PROTECTING RURAL PATIENTS AND COMMUNITIES: ACCESS TO CARE AND HOSPITAL CONSOLIDATION IN THE NORTH COUNTRY

EXECUTIVE SUMMARY

Hospitals are extremely important to the health and economy of the rural North Country region of New York state, but hospitals have reduced essential healthcare services over the last decade. To protect quality patient care, hospitals across the North Country must preserve services and maintain access to care as they face threats from impending Medicaid cuts and hospital consolidation around regional healthcare systems like the University of Vermont Health Network. Hospitals must prioritize access to care over income and preserve a baseline level of care when evaluating the need for services like pediatric, trauma, maternal, and mental healthcare.

Financial incentives and lax oversight over hospital bed closures have propelled those closures and reduced access to care over the last decade. Between 2013 and 2024:

- Half of the region's hospitals are now considered "Critical Access," earning a higher Medicare reimbursement rate for services, but also meaning the loss of 226 beds.
- Nearly half of pediatric hospital beds have been lost—by far the largest reduction in capacity in the state. Over half of children under age 18 live more than an hour away from a hospital with inpatient pediatric beds.
- There are no Level I or II Trauma Centers in the North Country—the closest options are often hours away. Emergency rooms in the region that can triage and transfer patients are often overcrowded and underequipped, forcing them to divert patients, increasing time to treatment and risk to patients. This is likely to be exacerbated by impending Medicaid cuts.
- North County hospitals reduced maternal health beds by 13% – three hospitals reduced beds and four completely closed maternity units. This increases the emotional and financial burden on families, since hospitals in the region are so far apart. Pregnant

patients now travel farther to give birth – increasing the strain on hospitals that haven't expanded maternity capacity or are outside the region.

- The North County is one of the few regions in New York that has expanded much-needed mental health services, adding 10 beds overall. More recently, with the help of New York State grant funding, Claxton Hepburn Hospital has transformed into a 40-bed adult and child inpatient mental health facility, with plans to expand psychiatric services even more.

The North Country stands to lose even more services as more New Yorkers lose health coverage due to the One Big Beautiful Bill Act, ramping up costs for hospitals. New York needs to do more to protect hospitals and patients from these cuts, as well as increase transparency during the closure process and provide sufficient financial incentives for hospitals to fully staff and operate services that would otherwise be at risk of closure.

OVERVIEW

New York's North Country, referred to here as Clinton, Franklin, Lewis, Jefferson, Essex, Hamilton and St. Lawrence Counties, is the largest region in the state by geography. It covers 11,420 square miles, and more than 200 towns and villages. The region's population is older, less diverse and lower-income than the state at large. In 2024, the median household income was $59,537[1], lower than the statewide number that year[2]. Hospitals are three of the top eight employers in the North Country[3], meaning that local health systems have a major impact not just on population health, but the economy as well[4].

Despite their outsize role in the local economy and job market, hospitals in the North Country have continuously reduced services and hospital beds, making it harder to access necessary healthcare. Many of these reductions occurred when hospitals moved to Critical Access status, affording higher reimbursements from Medicare but requiring a capacity of 25 inpatient beds or fewer.

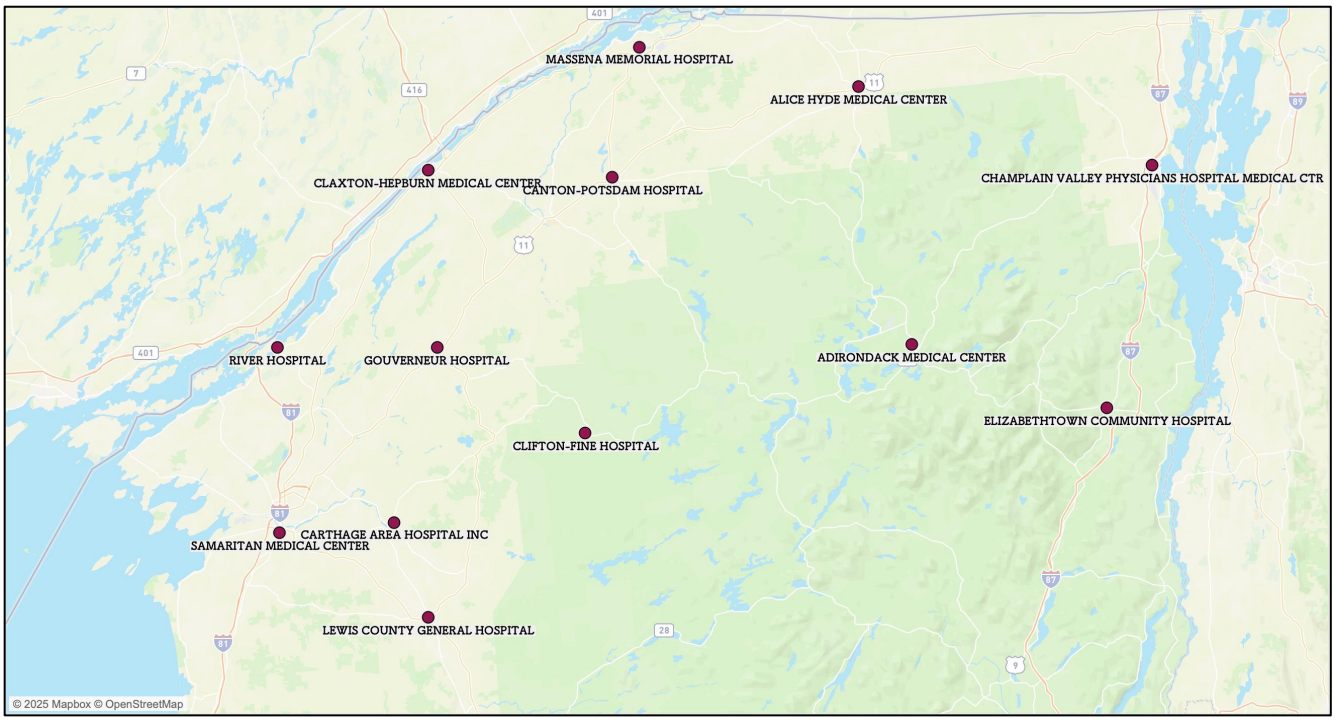
While the stated intention of these conversions is to maintain the availability of hospital care, a lack of comprehensive oversight and regulation by the state has allowed 12 hospitals to convert to Critical Access Status between 2013 and 2024[5]. Critical Access does provide added financial benefits for hospitals but requires them to size down to 25 beds or fewer. The total bed loss

[1] https://regionalcouncils.ny.gov/sites/default/files/2025-11/NCREDC%20Annual%20Report%202025.pdf pg. 6
[2] https://fred.stlouisfed.org/series/MEHOINUSNYA672N
[3] https://regionalcouncils.ny.gov/sites/default/files/2025-11/NCREDC%20Annual%20Report%202025.pdf pg. 5
[4] https://regionalcouncils.ny.gov/sites/default/files/2024-11/2024%20Annual%20Report%20Final.pdf pg. 2
[5] https://health.data.ny.gov/Health/Certificate-of-Need-Applications-Beginning-1974/h343-jwie/about_data

from these conversions in the North Country was 226 beds, including maternity, pediatrics, coronary care, and medical-surgical beds[6].

The financial viability of the North Country's healthcare system cannot rely on hospitals reducing their capacity so dramatically that entire service lines risk going extinct. Large hospital systems like the University of Vermont Health Network and Rochester Regional Health (which owns the St. Lawrence Health System) must fulfill their role of providing essential healthcare services. Reducing hospital capacity to the minimum amount necessary to meet occupancy levels leaves the region unprepared for another pandemic requiring mass hospitalizations[7], or other potential emergencies with mass injuries.

