fiscal Year 2026 (CMS IPPS, 2026), with some also designated as CAHs or SCHs. Unlike CAHs and SCHs, RRCs do not receive targeted Medicaid managed care payment add-ons, meaning their exposure to financial issues due to the new public law (PL 119-21) operates through different mechanisms- primarily through Medicaid patient volume and Disproportionate Share Hospital (DSH) payment changes. Each of these designations can influence how Medicaid cuts will impact a hospital’s financial situation and what the hospital network might look like after closures. Though these designations are not directly incorporated into this analysis, they are noted in the results to give further context, and inform future analysis that may more deeply consider these fiscal mechanisms.

Data and Methods

The goal of this white paper is to establish the current extent of emergency care deserts in the state and estimate the impacts of potential hospital closures due to Medicaid cuts on emergency care deserts. First, data on hospitals providing emergency medical care were retrieved from NYSDOH (updated in 2025), and included facility names, addresses, and type of hospital/services offered. Because in some areas the closest hospital is in another state, the NYS facility data was supplemented with data obtained from health departments of the five neighboring states: Pennsylvania, New Jersey, Connecticut, Massachusetts, and Vermont. To calculate the share of each hospital’s net patient revenue from Medicaid and government appropriations, the 2024 Centers for Medicare & Medicaid Services (CMS) financial data was merged with the universe of hospitals. The CMS data was accessed through the National Academy for State Health Policy's (NASHP) Hospital Cost Tool (HCT).

Because of differences in the data availability, file layouts, and naming schema across states and between data sources, the multistate health department data needed to be harmonized with the CMS file. Locations of hospitals in the NASHP/CMS data were matched to the locations from the health departments, first by address then by facility name to account for variation in naming conventions across sources and years. Where a facility name was similar but the address differed, the facility type and location were manually verified. Facilities appearing in only one of the two source lists were investigated to confirm whether they remained open, were still classified as

hospitals, and maintained an emergency room, and otherwise removed as needed. Three off-campus emergency sites listed in the NYSDOH data were excluded from the final database, as they are not full hospital facilities. The database of hospital locations and financial information was then imported into QGIS for spatial validation. Where address information was incomplete or inaccurate (for example, mailing addresses sometimes list a P.O. Box) geocoding was performed to assign correct geographic coordinates.

Following the methodology of the Fiscal Policy Institute (FPI), the share of a hospital’s net patient revenue (NPR) from Medicaid and government appropriations¹ was calculated and used to classify facilities into three groups. If the share was 25% or more, that hospital was considered “high risk” of closure. Hospitals where this share was between 20% and 25% were considered at “potential risk”, and those below 20% were classified as not at risk (Eisner & Kinnucan, 2025). Missing Medicaid data were addressed through a tiered method of imputation. For New York State hospitals missing values in the 2024 Medicaid data, their “risk level” was borrowed from the Financial Profile Index (FPI) list (which utilized the 2023 CMS data). When a facility in NYS was not present on the FPI list, the calculations were made directly using the 2024 CMS data (and 2023 CMS data if 2024 was unavailable). For hospitals outside of New York State with missing 2024 Medicaid data, calculations using 2023 CMS data were also used, given they were non-missing on all required fields. Classifications were assigned to all but two hospitals in New Jersey that were missing necessary financial information. *Table 1* shows the breakdown of hospitals by region and risk of closure. Over a third (93) of the hospitals in and around NYS were considered at risk of closure, meaning they receive 20% or more of their NPR from Medicaid and government appropriations. The majority (61) of those hospitals were considered high risk, with over a quarter of their NPR coming from Medicaid and government appropriations. There is a larger share of “high risk” hospitals in downstate⁺ (54.1%) than upstate (45.9%), but a higher proportion of upstate hospitals overall are considered at any level of risk. There were no hospitals in adjacent counties considered at high risk.

Table 1: Hospitals with Emergency Rooms in and Around NYS, by Risk of Closure

	All Areas	Downstate	Upstate	Other States
Total Hospitals	260	93 (35.8%)	102 (39.2%)	65 (25.0%)
Between 20% and 25% NPR from Medicaid (Potential Risk)	32	4 (12.5%)	20 (62.5%)	8 (25.0%)
> 25% NPR from Medicaid (High Risk)	61	33 (54.1%)	28 (45.9%)	0

⁺Note: For this tabulation, downstate includes counties of Rockland and Westchester and below, including Suffolk County (eastern Long

Analysis

The first goal of the analysis was to calculate the population living in emergency care deserts (ECDs). Living in an ECD is defined as residing beyond a certain distance from the nearest emergency room, with thresholds varying by geographic context to reflect differences in road

¹ Net patient revenue (NPR) from Medicaid and government appropriations divided by the total NPR.

network density and hospital concentration across the state. Research on healthcare deserts generally defines those living over 30 minutes away from a certain type of care such as primary, pediatric, or mental health care providers as being in a “desert” of that type of care (Nguyen et al., 2025). Though the conversion of miles to minutes of driving time varies by a number of factors including road type, driving speed, and type of transport (e.g. ambulance vs personal car), food access studies tend to use two classifications each for urban and rural areas to define low access to food stores: 0.5 miles or 1 mile away for those living in urban areas, and 10 miles or 20 miles for rural areas (United States Department of Agriculture, 2026). To determine the population living in ECDs, distance buffers for each hospital were generated, based off the healthcare and food desert precedent and according to what broad region they were located in. Though Long Island in its entirety (Nassau and Suffolk counties) is generally considered part of the “downstate” region, here they were split up due to differences in population density and road spread. Nassau County was considered more similar to Westchester and Rockland counties (adjacent suburbs of NYC) and the five New York City boroughs (Bronx, Brooklyn, Manhattan, Queens, and Staten Island), in a group denoted as downstate*. Rockland, Westchester, and Nassau counties each have a population density of over 1,800 people per square mile, while Suffolk, Orange and Putnam (adjacent to Rockland and Westchester) have population densities below that threshold (2020 Decennial Census), so this divergence was used as a basis for the split of buffer bins. Suffolk County, as well as all counties above Rockland and Westchester, is thus denoted as Upstate/Suffolk, and the radii around hospitals in this area were set to 15 miles (between the 10- and 20-mile threshold from USDA to account for variation in topology). Hospitals in Connecticut were considered a special case. Though the population density of the two CT planning regions that contain NY-bordering hospitals both fall within the “upstate” level of population density (under 1,800 people per square mile), when mapped, the 15 mile radial buffer appeared impractical because of the relatively small land area (e.g. buffers covered parts of Long Island, which would require boat travel to access and is unlikely in an emergency). Therefore, the distance radii around three of the hospitals located in the Western CT planning region were adjusted down to 10 miles. Though it would be possible to attempt to adjust the radii used by factors such as county-level rurality, this would require additional methodological research and would likely still result in loss of nuance (for example, “rural counties” can still contain urban areas) plus some methodological difficulties in the calculation of ECDs. For this study, however, these three classifications should be sufficient to generate a reasonable estimate of the current population in care deserts.

To locate the closest hospital for the population in NYS, centroids were generated for each block group in QGIS. The distances between each centroid and their three closest hospitals were calculated using an Origin-Destination Matrix and the results exported into an Excel workbook. It is important to note that since these estimates were calculated as straight-line measurements they do not account for practical or geographic barriers such as road conditions, traffic, or terrain. Though this is a limitation, it is likely to result in a more conservative estimate of travel time rather than an overestimation. This initial analysis was used to map the network of the three closest hospitals for block groups across the state (*Figure 1*) and to assess the impact of potential hospital closures. To determine the population in emergency care deserts, block group population data from the 2020 Census Redistricting File (PL 94-171) was obtained along with the 2020 block group boundary shapefile from Tigerline to map population by block group across New York State. Using the 2020 Census data assumes the population structure since the Census has

remained approximately the same. Though the components of population change (births, deaths, and migration) have shifted during these years in New York State, the state population remained similar to 2020, only declining about 1% between 2020 and 2025 (U.S. Census Bureau Vintage 2025 Population Estimates). The ECD buffer layer was intersected with the block group population layer to identify areas falling outside the appropriate hospital distance range (i.e. not covered by circles on the map). For block groups that were only partially within an ECD, the population was allocated proportionally based on the share of block group area located within the uncovered zone, using this formula:

$$BG_x \text{ Population in ECD} = \left(\frac{\text{area of } BG_x \text{ not covered by a buffer}}{\text{Area of } BG_x} \right) * \text{Population of } BG_x$$

This process was performed first for the current configuration of hospitals, then repeated as if the “high risk” hospitals had closed (> 25% NPR from Medicaid and govt. appropriations), then all “at-risk” (> 20% NPR from Medicaid and govt. appropriations). This approach is limited in that it assumes population is evenly distributed within each block group, which in reality is very rare. Additionally, these closure scenarios are simply estimation exercises, as it would be unlikely that either hospital risk group would close all at once. However, the results still illustrate the maximum damage that posited closures due to implemented Medicaid cuts could inflict on emergency care accessibility in New York State.

Current Hospital Accessibility

To estimate the impact of potential hospital closures due to Medicaid cuts on emergency care deserts, it is important to establish a baseline of hospital access in NYS. *Table 2* shows summary statistics of the three closest hospitals for block groups across the state. The distance from block groups to their closest hospital ranges from 0.01 miles to 47.2 miles, with a median of 2.8 miles. This is indicative of the regional variation we expect in a state like New York with large rural and mountainous swaths, as well as densely populated urban areas. The range of travel distances is large but widens further as hospital order increases, such that the travel distances from block groups to their 3rd closest hospital has a range of 47 miles. While the minimum of the distance range doesn’t change much across the three options, the maximum distance rises which likely reflects areas with few choices for hospitals. *Table 3* shows the median gap between the 1st and 2nd, and 1st and 3rd closest hospitals. Unsurprisingly, avoiding the closest hospital in upstate/Suffolk takes more miles on average than doing so downstate*.

Table 2: Distance from Block Groups to their Top 3 closest Hospitals, Summary Statistics

	Minimum Distance (mi)	Maximum Distance (mi)	Median Distance (mi)
1st Closest Hospital	0.01	41.1	1.6
2nd Closest Hospital	0.02	42.8	3.1
3rd Closest Hospital	0.09	47.2	4.1

Table 3: Median Distance Gaps Between the Closest hospitals for block groups, by area

	Median Difference between 1st and 2nd closest hospitals (mi)	Median Difference Between 1st and 3rd closest hospitals (mi)
New York State	-0.90	-1.87
Downstate*	-0.34	-0.68
Upstate/Suffolk	-1.12	-2.39

New York is a large and geographically diverse state, and therefore it is difficult to assess disparities based on summary statistics alone. *Figure 1* maps the population size by block group, overlayed by the three closest hospitals (in miles) to each block group centroid (the output from the Origin-Destination Matrix discussed previously). The first closest hospital is shown in red, second closest in blue, and third closest in yellow. If a hospital does not have any lines leading to it, then it is not a top 3 hospital for any block group in NYS. Five counties in the state have zero hospitals with emergency rooms: Tioga, Greene, Washington, Hamilton, and Seneca. While that does not necessarily mean people in these counties have the farthest distances to travel to an emergency room, the block groups with the top five longest distances to their closest hospital (*Table 4*) do fall within Hamilton County. However, the next five longest distances are in Warren, Herkimer, Oswego, and Essex counties- which all contain at least one hospital. Glens Falls Hospital appears in this list most often and has the longest measured distance as closest hospital to a block group (41.1 miles away).