This paper will focus on four areas of hospital care—pediatric, trauma, maternal, and behavioral care—where access must be improved for those living in the North Country. Each section will provide an assessment of the currently available access to these services, specific challenges facing each service, and the ways that North Country residents can benefit from increased access.



Map: North Country Hospitals

[6] NYSE CON 231171, 212164, 191331, 191208, 231286
[7] https://citylimits.org/decades-of-shrinking-hospital-capacity-spelled-disaster-for-new-yorks-covid-response/

PEDIATRICS

Pediatric care in the North Country is among the most common bed types taken out of service when hospitals begin reducing capacity. Over 56% of the region's children live more than an hour from a hospital with pediatric hospital care, forcing pediatric patients to travel long distances for care or to seek care in adult units which are not designed for children's safety. Cuts to Medicaid, which covers almost half of pediatric patients, threaten to make the situation even worse.

BED CHANGES: 2013 -2023

The total number of certified pediatric beds statewide (which does not include Pediatric ICU beds) decreased in New York from 2,578 in 2013 to 2,432 in 2023 (-5.7%)[8]. The North Country had the highest drop in beds, losing almost half of its pediatric inpatient capacity. The North Country lost 43.9% of its certified inpatient pediatric beds between 2013 and 2023, according to cost reports submitted by the hospitals (Figure 1). This number doesn't include the fact that both Champlain Valley Physicians Hospital (CVPH) and Adirondack Medical Center have certified pediatric beds still listed among their available services on the New York Department of Health (DOH) website[10,11]. But neither hospital reported those beds as part of their certified bed capacity in their annual cost reports[12].

Hospital-Reported Certified Pediatric Beds, 2013 – 2023[9]

	2013	2023
Adirondack Medical Center		
Canton-Potsdam Hospital		
Carthage Area Hospital	4	3
Claxton-Hepburn Medical Center		
Champlain Valley Physicians Hospital		
Clifton-Fine Hospital		
Gouverneur Hospital	3	
Lewis County General Hospital		
River Hospital		
Samaritan Medical Center	34	20
Grand Total	41	23

Figure 1

Carthage Area Hospital counted certified pediatric beds in its Institutional Cost Report but is not currently operating pediatric beds[13]. That further reduces the number of hospitals providing inpatient pediatric services to one hospital, Samaritan Medical Center, with 20

[8] Institutional Cost Reports, 2013-2023
[9] Institutional Cost Reports, 2013-2023
[10] https://profiles.health.ny.gov/hospital/view/103048
[11] https://profiles.health.ny.gov/hospital/view/102949
[12] Champlain Valley Physicians Hospital Institutional Cost Report 2013, Champlain Valley Physicians Hospital Institutional Cost Report 2023, Adirondack Medical Center Institutional Cost Report 2013, Adirondack Medical Center Institutional Cost Report 2023
[13] Reported by NYSNA nurses at Carthage Area Hospital

certified beds. However, Samaritan is located at the very Western edge of the region, leaving much of the seven counties without easy access to a pediatric unit.

At the moment, 48,789 children under age 18 in the North Country live over an hour away from a New York hospital providing inpatient pediatric beds. This makes up 56% of the region's 86,158 children (Figure 2). 13,281 children under 18, or 15.4% of North Country children, live over two hours away from an inpatient pediatric unit[14].

NYSNA nurses report instances where pediatric patients show up in adult units when there are no beds for patients their age. This is inappropriate at best and dangerous at worst for these patients and clearly demonstrates a need for North Country hospitals to increase pediatric inpatient capacity.

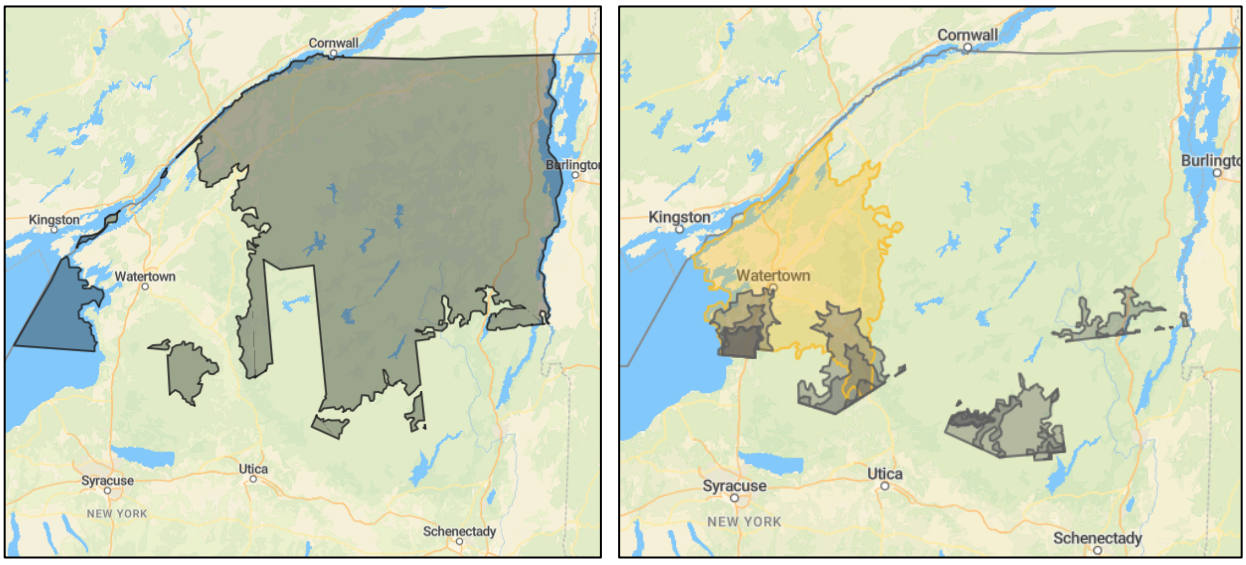


Figure 2: Left - Areas of the North Country over a 1-hour drive away from inpatient pediatric beds in New York.

Right - shaded areas represent areas in the North Country within a 1-hour drive of inpatient pediatric beds. Samaritan Medical Center is represented in yellow, and grey areas represent hospitals located outside the region.

RURAL CONSIDERATIONS FOR PEDIATRIC CARE

Children needing hospital care are not always able to access it locally. While there is a decline in overall pediatric hospitalizations nationally, the decline is steeper for children residing in rural areas. As few as 1 in 5 children residing in rural counties are hospitalized close to home, and an increasing share are hospitalized in metropolitan areas. In New York specifically, the median

[14] 2023 ACS 5-year estimates, via smappen.com

distance traveled by rural children (in miles) for hospitalization increased from 12.7 in 2017 to 35.8 in 2022.[15]

There are several theories that might explain the drop in pediatric hospitalizations at rural hospitals. A national decline in pediatric hospitalizations might have been more dramatic in rural areas, which experienced a population decrease between 2010 and 2020. Medicare's "two-midnight rule", which limits reimbursement at the higher inpatient rate to stays lasting more than two midnights, may have adversely affected hospital inpatient pediatric revenue, since the average pediatric length of stay is 1.9 days, and pediatrics is a Medicaid-heavy patient population. Finally, the drop in hospitalizations for vaccine-preventable illnesses, theorized to be a possible explanation for a decline in pediatric hospitalizations in the last decade[16]. That drop, though, maybe be threatened by recent federal vaccine policy is increasingly inconsistent and rates of childhood and adult vaccinations on the decline[17].