Figure 1: Closest Three Hospitals by Block Group in New York State

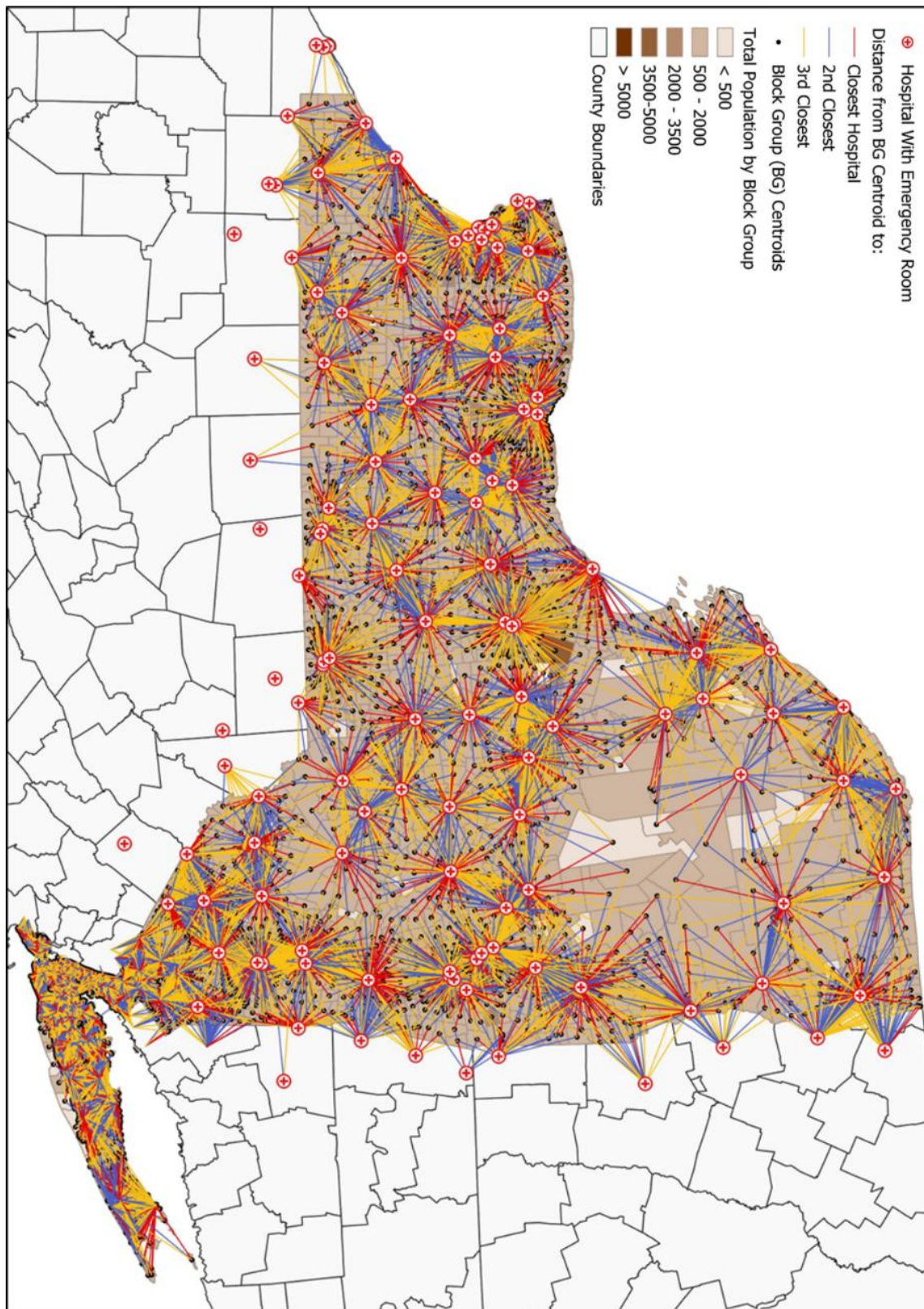
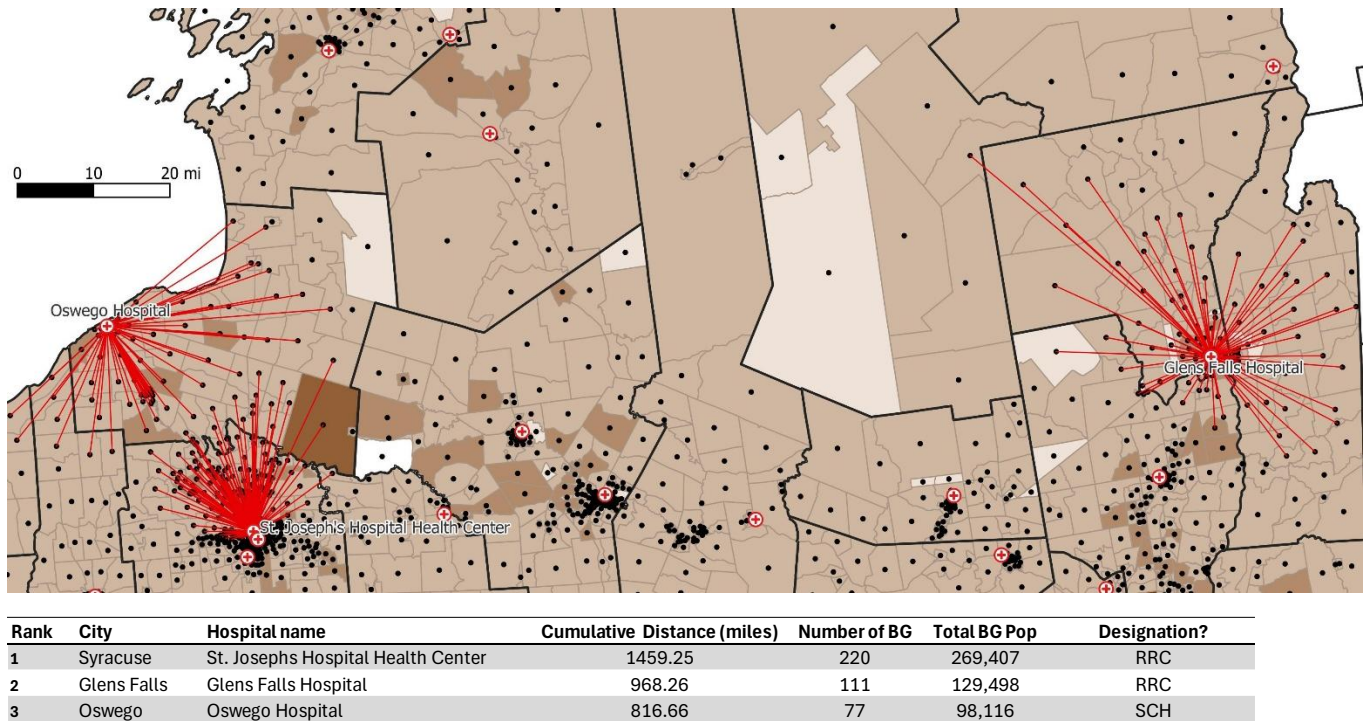


Table 4: Top 10 Farthest Distances between a Block Group and the Closest Hospital with an Emergency Room

Block Group	BG County	BG Population	Closest Hospital	Distance (mi)
360419503002	Hamilton	620	Glens Falls Hospital	41.1
360419503001	Hamilton	743	Adirondack Medical Center	38.2
360419505002	Hamilton	897	Nathan Littauer Hospital & Nursing Home	34.7
360419501002	Hamilton	355	Clifton-Fine Hospital	33.9
360419505001	Hamilton	384	Nathan Littauer Hospital & Nursing Home	33.5
361130740003	Warren	886	Glens Falls Hospital	33.4
360430115023	Herkimer	643	Lewis County General Hospital	30.5
360750201013	Oswego	805	Oswego Hospital	29.4
360319614001	Essex	773	Elizabethtown Community Hospital Moses Ludington	29.2
361130740002	Warren	648	Glens Falls Hospital	28.3

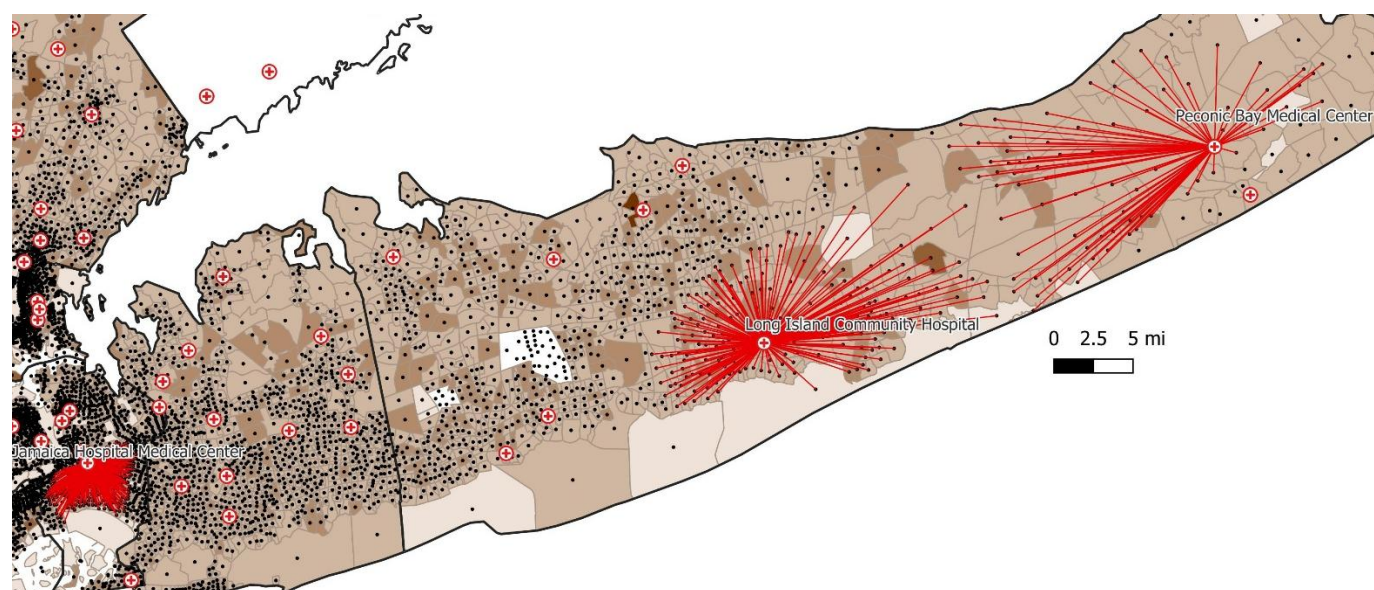
Figure 2: Top 3 Hospital "Hubs" Upstate (largest cumulative distance as closest hospital)



To explore the primary service area of hospitals, we measured the distance between block groups and their closest hospitals then found the total distance covered by hospital. Because of the geographic differences between upstate and downstate, we show the top 3 largest service areas in upstate in *Figure 2*, and the top 3 largest service areas in downstate in *Figure 3*. However, for ease of visualization Suffolk was considered part of downstate along with Nassau, though they are treated differently during the ECD analysis. In upstate, St. Josephs Hospital Health Center has the largest spanning service distance. Not only is it the closest hospital for block groups in the northern part of Onondaga County, but for Southeast Oswego County as well (and one block group in Madison County). The hospital with the second largest service span is Glens Falls, which has longer individual travel distances from block groups, but fewer block groups in the immediate service area than St. Josephs. Oswego hospital, the third largest service span, is

designated as a Sole Community Hospital (SCH) and is the closest option for most of Oswego County, the northern part of Cayuga County, and even eastern parts of Wayne. For 61% of the block groups in its primary service area, the distance away is over 10 miles. The picture of the largest service areas downstate is slightly different, but more similar than one might think. The top three are located on Long Island- two in Suffolk County and one in Nassau County. However, the reasons for their large cumulative distances differ. Long Island Community Hospital immediately serves approximately 290,818 people in 199 block groups, over a cumulative straight-line distance of 1,093 miles. Jamaica Hospital Medical Center in Nassau County serves almost double the population (506,397 people) but only about two-thirds of the distance (738.8 miles). The Peconic Medical Center service area covers 708 cumulative straight-line miles, but serves less than a third of the population that Long Island Community Hospital does (91,067 people), emphasizing that hospital accessibility can be nuanced in downstate as well as upstate.