As mentioned above, many pediatric patients, particularly in rural areas, are also covered by Medicaid (Figure 3). This leaves them not only more vulnerable to the financial burden of traveling long distances for care, but also to the recent federal funding cuts.

Payor Mix, inpatients aged 0-17, North Country Hospitals, 2023[18]					
	Blue Cross/ Blue Shield	Federal/State/ Local/VA	Medicaid	Private Health Insurance	Self-Pay
Adirondack Medical Center-Saranac Lake Site	50%	0%	30%	10%	10%
Canton-Potsdam Hospital	38%	0%	52%	6%	4%
Carthage Area Hospital Inc	25%	13%	63%	0%	0%
Claxton-Hepburn Medical Center	15%	0%	19%	67%	0%
Lewis County General Hospital	0%	0%	100%	0%	0%
Samaritan Medical Center	10%	27%	39%	11%	14%
The University of Vermont Health Network - Alice Hyde Medical Center	29%	0%	71%	0%	0%
The University of Vermont Health Network - Champlain Valley Physicians Hospital	22%	1%	67%	8%	2%
North Country Average	19%	10%	47%	18%	6%

Figure 3

Meanwhile, the University of Vermont Medical Center (UVM) will be expanding its pediatric care offerings, but in Vermont—a ferry ride away for New Yorkers[19]. The UVM system should consider how it can bring pediatric beds back over the border, where they would be more accessible for

[15] https://pubmed.ncbi.nlm.nih.gov/39111620/ pg. 8
[16] https://pubmed.ncbi.nlm.nih.gov/39111620/ pg. 2-3
[17] https://www.kff.org/medicaid/kindergarten-routine-vaccination-rates-continue-to-decline/
[18] https://health.data.ny.gov/Health/Hospital-Inpatient-Discharges-SPARCS-De-Identified/46xm-urtu/about_data
[19] https://vtdigger.org/2025/10/28/uvm-healths-childrens-hospital-receives-25-million-donation/

those struggling with the time, money and transportation, and where they could relieve the pressure on the few providers of pediatric care that remain.

TRAUMA

Deaths from trauma, the leading cause of mortality among adults aged 19 to 44, can be extremely dependent on how long it takes a patient to access care. Cuts to Medicaid will weaken an already fragile network of trauma care in the North Country, where emergency rooms are understaffed, and hospitals providing the highest levels of trauma care are located outside of the region. Hospitals must do their part to ensure that they have the staff and equipment necessary to care for the patients they receive.

THE NEED FOR TRAUMA CARE

Trauma is the leading cause of death among adults aged 19 to 44[20]. Most deaths from traumatic injuries happen in the early hours after injury, and receiving even basic first aid during that time can be crucial for saving lives.

Level 1 Trauma Centers are shown to reduce mortality by as much as 25%. Higher numbers of experienced nurses, as well as on-duty specialists may contribute to this reduced mortality rate and also provide a community benefit outside of trauma care for patients with unique needs[21]. Level 1 Trauma Centers do not operate alone, and implementing effective pre-hospital systems may also improve outcomes for patients who are at risk of mortality within the first four hours after injury[22]. Planning and executing an effective system of pre-hospital trauma care is an essential consideration given the financial challenges of operating a Level 1 trauma center, which are likely to be exacerbated by recent federal funding cuts.

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20 https://pmc.ncbi.nlm.nih.gov/articles/PMC8627499/#:~:text=For%20Americans%20aged%2019%20to%2044%20years%2C%20unintentional%20injuries%20and%20homicide%20were%20collectively%20responsible%20for%20more%20than%2050%25%20of%20deaths%20in%202010%E2%80%932019

21 https://pmc.ncbi.nlm.nih.gov/articles/PMC4307735/#:~:text=The%20authors,center,-%2E

22 https://pmc.ncbi.nlm.nih.gov/articles/PMC11749964/#:~:text=Good%20prehospital%20care%20systems%20may%20improve%20outcomes%20among%20trauma%20patients%20who%20are%20at%20risk%20of%20early%20mortality%20within%20the%20second%20mortality%20peak

Trauma readiness can cost between $6 million and $10 million annually for Level I Trauma Centers[23], a sharp increase from the $2.7 million estimate in 2004[24]. Trauma care is also expensive, for both providers and patients. In 2023, the average cost per trauma discharge in New York was $39,943.97, an 82% increase from the average cost in 2013. On average, hospitals charged trauma patients 4 times the cost of care in 2023, compared to 3.4 times as much in 2013[25].

The implementation of Medicaid cuts poses a risk to the financial viability of expanding Trauma care. Uninsurance is associated with higher trauma mortality rates when compared to having private insurance[26], and has a significant impact on the recovery process after injury. Access to rehabilitation services, which increased after the ACA and subsequent Medicaid expansion, affects a patient's likelihood of returning to work after hospitalization and lessening the financial burden of their stay[27]. At the moment, both the average fatality rate and mortality rate for trauma deaths were lower in Northeastern New York (which includes parts of the Capital Region) than most other regions between 2016 and 2020[28]. It should not be allowed to slip behind its current status.

Research conducted before the implementation of the Affordable Care Act found that uninsured patients posed a financial risk for the future of trauma care in hospitals[29]. At the time of data collection, in 2009, the percent of New Yorkers without health insurance was 11.4%. By 2018 that number dropped to 5.4%[30]. With the passage of the OBBA, New York could return to pre-ACA levels of uninsured[31], which would only make it more difficult to expand access to vital trauma services.

Given its high population of residents insured through Medicaid, the North Country is at risk of losing access to existing trauma services if the status quo remains. The state must act to ensure not only that there are measures in place to prevent a loss of coverage, but also that the region's health systems assume responsibility for ensuring patients can continue to access vital services. Higher rates of uninsured won't just contribute to disparities in access to care, but also in outcomes.

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[23] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800724#:~:text=Previous%20work%20by%20Ashley%20et%20al2%20estimated%20the%20mean%20cost%20of%20trauma%20readiness%20as%20%246%20million%20to%20%2410%20million%20annually%20among%20level%20I%20trauma%20centers

[24] https://pmc.ncbi.nlm.nih.gov/articles/PMC4307735/#:~:text=Although%20effective%2C%20the%20resources%20available%20at%20a%20trauma%20center%20can%20be%20costly%2E%20In%20one%20study%2C%20the%20cost%20of%20trauma%20center%20readiness%20%28excluding%20trauma%20care%20costs%29%20was%20%242%2E7%20million%20annually

[25] SPARCS de-identified inpatient discharges, 2013, 2018, 2023

[26] https://pmc.ncbi.nlm.nih.gov/articles/PMC3641534/#S18:~:text=evidence%20that-,disparities,group

[27] https://pmc.ncbi.nlm.nih.gov/articles/PMC8627499/#S15:~:text=Overall%2C%20this,mortality

[28] https://www.health.ny.gov/professionals/ems/state_trauma/docs/2016-2020_trauma_report.pdf pg. 17

[29] https://pmc.ncbi.nlm.nih.gov/articles/PMC4307735/#:~:text=The%20future%20viability%20of%20trauma%20centers%20is%20vulnerable%20to%20the%20escalating%20cost%20of%20care%20provided%20to%20uninsured%20patients%2E

[30] https://www.empirecenter.org/wp-content/uploads/2019/09/Census-uninsured-2018.png