Figure 3: Top 3 Hospital "Hubs" Downstate (largest cumulative distance as closest hospital)

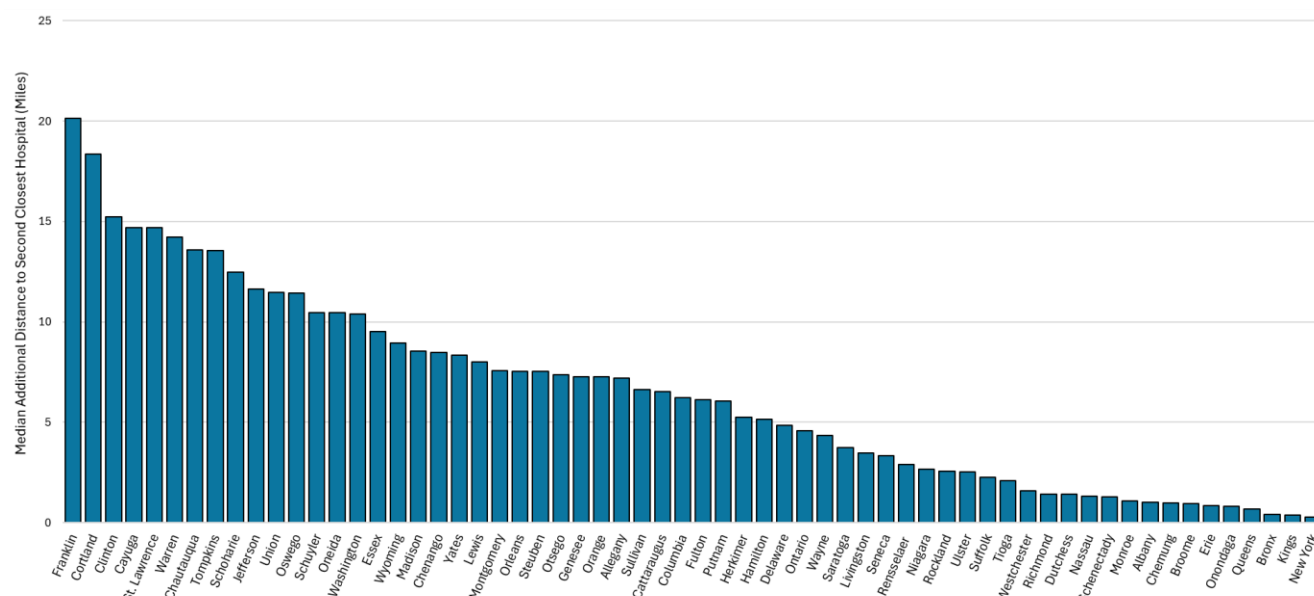


Rank	City	Hospital name	Cumulative Distance (miles)	Number of BG Closest for	Population Closest for	Classification?
1	Patchogue	Long Island Community Hospital	1093.36	199	290,818	None
2	Jamaica	Jamaica Hospital Medical Center	738.75	360	506,397	Rural Referral Center*
3	Riverhead	Peconic Bay Medical Center	708.10	76	91,067	None

Distance to the closest hospital is a key indicator of hospital access, but it does not necessarily tell us who is most vulnerable to loss of access due to a closure. In many areas, people may have choices of where to go for emergency care while in others one hospital can be the closest and only reasonable option. Areas with large gaps in travel distance between the first and second closest hospitals may therefore be at increased risk of becoming emergency care deserts. *Figure 4* shows the median difference between the first and second closest hospital for block groups within each county, ranked from largest to smallest. Franklin, Cortland, and Clinton counties have the largest median travel gaps, all over 15 miles. This means that if the closest hospital for

block groups in these counties were to close, people would have to travel over 15 miles farther than they do now to get to a hospital for emergency care. While most of the counties with the top 10 largest gaps are in the bottom half of NYS counties in terms of population (U.S. Census Bureau Vintage 2025 Population Estimates), some metropolitan and micropolitan counties are also highly vulnerable. Some mid-sized cities such as Jamestown, Ithaca, and Cortland, whose counties are in the top 10, only have one hospital- so in the case of a closure a sizeable number of block groups would have to travel longer distances. Unsurprisingly, four of NYC’s boroughs have the four smallest distance gaps. Staten Island (Richmond County) is the exception however, with 1.4 additional miles to the next closest hospital on average.

Figure 4: Median Additional Miles to the Second Closest Hospital, Ranked by County



Hospital closures in areas with already low access to care, such as the previous example of single hospitals serving a city and its surrounding areas, can be incredibly detrimental to populations. To illustrate the precariousness of hospital accessibility under the potential impacts of hospital closures, for each hospital the average additional distance to the next closest option was calculated and weighted by block group population size. The hospitals with the top 10 largest distance gaps by population immediately served, CMS designation, and closure risk (using the FPI definitions) are shown in *Table 5*. Unsurprisingly, each of these hospitals is in one of the top 10 most geographically vulnerable counties, shown in *Figure 4*. People whose closest hospital is Alice Hyde Medical Center, located in Franklin County, would have the farthest to go on average if it were to close (18.7 miles). Oswego hospital has the second farthest travel gap at 16.7 miles, and it is the closest option for approximately 98,116 people. Both hospitals are “at risk” according to the FPI definitions, with over 20% of their net patient revenue coming from Medicaid and government appropriations. Because of their special designations (CAH and SCH) it would be difficult to close completely without intense regulatory scrutiny, but loss of certain services or conversion to Rural Emergency Hospital (REH) are also possibilities in the face of

funding issues. These options would allow populations to maintain a minimum level of emergency care but could still cut access to certain types of care or inpatient services.

Table 5: New York State's Most Geographically Vulnerable Hospitals

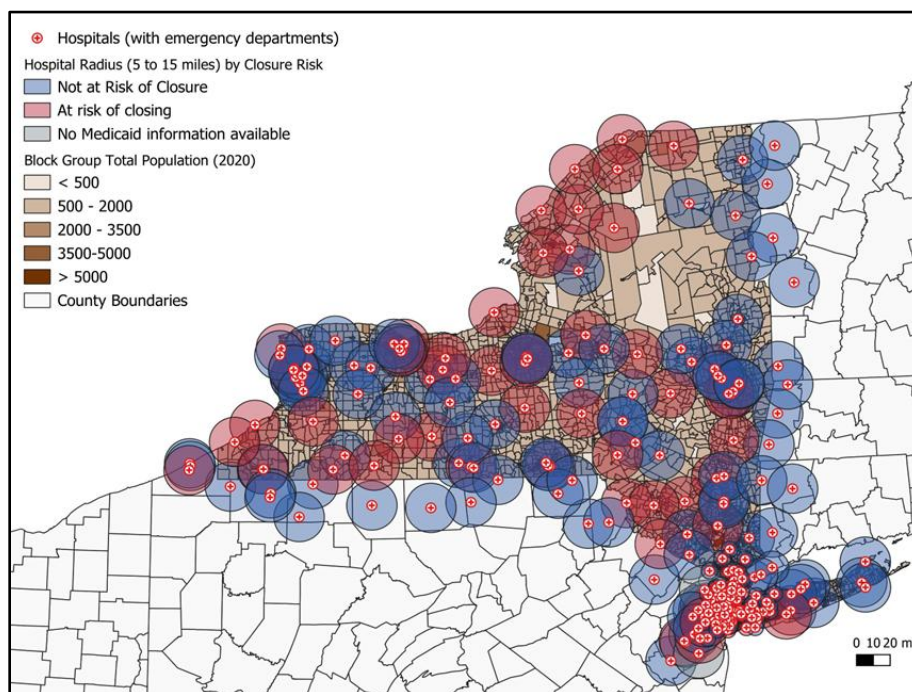
Hospitals	County	Population Hospital is Closest for	Average* Additional Distance to Next Closest Hospital (miles)	"At risk" of closure?	Designation?
Alice Hyde Medical Center	Franklin	33,696	18.7	Yes	CAH
Oswego Hospital	Oswego	98,116	16.7	Yes	SCH
Claxton Hepburn Medical Center	St. Lawrence	21,925	15.4	Yes	CAH/SCH
Clifton-Fine Hospital	St. Lawrence	17,158	14.8	Yes	REH
Adirondack Medical Center	Franklin	25,055	14.4	No	SCH/RRC
Champlain Valley Physicians Hospital	Clinton	74,344	13.9	No	SCH/RRC
Guthrie Cortland Medical Center	Cortland	65,670	12.4	Yes	SCH
Auburn Community Hospital	Cayuga	80,788	12.1	Yes	SCH
Glens Falls Hospital	Warren	129,498	11.6	No	RRC
Cayuga Medical Center at Ithaca	Tompkins	106,308	11.4	No	SCH

Bolded = "most" at risk of closure; over 25% net patient revenue (NPR) from Medicaid and government appropriations

Emergency Care Deserts in NYS

The most prominent disparities in hospital distance only scratch the surface of accessibility issues. By visualizing and measuring the population in emergency care deserts, we can better assess current and prospective gaps in emergency care. *Figure 5* illustrates the prevalence of emergency care deserts across the state under the current configuration of hospitals. The distance buffers around each hospital were adjusted to correspond with the appropriate region type (downstate*, upstate/Suffolk, and Connecticut). Areas of the state not covered by a colored buffer are considered living in an emergency care desert.

Figure 5: Emergency Care Deserts in New York State



While ECDs are prominent in more isolated and rural areas like the North Country, they appear in all 10 of the state’s economic development regions including NYC- though in the current hospital landscape they only appear within the boroughs of Staten Island and Queens. *Figure 6* zooms in to the locations of ECDs throughout downstate*. Though the gaps in Staten Island, Queens, and Nassau Counties are smaller than those across upstate and Suffolk County, because of the high population density the ECD population is not as negligible as it appears based on visuals alone. From the calculated intersections of block groups and the hospital buffers, an estimated 389,455 people (1.9%) live in emergency care deserts across New York State (*Table 6*). The upstate/Suffolk area contains 92% of the population in ECDs (389,455 people), while downstate* contains the remaining 8% (31,979 people). The current network of hospitals is already delicate, and closures or conversions have the potential to intensify the ECD problem in NYS.

Figure 6: Emergency Care Deserts Downstate*

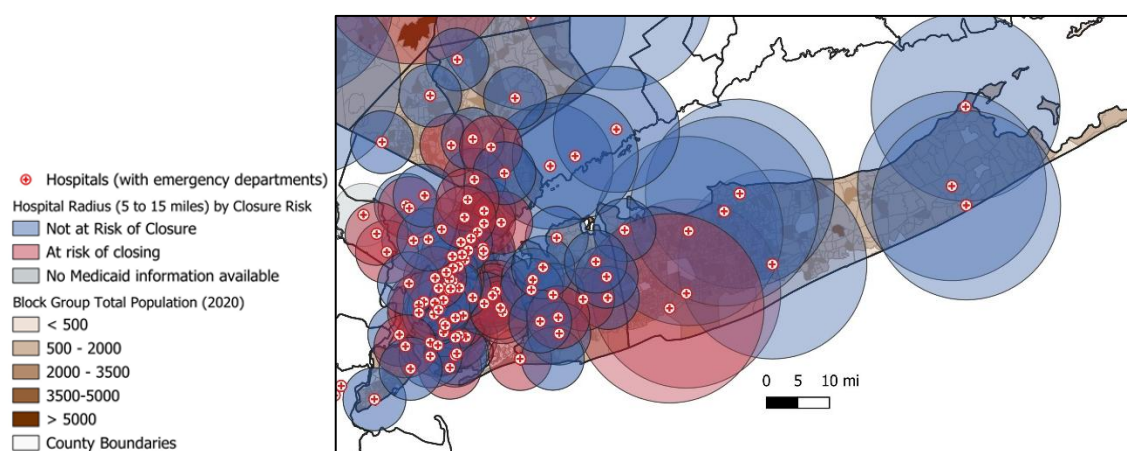


Table 6: Population⁺ in Emergency Care Deserts, by region

Region	Total Population	ECD Population	Share in ECDs
New York State	20,201,249	389,455	1.90%
Downstate*	11,542,750	31,979	0.30%
Upstate/Suffolk	8,658,499	357,476	4.10%

⁺Population figures calculated using 2020 Census Redistricting File

Impact of Closures

The final part of analysis examines the impact of potential hospital closures due to Medicaid cuts on the population in ECDs. There are infinite configurations in which hospitals “at risk” could close, but this analysis considers two “worst-case” scenarios to illustrate the maximum possible impacts. The first scenario estimates the ECD population if all “high risk” (> 25% NPR) hospitals were to close, and the second if all “at risk” (> 20% NPR) were to close. If all “at risk” hospitals were to close, large swaths across New York State would be over 15 miles (5 miles for

downstate*) from a hospital (*Figure 7*). Compared with *Figure 5*, the population in emergency care deserts is substantially larger, and spans block groups of all population sizes.