[31] https://fiscalpolicy.org/wp-content/uploads/2025/06/2025.06.30-NY-Individual-Market-under-OBBBA.pdf pg. 5-6

TRAUMA CARE IN THE NORTH COUNTRY

North Country Hospitals, by Level 1 Trauma Center System[32,33]	
Albany Medical Center	**Upstate University Hospital**
Adirondack Medical Center	Canton Potsdam
Alice Hyde Medical Center	Carthage Area Hospital
Champlain Valley Physicians Hospital	Claxton-Hepburn Medical Center
	Clifton-Fine Hospital
	Gouverneur Hospital
	Lewis County General Hospital
	Massena Memorial Hospital
	River Hospital
	Samaritan Medical Center

Figure 4

New York's trauma care is divided into regional systems, which center around a Level I Trauma Center (Figure 4), a national designation requiring the facility to have trained specialists and corresponding equipment available 24/7 to handle the most serious trauma cases[34]. While this does not mean hospitals must exclusively transfer patients within those systems, they provide a level of organization to triage and transfer patients appropriately. North Country hospitals are divided among two regional trauma systems, with Upstate University Hospital in Syracuse, NY, and Albany Medical Center in Albany, NY, as the Level I Trauma Centers. Neither Albany Medical Center nor Upstate University Hospital are located in the North Country.

Statewide, trauma visits to hospitals have kept a relatively steady pace, with a 1% increase in cases between 2021 and 2024. Individual hospitals, however, have had more dramatic fluctuations—Albany Medical Center had 28% (n=1,249) fewer trauma cases in 2024 compared to 2021, while Upstate University Hospital had an increase of 7% (n=250). Among the North Country's Level 3 trauma centers, Canton-Potsdam had 14% (n=42) fewer cases in 2024, and CVPH had a 27% increase (n=81) in trauma cases between 2021 and 2024[36].

Median EMS Time (minutes), 2016 – 2020 Average[35]			
	Median Time to response	**Median time at scene**	**Median Transport time**
Central NY	6.4	14.2	18.4
Northeastern NY	6.6	14.1	23.6
Statewide	6.8	17.6	17.2

Figure 5

Not all North Country patients are admitted to Albany Medical Center or Upstate University Hospital. In 2020, for instance, 765 admissions to UVM Medical Center in Burlington (UVMMC) were New York trauma patients, which made up 5% of total New York patient admissions that year. Comparatively, 605 New

[32] https://www.albanymed.org/specialty/trauma-care-education/
[33] https://www.upstate.edu/cny_trauma/
[34] https://www.amtrauma.org/page/traumalevels
[35] https://www.health.ny.gov/professionals/ems/state_trauma/docs/2016-2020_trauma_report.pdf pg. 38
[36] https://www.health.ny.gov/professionals/ems/state_trauma/docs/audit_rpt_trauma_case_submitted.pdf pg. 1

Yorkers were admitted to UVMMC as trauma patients in 2014, making up 4% of all NY admissions to UVMMC that year[37].

The distance required for travel within the regions covered by both trauma systems is reflected in the average EMS response and transport times. While median EMS response times and time at the scene were less than the statewide average, median transport time was longer. Maximum response and transport times for both regions were also the highest in the state. Maximum transport times for both were over 2 hours and maximum response times were close to 40 minutes[38].

Trauma care references a "golden hour" and "platinum ten minutes" to improve chances of recovery. The "platinum ten minutes" refers to the ideal maximum amount of time until EMS arrives at the scene. The "golden hour" reflects the fact that most trauma deaths occur within the first several hours, as well as the findings of numerous studies that demonstrated a relationship between shorter pre-hospital time and better patient outcomes. For instance, one study reported that transport time under 60 minutes increased the odds of survival threefold[39].

However, the concept of the "golden hour" is complicated by the fact that pre-hospital time and improved outcomes are not determined to have a strictly linear relationship.[40] Peak trauma mortality is sometimes described as "trimodal" – most deaths either occur immediately on the scene, less than four hours after injury or longer than four hours after injury.[41] Moreover, in rural areas, meeting both the golden hour and platinum 10 standards would require a massive scaling up of ground and air emergency services[42].

Adding to possible transportation barriers is the frequency with which hospital emergency departments in the North Country divert ambulances away, particularly for trauma cases. North Country hospital EDs were on some form of diversion at least 65 times between February and October of 2025. Overcrowding played a big role in over one third of these events – for instance, Samaritan Medical Center diverted patients due to overcrowding at least 14 times[43].

However, unique problems, usually equipment failures, force more targeted diversion requests for stroke and trauma patients. Carthage Area Hospital diverted trauma patients specifically 16 separate times, including repeatedly over a two-week period in October when both the CT scanner and MRI machines were out of order. River and Lewis County General Hospitals also both specifically diverted trauma patients at least twice each in 2025[44][45]

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[37] Vermont All-Payer Database statistics, obtained via FOIL

[38] https://www.health.ny.gov/professionals/ems/state_trauma/docs/2016-2020_trauma_report.pdf pg. 39

[39] https://pmc.ncbi.nlm.nih.gov/articles/PMC11190012/#:~:text=The%20%E2%80%9CGolden,insufficient

[40] https://pmc.ncbi.nlm.nih.gov/articles/PMC11190012/#:~:text=Evidence,patients

[41] https://pmc.ncbi.nlm.nih.gov/articles/PMC11749964/#:~:text=trimodal

[42] https://pmc.ncbi.nlm.nih.gov/articles/PMC11190012/#:~:text=9%5D%2E-,In,insufficient

[43] https://nydiverts.juvare.com/ - Data collected between February and October 2025

[44] https://nydiverts.juvare.com/

Hospitals must ensure that they have the proper equipment, whether by their parent organization assuming increased responsibility to repair and replace equipment, or New York State providing the funding when they cannot. When so few options exist within a large area, diversions risk prolonging the "golden hour" and affect the quality of patient care.

North Country hospitals with Trauma certification must maintain trauma readiness with the trained staff and adequate equipment and all hospitals in the region must ensure that their emergency departments are properly staffed and equipped to transfer patients to the appropriate level of care when they arrive at the hospital. Diversions in this region only extend the long distances patients need to travel for care and risk worsening their outcomes.

MATERNITY CARE

Amidst a national maternal mortality crisis, hospitals in the North Country are prioritizing profit over pregnant people and children when they consolidate maternal care services. Of the 10 North Country hospitals that provided maternity care between 2012 and 2023, 3 reduced their bed counts, and 4 closed their maternity units entirely. Increasing the distance between pregnant people and healthcare providers increases the risk for adverse outcomes and puts a strain on patients. As North Country hospitals consolidate into large healthcare systems, like the University of Vermont Health Network, they should uphold their responsibility to provide this essential service

CUTS TO MATERNITY CARE

New York State lost 502 certified maternity beds (15.9%) between 2012 and 2023[46]. These losses have been unevenly dispersed in number and impact across the state. Maternity services in the North Country have been closing at a rate that should raise alarm because of how geographically distant hospitals in the area are from each other, and how few acute care services are available in the region overall. A 13% decrease in certified maternity beds over 10 years and a spate of recent closures is putting parents and babies in danger. Of the 10 North Country hospitals that provided maternity care between 2012 and 2023, 3 reduced their bed counts, and 4 closed their maternity units entirely. In a region where hospitals can be at least an hour's drive from each other, this greatly increases not just the burden on the remaining maternity units but also on patients who will need to travel farther for care.