Figure 7: Emergency Care Deserts if All "At Risk" Hospitals (>20% NPR from Medicaid and govt. Appropriations) were to Close

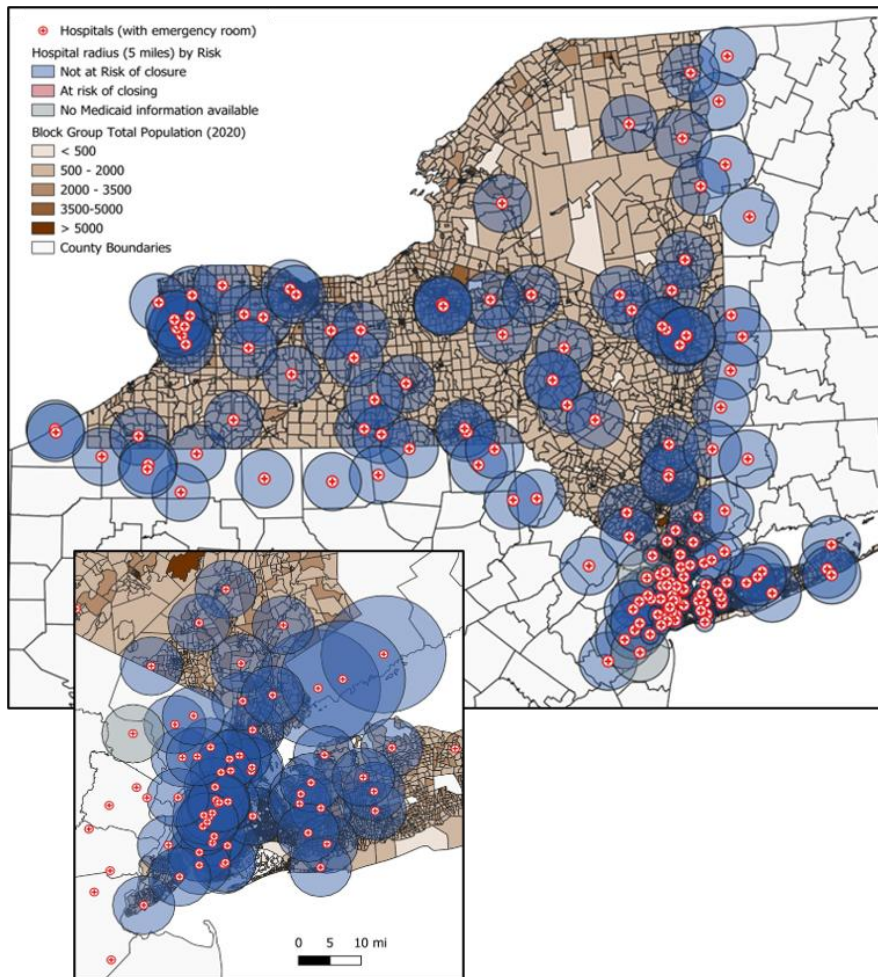
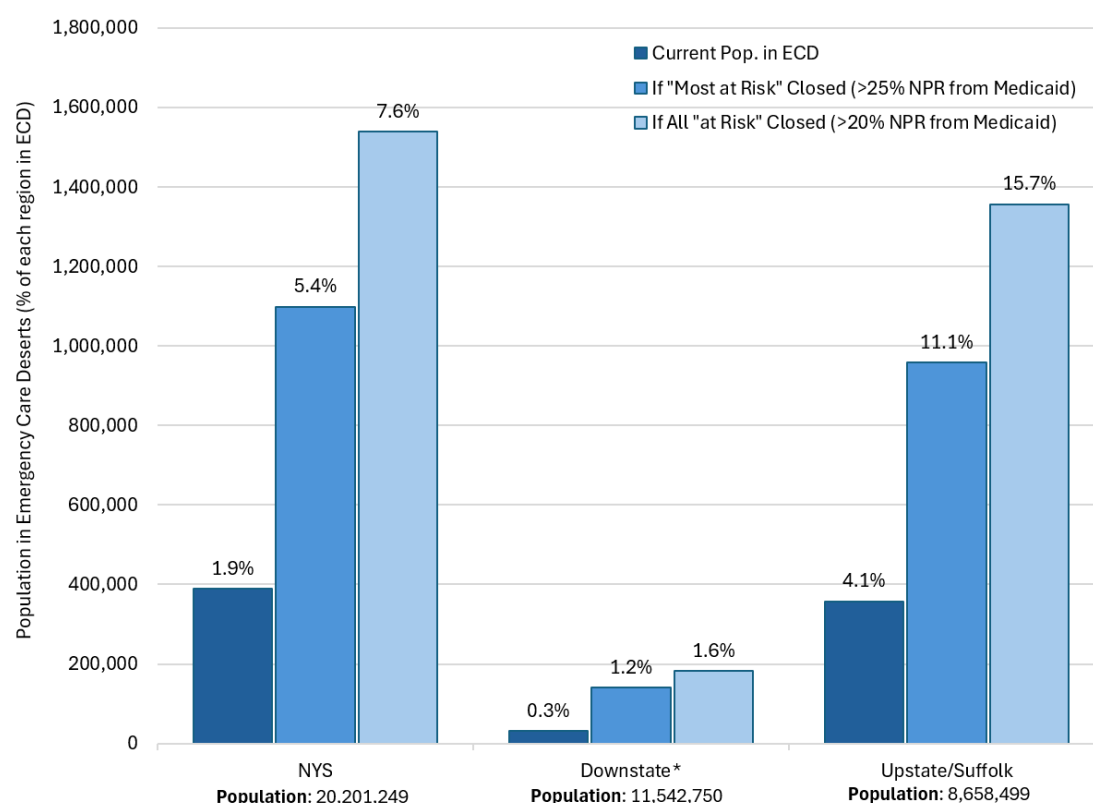


Figure 8 quantifies the current population in ECDs under each of the two closure scenarios. Approximately 2% of the population in New York State (389,455) resides in an ECD under the current configuration of hospitals, but if all “high risk” hospitals were to close, the ECD population in New York State would nearly triple (1.1 million people). If all “at risk” hospitals closed, the population in ECDs would almost quadruple (1.5 million). While downstate* is over half of the state’s population (11.5 million), it makes up only 8% (31,979) of the state’s Emergency Care Desert (ECD) population. Approximately 0.3% of the downstate* population is currently in ECDs, and this would grow to 1.2% if the “most at risk” hospitals were to close (139,992 people). Under the most severe closure scenario if all “at risk” were to close, this share would rise only slightly to 1.6% (182,671 people). However, Emergency Care Deserts disproportionately impact upstate/Suffolk and would continue to do so under both closure scenarios. An estimated 4.1% of the population in upstate/Suffolk lives in ECDs, and this would rise to 11.1% if the “most at risk” hospitals were to close- impacting nearly one million people.