[46] Institutional Cost Reports, 2012 - 2023

Throughout the region, births have declined (Figure 6)[47], and hospitals cite the lower occupancy rates as a reason closure is financially necessary. However, the number of babies born to patients with a North Country address is consistently higher than the number born in hospitals actually located in the North Country (Figure 7)[48]. In fact, live births attributed to North Country residents declined by 22% between 2012 and 2022, but births in the region's hospitals dropped by 29%. This suggests that the hospital closure of maternity beds did require parents to seek care elsewhere, whether outside the region or outside of the hospital altogether (Figure 8).

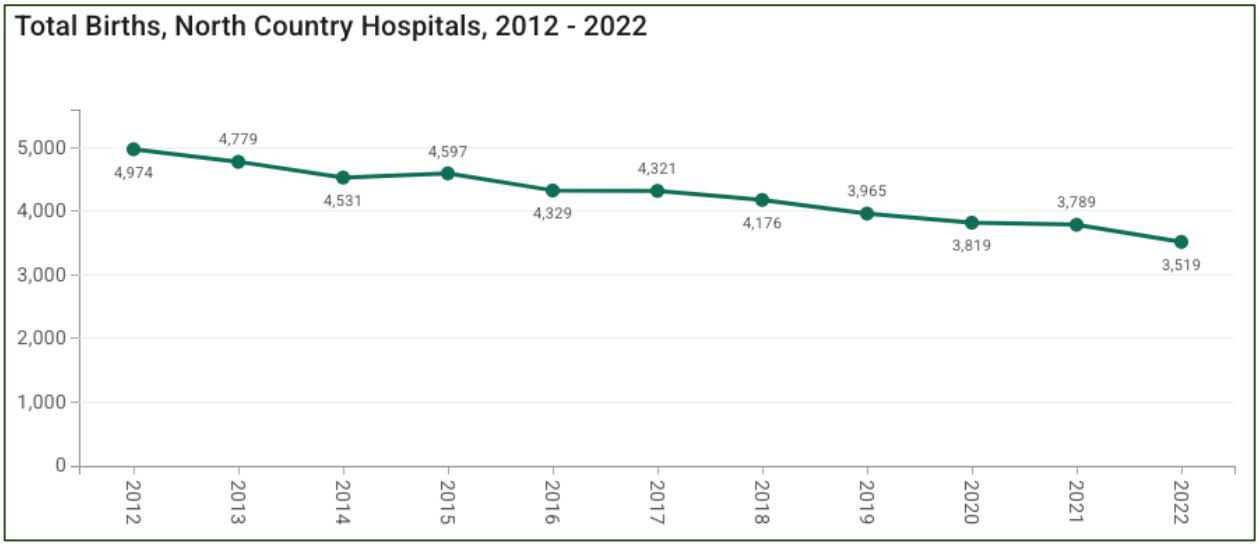

Figure 6

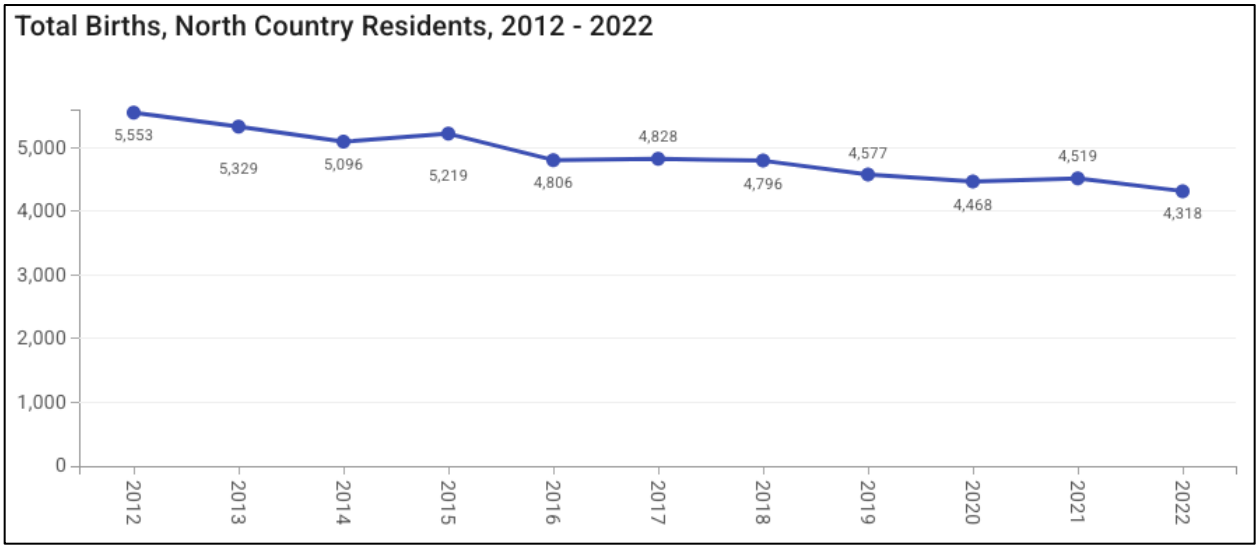

Figure 7

[47] https://health.data.ny.gov/d/ch6v-izr4
[48] https://health.data.ny.gov/d/net3-iygw

Publicly available patient data categorizes patients by 3-digit ZIP codes, as opposed to resident counties, which makes it hard to directly compare with vital statistics that measure by resident and hospital county. However, examining several selected 3-digit ZIP codes that most closely correspond to county boundaries shows big changes in where residents give birth between 2012 and 2022. Specifically, the number of individual hospitals patients chose from drastically shrank in that time period.

In 2012, residents of the 129 3-digit ZIP code (Clinton and Franklin counties and part of Essex County[49]) gave birth at 8 different hospitals[50]. 65% of those babies were born at CVPH, 18% at Alice Hyde Medical Center and 12% at Adirondack Medical Center. By 2022, births were split among 5 hospitals, with 73% born in CVPH, 17% at Adirondack Medical Center and none at Alice Hyde[51]. Notably, the number of New Yorkers who gave birth at the University of Vermont Medical Center in Burlington, VT increased from 700 in 2014 to 840 in 2020[52].

ZIP 136, representing most of St. Lawrence and Jefferson Counties, experienced less change: residents gave birth in 13 hospitals in 2012 and 12 in 2022. The share of babies born in Samaritan hospital increased from 48% in 2012 to 60% in 2022, and Canton-Potsdam Hospital went from 10% of all births to 20%.

Total Births, North Country Hospitals, 2012 - 2022[53]

	2012	2022	% Change
Adirondack Medical Center	168	192	14%
Canton-Potsdam Hospital	364	566	55%
Carthage Area Hospital Inc	446	369	-17%
Claxton-Hepburn Medical Center	344	135	-61%
Gouverneur Hospital	92		-100%
Lewis County General Hospital	329		-100%
Massena Hospital	223		-100%
Samaritan Medical Center	1,743	1550	-11%
Alice Hyde Medical Center	367		-100%
Champlain Valley Physicians Hospital	898	707	-21%

Figure 8

Importantly, neither ZIP code shows patients moving to hospitals outside of the region but rather that hospital births appear to be consolidating among a smaller number of individual hospitals. As mentioned above, none of these hospitals have significantly expanded maternity care capacity in the last decade. The data used here is limited to inpatient hospital stays, though, and would not show if patients have increasingly given birth outside of a hospital setting, which could explain the discrepancy shown in Figures 6 and 7.

More detailed data is needed on births at home, at birthing centers, and other non-hospital settings in order to fully determine if this is the case. Fewer maternity units may have led to

[49] https://your-vector-maps.com/new-york-3-digit-zip-code-map-with-counties/
[50] Measured using newborn admissions
[51] Inpatient De-identified SPARCS data, 2012 and 2022, accessed at health.data.ny.gov
[52] Vermont all-payer de-identified data, accessed via FOIL request, measured using "newborn, born at this hospital"
[53] https://health.data.ny.gov/Health/Hospital-Maternity-Information-Beginning-2008/net3-iygw/about_data

more births in emergency departments and ambulances, or the choice to opt out of hospital care altogether. Without a clear way to measure these cases, we won't be able to fully assess the impact of closures.

MATERNAL HEALTH DISPARITIES

There are also specific challenges that accompany giving birth in a rural area, which means that decertifying maternity beds, especially entire maternity units, poses a much higher risk to patients in the North Country than it would in a region with a higher hospital density.

The distance mothers travel for maternity care impacts the health of the mother and child. Pregnant people who travel more than one hour for care may experience up to 7 times more stress during pregnancy, as measured using a tool designed to evaluate stressors specific to the rural experience of pregnancy[54]. To avoid delivering at home or en route, some pregnant people stay near a hospital for weeks before delivery, which can add an emotional and financial burden to their families[55].

In addition to longer travel times, the demographics of the North Country correlate with a likelihood of adverse outcomes during pregnancy and birth. Pregnant people in rural areas are at increased risk for health complications and have 9% higher rates of morbidity and mortality than pregnant people in urban areas. In the North Country, the population's risk factors also include a significantly higher poverty rate than the New York average (excluding NYC), 6.2% more births within 24 months of a previous pregnancy, and 9.1% more unintended pregnancies than the Prevention Agenda Benchmarks[56].

Decertifying maternity services in the North Country could pose even higher risks for the non-white population. Nationally, non-Hispanic Black pregnant people and American Indian/Alaskan pregnant people are over 3 times more likely to die from pregnancy-related causes than their white counterparts as of 2022[57]. Overall, 3.3% of the North Country's population is Black, and 1.3% is American/Indian or Alaska Native[58].

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[54] https://www.sciencedirect.com/science/article/abs/pii/S0266613822003217#:~:text=The%20RPES%20was%20developed%20through%20focus%20groups%20with%20women%20in%20rural%20Canada%20and%20designed%20to%20specifically%20assess%20stressors%20relevant%20to%20the%20rural%20experience%20of%20pregnancy%2E

[55] https://link.springer.com/article/10.1186/1472-6963-11-147#Sec4:~:text=Costs%20of%20travel%2C%20accommodation%2C%20lost%20income%20for%20both%20partners%20and%20supplemental%20food%20costs%20can%20be%20substantial

[56] https://ahihealth.org/wp-content/uploads/2025/01/2019-2021-ARHN-Executive-Summary.pdf pg 10

[57] https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance-data/index.html?cove-tab=1

[58] American Community Survey 5-year estimates, 2019. Accessed at: www.census.gov

The U.S. portion of Akwesasne, where members of the St. Regis Mohawk Tribe live[59], is in Franklin County and located about a 20-minute drive from Massena Hospital, which shuttered its maternal health unit. 8.7% of the Franklin County population identifies as American/Indian. It also has a slightly higher proportion (3.8%) of Black residents than the region overall[60].

New York's overall maternal mortality rate was lower than the national rate between 2018 and 2020. However, the gap between the maternal mortality rate among Black pregnant people was more than 4 times higher than the rate for white pregnant people in New York during the same period[62]. In fact, the Black maternal mortality ratio in New York has been higher than the national Black maternal mortality ratio since 2003[63].

PATIENTS AND WORKERS PAY THE PRICE

In 2022, 37% of live births in the North Country were covered by Medicaid, compared to 50% statewide and 42% in New York excluding New York City. An additional 20% were covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), compared to 1% statewide[64].

A Health Affairs study from 2015 showed a widening gap between the payments private insurers made to hospitals for inpatient services when compared to Medicare and Medicaid. From 1996 to 2012 private insurers' payment rates went from being 10% higher than public insurance rates to 75% higher[65]. The difference between Medicare and Medicaid rates and private insurance rates slowed between 2012 and 2016, but for Emergency Department visits, the gap never narrowed during the period, and charges for ED visits as a percentage of Medicare rates increased[66].

North Country Live Births by Payor, 2022[61]

Financial Coverage	Number of Live Births	Percent of Total
Medicaid/Fam Health Plus	1,610	37%
Private Insurance	1,332	31%
CHAMPUS	871	20%
Unknown	181	4%
Self-Pay	155	4%
Other Insurance	124	3%
Other Govt	36	1%
Indian Health	9	0%
Total	4,318	100%

Figure 9

[59] https://www.akwesasne.ca/about-us/our-community/

[60] https://data.census.gov/profile/Franklin_County,_New_York?g=050XX00US36033#race-and-ethnicity

[61] https://health.data.ny.gov/d/ch6v-izr4

[62] https://www.health.ny.gov/community/adults/women/maternal_mortality/docs/2023_mmm_council_report.pdf pg. 6

[63] https://www.health.ny.gov/community/adults/women/maternal_mortality/docs/maternal_mortality_review_2018-2020.pdf pg 14

[64] Vital Statistics Live Births by Primary Financial Coverage and Resident County: Beginning 2008. Health Data NY.

[65] Selden, T. M., Karaca, Z., Keenan, P., White, C., & Kronick, R. (2015). The growing difference between public and private payment rates for Inpatient Hospital Care. *Health Affairs*, *34*(12), 2147–2150. https://doi.org/10.1377/hlthaff.2015.0706

[66]

Maternity services already face an uphill battle to being a budget priority for hospitals, since they generally pull in less money per patient than other services[67]. Hospitals with a higher percentage of Medicaid and other public insurers may have a greater financial incentive to reduce maternal health services.

Reducing maternal health services can also increase healthcare costs for patients. It is possible that patients could face additional costs when giving birth in a hospital without a maternity ward. "Upcoding", or the practice of billing for visits coded as more complex, which yield higher reimbursement rates, is becoming more common. OB/GYN physicians were in the top 5 specialties billing at the highest codes between 2001 and 2010[68], a practice that affects all insurance payors, both public and private[69].

As some New York Counties face steep declines in the availability of maternity services, patients risk being burdened with additional costs if they give birth at their local hospital emergency room, on top of any transport costs if they need to be moved to a larger facility. In this way, hospitals are potentially looking at two profit incentives to eliminate services, by reducing the costs of operating maternity units with declining occupancy while being able to charge higher fees for childbirth. Both financially, and in terms of potentially worse health outcomes, patients are bearing the risks. Health systems like the UVM Health Network, which have adopted a regionalized model of maternal health care, should take into account how it burdens patients with extra travel and accommodations while potentially resulting in worse outcomes for both birthing people and babies.