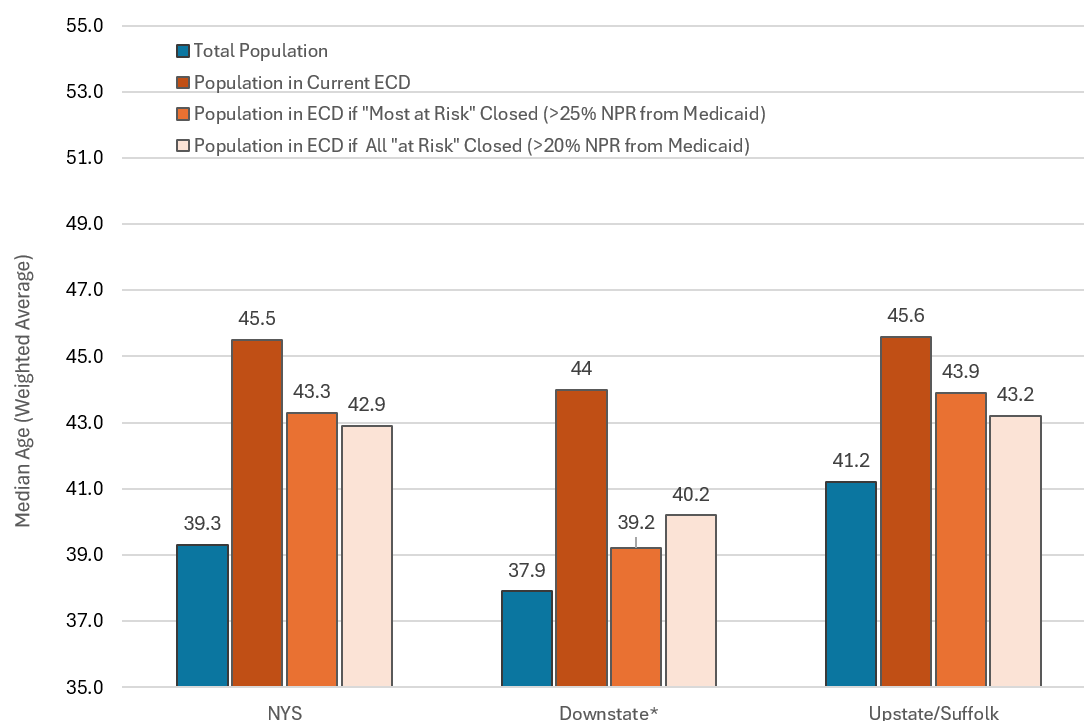
If all hospitals “at risk” were to close, almost 1.4 million people in upstate/Suffolk would be living in ECDs. This demonstrates that the ECD population in NYS is heavily driven by the ECD population in upstate/Suffolk.

Figure 8: Population in ECDs by Region and Closure Scenario



To further examine the impact of the two closures scenarios on the population in ECDs, the weighted average of median age across all block groups by population size was calculated for the total population, current ECD population, and ECD population in each closure scenario. The results of this analysis for each region are shown in *Figure 9*. In New York State, the median age of the current population in emergency care deserts tends to be older (45.5) than the total population (39.3). If the “most at risk” hospitals were to close, the age of the population impacted by ECDs would become younger (43.3), and slightly younger still if all “at risk” hospitals were to close (42.9). In both regions, the population in ECDs is older than the total population, but the impacts of the two closure scenarios vary slightly. The total population in Upstate/Suffolk skews older (41.2) than the downstate* region (37.9). The population living in ECDs in both regions tend to be older than the total population, with upstate/Suffolk (45.6) still skewing slightly older than downstate* (44.0). If the “most at risk” hospitals were to close, the population in ECDs for both regions would become younger, more so in downstate* (39.2) than upstate/Suffolk (43.9). If all “at risk” hospitals were to close however, the age of those impacted by ECDs would continue falling in upstate/Suffolk (43.2) but rise slightly in downstate* (40.2).

Figure 9: Median Age of the ECD Population by Region and Closure Scenario



Conclusions

With the passage of PL 119-21, discussions have arisen over the possible immediate and future impacts on hospital funding and operations. While organizations have posited which hospitals may close, the impact of those hypotheses is often left open-ended. There are existing disparities in emergency care access across the state, which hospital closures have the capacity to deepen. Within New York State, people in Franklin, Cortland, and Clinton counties would have the most additional distance to travel on average if their closest hospital were to close (over 15 miles further). Half of the top 10 counties most geographically vulnerable in the case of a closure were in the North Country, where people already tend to be farther away from hospitals. Unsurprisingly, upstate/Suffolk was found to be disproportionately impacted by emergency care deserts with 92% of the emergency care desert population located in those areas. If all “at risk” hospitals (under the FPI definitions) were to close, over 1.5 million people could live in emergency care deserts, with 88% of the affected population living in upstate/Suffolk. However, ECDs could be an escalating problem for both regions, with downstate* growing from 0.8% of the ECD population to 12% if all “at risk” hospitals were to close. As the scenarios closed more hospitals, the estimated population living in ECDs skewed younger. This analysis was a first step to quantifying emergency care deserts in the state and assessing the potential impacts of hospital closures.

The estimates produced here are estimates and therefore contain sources of error, and a multitude of possible adjustments that could be made depending on your focus. This analysis focused on the entire state and therefore did not attempt to customize the distance thresholds for each urban

area (as there are more than just NYC). Additionally, the straight-line distance could be adjusted with driving factors as some have done (Nguyen & Chase, 2025) or could be conducted as a road network analysis where factors such as driving speed, road direction, and terrain could be considered. As previously mentioned, hospital closures are based on numerous factors and are unlikely to occur as a sweeping list. Future work could examine the impacts of specific hospital or hospital network closures, or conversion of “at risk” hospitals to REHs. Other types of care are also vital to maintaining quality of life and community health, for example labor and delivery and treatments such as dialysis for chronic illness, which should be considered by future research examining the impacts of hospital closures.

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