Moreover, hollowing out maternity services has an impact on the healthcare system's ability to staff hospitals. The healthcare industry is one of the biggest employers in the region, and one of the few that is gaining jobs[70]. Healthcare workers, especially new and younger members of the workforce, want to know they will be able to access healthcare services that make it possible to start and raise a family. The dearth of maternity care will make it harder to recruit new workers to the area and to retain them.

https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00415#:~:text=Private%2Dpublic%20payment%20rate%20differences%20widened%20substantially%20during%20the%20first%20decade%20after%202000%2C%20not%20just%20for%20inpatient%20care%20but%20also%20for%20ED%20visits%20and%20outpatient%20visits%2E

[67] Institutional Cost Reports, charges per discharge

[68] https://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf pg 12

[69] https://civhc.org/wp-content/uploads/2017/07/Data-Byte-ED-Severity-Level-Trends-by-LOB-April-2017.pdf

[70] https://dol.ny.gov/system/files/documents/2025/10/north-country.pdf pg 1

BEHAVIORAL HEALTH

The North Country has significant behavioral health needs and some of the worst scores statewide on specific measures of behavioral health. Recently, and with the help of state funding, important steps were taken to expand access to behavioral healthcare in the region. These services should continue to be preserved and expanded even as federal funds for healthcare are reduced.

CHANGES IN BEHAVIORAL HEALTH CARE

New York State lost 1,769 inpatient psychiatric beds (31%) between 2013 and 2023, but the North Country defied that trend. The region gained 10 beds during that period, a 9% increase (Figure 10). This was largely due to gains at Claxton-Hepburn Medical Center, which transformed from a 192-bed acute care hospital with 28 inpatient psychiatric beds into a 40-bed inpatient behavioral health hospital. Only one other region of the state, the Hudson Valley, gained psychiatric beds during the same period.

All 7 North Country counties are considered high need Mental Health Professional Shortage Areas (MHPSA). Most counties throughout New York State are also considered high-need MHPSAs, except for counties near the Capital Region and Long Island, as well as a select few others[72].

Inpatient Psychiatric Beds, North Country 2013-2023[71]		
	2013	2023
Adirondack Medical Center	12	12
Champlain Valley Physicians Hospital	34	30
Claxton-Hepburn Medical Center	28	40
Samaritan Medical Center	32	34
Total	106	116

Figure 10

The North Country does perform better than most of the state when it comes to opioid mortality rates. However, North Country counties have some of the highest rates of frequent mental distress in New York State, and some also had the top rates of suicide death rates. Lewis County had the highest suicide mortality rate statewide and Clinton County had the highest prevalence of lifetime depression in the state[73].

AN INCREASE IN BEHAVIORAL HEALTH BED CAPACITY

In 2023, Samaritan Health certified an additional 7 inpatient psychiatric beds[74], while the year prior CVPH decertified 4 of their psychiatric beds[75]. However, by far the biggest change to

[71] Institutional Cost reports, 2013-2023
[72] https://omh.ny.gov/omhweb/tableau/needs-assessment.html
[73] https://omh.ny.gov/omhweb/tableau/mappt-a.html
[74] NYSE CON 23131, CON 161031
[75] NYSE CON 162589

psychiatric capacity came with the affiliation between Claxton-Hepburn and Carthage Area Hospitals.

In 2022, Carthage Area Hospital and Claxton-Hepburn Medical Center applied to convert Claxton-Hepburn into a 40-bed inpatient psychiatric facility, among other changes. The new facility would have an entrance, waiting and reception area distinct from the former hospital[76].

At present, Claxton's inpatient hospital has 28 inpatient psychiatric beds for adults[77], and 12 beds available for children and adolescents[78]. In August, Claxton received an $18.9 million Transformation Grant from New York State to continue expanding their inpatient psychiatric services and create a Comprehensive Psychiatric Emergency Program (CPEP)[79].

The transformation grant begins to address the dearth of services considered "unprofitable" for hospitals to operate in the region. Now, for instance, the North Country does not have a single CPEP. The closest option within the state is at St. Joseph's Hospital in Syracuse[80], a 2 hour and 15-minute drive from Claxton-Hepburn and a 4-hour drive from Plattsburgh, where CVPH is located.

Net patient revenue for inpatient psychiatric services steadily decreased between 2000 and 2018, potentially exacerbated by changes in reimbursement methodology that aimed to reduce the length of stay for psychiatric patients. Psychiatric beds are also less lucrative for hospitals since they usually involve fewer expensive procedures, so hospitals generate less net patient revenue per bed than for other types of care[81].

Regardless of the service's financial viability, the need in the North Country for psychiatric services remains high. Even with Claxton's expanded capacity, its emergency room still diverted psychiatric patients over 10 times in 2025, with some of those instances explicitly due to overcrowding[82]. Diversion requires patients to seek care elsewhere, and, since Claxton Hepburn has the largest psychiatric unit in the region, that could mean traveling hours away. The added travel time creates a burden for visiting family members or patients who struggle with access to transportation. For family members particularly, the need for childcare or time away from work could prevent a visit altogether.

The transformation grant expanding services at Claxton Hepburn is a positive effort towards meeting the need for more psychiatric beds and should be viewed in that light. New York State

[76] CON Application 231286, via FOIL

[77] https://www.claxtonhepburn.org/blog/2025/august/ending-stigma-and-fostering-support-mental-healt/

[78] https://www.claxtonhepburn.org/our-services/mental-health-services/children-adolescent-mental-health-unit/

[79] https://www.claxtonhepburn.org/blog/2025/august/claxton-hepburn-medical-center-secures-18-9-mill/

[80] https://profiles.health.ny.gov/hospital/county_or_region?countyRegion=&service=Comprehensive+Psychiatric+Emergency+Program

[81] https://www.nysna.org/sites/default/files/attach/ajax/2020/08/Psych%20Whitepaper%20NYSNA.pdf pg 12

[82] https://nydiverts.juvare.com/

has a responsibility to ensure its residents can access care close to their home, and it should be proactive about assisting hospitals in providing it.

FEDERAL FUNDING CUTS

The One Big Beautiful Bill Act (OBBBA), passed in July 2025 by Congressional Republicans and signed into law by President Trump, cut access to Medicaid in several ways. Changes to Affordable Care Act enrollment, premium tax credit eligibility, Essential Plan funding and the implementation of work requirements will all increase the number of uninsured New Yorkers[83]. As an effect, not only will the newly uninsured be discouraged from seeking healthcare, the amount of uncompensated care that hospitals provide will go up. Health insurance premiums are expected to rise with the expiration of enhanced premium tax credits[84]. The AFL-CIO estimates that premiums for workers with job-based insurance could soar by nearly $500 a year for each person covered and nearly $2,000 for families[85]. Patients may delay care because of higher healthcare costs, leading to more serious and costly care in the future.

Hospitals are projected to lose close to $1.4 billion statewide from federal cuts[86]. Further cuts to safety net hospital funding in the act will further threaten the financial viability of these providers—in particular rural hospitals. Many rural hospitals in New York are heavily dependent on Medicaid revenue, and approximately 70 out of New York's 156 hospitals are at risk of closing if they lose a significant amount of Medicaid funding[87].

Federal funding cuts will further strain the finances of North Country hospitals. Further consolidation and regionalization of healthcare in the region is not the solution and will reduce access to care even further.

When determining the budget for the UVM Health Network's flagship hospital, UVM Medical Center, Vermont's Green Mountain Care Board (GMCB), the regulatory agency for hospitals in Vermont, expressed deep concern about the system's allocation of funds to its New York affiliates. The network, the GMCB argues, has been subsidizing the poor performance of its New York hospitals while generating "excess revenues" at its Vermont facilities and charging patients higher rates.

[83] https://fiscalpolicy.org/wp-content/uploads/2025/06/2025.06.30-NY-Individual-Market-under-OBBBA.pdf pgs 4-6
[84] https://www.urban.org/sites/default/files/2025-09/4.8-Million-People-Will-Lose-Coverage-in-2026-If-Enhanced-Premium-Tax-Credits-Expire.pdf
[85] https://aflcio.org/press/releases/new-afl-cio-report-shows-medicaid-cuts-will-spike-health-care-costs-everyone
[86] https://www.governor.ny.gov/sites/default/files/2025-05/House-Budget-Impacts-on-the-Essential-Plan-and-Medicaid.pdf
[87] https://fiscalpolicy.org/wp-content/uploads/2025/07/2025.06.27-hospital-closures-FINAL.pdf pg 1

Since acquiring its New York hospitals, UVM transferred an increasing number of services to its flagship hospital in Burlington, according to NYSNA nurses. For instance, CVPH has quietly ceased offering a number of services, like pediatrics or certain emergency procedures, requiring patients to travel to UVM Medical Center across Lake Champlain. These mainly occurred as "shadow closures", without an official application through the state, and without removing them from the hospitals' operating license, making them more difficult to track.

UVM has also officially closed maternal health, acute dialysis and intensive care services at Alice Hyde[88]. The same service cuts causing funding shortfalls in New York are prompting UVMHN to hike rates in Vermont. Regionalization has increased travel times and costs to patients without expanding access to essential health services or meaningfully improving hospital finances.

In the case of UVM, the regionalized system is still experiencing capacity issues, particularly at the flagship "hub". Between July 2022 and July 2025, the University of Vermont Medical Center in Burlington denied 740 transfer requests from New York hospitals, 279 of which came from Canton-Potsdam Hospital. The top reasons for these declines were a lack of capacity at the receiving hospital, a denial by the accepting physician and a lack of the necessary specialty or service[89].

Hospitals have a financial incentive to reduce or eliminate "unprofitable" services like trauma, maternal, child, and mental health care, and they spend millions doing it. Applications to add, remove or convert beds from one type to another submitted by North Country hospitals between 2016 and 2024, managed to rack up over $163 million in total costs. Many of these applications also include renovation or construction plans that drive up the cost, but have not expanded access to inpatient services, since they resulted in a net loss of 205 beds.[90]

CONCLUSION AND RECOMMENDATIONS

The negative trends of hospital consolidation and healthcare service closures over the last decade in the North Country must be countered to preserve access to quality care.

NYSNA recommends:

1. Strengthen Oversight of Hospital Bed Closures
2. Fair Hospital Funding
3. Preserve Healthcare Coverage

[88] CON 231171 and CON 212164

[89] https://gmcboard.vermont.gov/sites/gmcb/files/documents/2025-08-22%20REDACTED%20UVMMC%20Post-Budget%20Hearing%20RFI%20Redacted%20%281%29.pdf pg 24

[90] https://health.data.ny.gov/Health/Certificate-of-Need-Applications-Beginning-1974/h343-jwie/about_data

4. Invest in the Healthcare Workforce

1. STRENGTHEN OVERSIGHT OF HOSPITAL BED CLOSURES

New York needs to implement stronger oversight of service and bed closures to ensure access to quality care. The private hospitals in the North Country are all non-profits, a status that is meant to reflect their service to the community. Only one North Country hospital, Carthage Area Hospital, received an A on the Lown Institute Hospitals Index, which measures the extent to which hospitals' community service matches their tax savings[91]. As a regulator, New York State should take responsibility for making sure hospitals are transparent about their plans for service changes, and that those changes also reflect the community's needs.

New York can:

- Improve transparency and accessibility of the Certificate of Need (CON) process for approving major hospital changes, such as unit closures. Most hospital applications are reviewed by the Public Health and Health Planning Council (PHHPC) behind closed doors, with no transparency as to why applications were approved or denied. These "limited review" processes don't require input from elected officials, community members, or local stakeholders. The current process also only requires a public hearing 30 days after a full hospital closure. It is critical that the New York Department of Health (DOH), as well as the PHHPC make timely updates to its CON database and provide more opportunities for community input.

- Enact the Local Input on Community Healthcare (LICH) Act to add transparency about how proposed closures would affect the community and require additional state funding to make up for lost access. The act would also provide more opportunities for community input by requiring hospitals to submit a closure plan that is publicly posted by the DOH and hold a public forum, after which the hospital must submit a revised closure plan that addresses issues raised by the community. Crucially, these steps must occur before any closures or steps to begin closing beds take place.

- Improve the DOH's health equity impact assessment process by giving more consideration to the geographic distribution of services. One possible framework is a set of "essential healthcare services" for rural hospitals that includes pediatric, maternal, trauma and mental health services. The state should bear the need for the above types of care in mind when evaluating CON applications to prevent further closure of these service lines.

2. FAIR HOSPITAL FUNDING

The services discussed in this paper—pediatrics, maternity, behavioral health and trauma—are usually the first to be cut under financial pressure. New York should work to address this

problem by raising reimbursements for these services and creating additional financial incentives for hospitals to operate and even expand essential but "unprofitable" healthcare services.

New York should also prepare funds for hospitals put at risk by the budget, especially rural hospitals that rely heavily on Medicaid, as well as safety net hospitals throughout the state. DOH already administers programs to alleviate operational costs for hospitals, including the Vital Access Provider Assurance Program (VAPAP). While VAPAP is intended as temporary relief, more permanent funding streams may be necessary to weather the latest federal budget impacts.

3. PRESERVE HEALTHCARE COVERAGE

The OBBBA will reduce the number of New Yorkers, including North Country residents, who are insured. This will likely force even more "unprofitable" bed closures with the rise in uncompensated care.

New York State must do everything in its power to minimize the loss of health insurance coverage resulting from the OBBBA, including:

- Preserve New York's Essential Plan coverage.
- Provide robust support to minimize the number of people who will be dropped from Medicaid for failing to file their paperwork or navigate new work requirements.

New York should also explore enacting a single payer universal healthcare model in New York like the NY Health Act to offset the coverage losses of the OBBBA.

With some of the largest federal healthcare cuts not scheduled to go into effect until later in 2026 and beyond, New Yorkers also have an opportunity to reverse the cuts through the political process.

4. INVEST IN THE HEALTHCARE WORKFORCE

Hospitals in the North Country face different challenges compared to hospitals in more populated regions of the state, including low or unpredictable volume and a smaller supply of workers. Registered nurses are the largest part of the hospital workforce and are primarily responsible for delivering quality care to patients. Having enough trained nurses at the bedside is essential to hospitals delivering quality care. In rural areas where hospitals are the major employer, hospital workers are also patients who deserve access to quality care.

Hospitals must:

- Provide fair wages and healthcare benefits to healthcare workers to improve recruitment and retention.

- Ensure healthcare workers can access care with affordable health benefits and by preserving services to support workers and their families, such as pediatric and maternal health services.
- Provide safe working conditions to minimize injuries and improve retention.
- Work with educational institutions to restore rigorous clinical training and orientation programs, including transition to practice and nurse residency programs to improve nursing retention and patient outcomes.

New York State can also support healthcare staff recruitment and retention:

- Use current or pending federal 1115 and 1332 waiver authorities, and its pending application for the OBBBA Rural Health Transformation Program funding to support recruitment and retention programs for RNs and other direct care workers.

- Expand state funding for tuition support and loan forgiveness programs targeting rural safety net hospitals to support nurses who make commitments to work in those jobs for five years. Funding CUNY and SUNY nursing programs, increase instructor salaries, and encourage more clinical training and mentorship programs in hospitals.

- Improve enforcement of safe staffing, workplace violence, wage theft and other worker protection laws to improve working conditions and address the problems that lead to hospital understaffing, including high stress, high injury rates and high turnover.