

NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
FULL COUNCIL MEETING
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90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

Mr. Kraut We're a little early, but we are able to start the meeting right after the Codes committee, so I suspect I will do so. We've asked the Commissioner, I think he was planning to come down at 10:00am, so let's start at least the meeting and if the Commissioner comes in, we'll stop what we're doing and move to him immediately. I'm Jeff Kraut. I have the privilege to call to order the September 18th, 2025, meeting of the Public Health and Health Planning Council. I want to welcome members, eventually Commissioner McDonald, participant and observers. You know, this has been a busy and productive week for the council. I just want to thank the council members. I know some of you have been here for, we had a meeting yesterday, we have a meeting today, meeting in the afternoon, another meeting tomorrow. We had the Public Health Committee yesterday, Codes, Health Planning is going to be on Friday and the Ad Hoc Nursing is going to be today. I just want to thank everybody for making the effort to do it. You know, I think we have some forward momentum here. I just want to keep it up. I know it's a burden at times. It's important that we're doing it. I can't tell you how delighted I am that we are working on some of these issues. Another issue that you're going to be experienced today is the department has implemented a new process to access Wi-Fi. It's not quite working, but you should see Colleen or Mike for connectivity or ping my phone and I can grant it to you. The systems that the state's using is no longer NYS Guest. It's an ion suffix, which is not working properly now. We have two hotspots here. If they just raise your hand, they'll come over and connect you to the hotspot. Mike, I think you should just go around the table and just make sure everybody gets connected to it. For members of the public, it's not going to help you, but there's written instructions out on the reference table how to join the guest Wi-Fi now. Good luck. Our audience viewing the public meeting via the webcast is a form that we need you to fill out, which records your attendance at that meeting. We're required to do this in compliance with Executive Law 166. We've also posted this form on the Department of Health's website, which is www.NYHealth.Gov under Certificate Of Need. When you are finished and you could do the forms, please mail those completed forms to Colleen.Leonard@Health.NY.Gov. Thank you very much for helping us fulfill our responsibilities. I would like to remind council members, staff and the audience that this meeting is subject to the Open Meeting Law and is going to be broadcast over the Internet. Obviously, as you know, we have some ground rules to make this work. Keep the mic on mute when not speaking. Don't rustle papers. We're doing synchronized captioning. We can't have people talk over each other. The first time you speak, just briefly identify your name and whether you're a council member or staff. This is going to be helpful to us. Under the Establishment and Project Review today, we're going to look at the department's Certificate Of Needs. I'll come back to that in a minute. We encourage individuals to subscribe to Listserv that we regularly send out notices through the council's information and agenda and meeting dates and policy matters. We are really trying to encourage public awareness and participation. Even from veterans who have gone here, they seem to forget to check or check our website periodically. We publish our calendar a good year ahead. There really should be no reason that people are not reminded that we're having a committee meeting or a public meeting, that they are constantly should be checking our website to do that and by joining the Listserv we can push out some information to you as well. Today we're going to hear from Dr. McDonald, who will provide a report on the

departments of activities. Unfortunately, although you'll see the agenda that was sent out due to a heavy meeting schedule, Ms. Kim is unable to join us today and what will provide a report on the activities of the Office of Health Equity and Human Rights at the next full council meeting.

Dr. Kalkut Disappointing that she is not going to be able to speak, and if it was going to be a short time period, I don't think that's really enough time for the committee and the council to ask questions about the health equity assessments. I would think ask her to have a longer period of time or try to make a longer period time at the next cycle. I would also consider having Ad Hoc group on health equity for us to delve in a little deeper and use that time to understand the process, particularly interested in the learning tour that happened last Summer and what we can hear.

Mr. Kraut Just for everybody, the last meeting you had requested that Ms. Kim was supposed to join us to talk about the recommendations in changing HEIA that came out of that listening tour that she reported on the previous time she was at here. I will discuss that with Ms. Kim. I will talk to the department whether we should set up a separate meeting just for that or include it as part of our agenda. I understand. I know I've been promising this presentation for two cycles or more, so I'm sorry. You know, I think we'll figure it out. Thank you. Dr. Fish is going to report on the activities of the Office of Primary Care and Health Systems Management. Dr. Boufford will be reporting on the Activities of the Public Health Committee that met yesterday. Ms. Monroe will provide us an update on the Activities of the Health Planning Committee and discuss the upcoming meeting tomorrow. Mr. Holt, who will be in the room, and Mr. La Rue, who had a family emergency will be joining us through Zoom, will provide an update on the activities the Nursing Home Certificate of Need Ad Hoc Committee that is meeting following this meeting. As you just heard, Mr. Holt will present the results of the actions of the Code Committee, which just concluded. Under the category of Project Review and Establishment Actions, Mr. Robinson is going to be reporting on a number of applications that were reviewed at an earlier meeting of the Establishment and Project Review Committee. I just want to remind everybody that we have organized the agenda as by topics and in order to facilitate our review and our voting on them. We've batched certificate of need applications, particularly those that had no conflict, resolution or the committee was unanimous in a particular category. Just take a look at how we batch those applications. If there's any application that you want removed from a batch or want to discuss that or move it to a different category, we'd be happy to do it. Just let us know before we call the applications. Please tell that to Colleen or Mike as well. Before I ask, before I go through some motions to do the minutes, I just want to acknowledge Dr. Mario Ortiz, who is the Dean of the Decker School of Nursing at the State University in Binghamton. He has just been appointed the editor of the Nursing Science Quarterly. Those of you who know about this journal, it's really a journal that's really a thought leader in nursing theory, practice, quantitative and qualitative analysis, and I just want to congratulate you. That's quite an honor to be given that responsibility. He promises me he will not interfere with his activities with PHHPC, but who knows. Or maybe you guys will come up with some ideas that you can submit. It's a peer-reviewed journal. I look at it periodically. I know my nursing staff send it to me. It's well read in our organ. Congratulations, Dr. Ortiz. We're very proud of you.

All (Clapping)

Mr. Kraut You know, honestly it just speaks to the type of expertise and the diversity of the expertise that we have at this table. You know, that's why you're here and we're going to call on it to use it. Just a little housekeeping detail. We're going to have the Ad Hoc

Committee to follow this meeting. I don't know if it's going to be a long day. It's going to be a longer day than we're used to. The department is going to provide lunch for those of you who are staying. Could you just raise your hand if you're staying for the Ad Hoc Committee

Mr. Kraut If there's any dietary concerns other than pizza, please tell Colleen. I think that's the easiest thing to bring up here to do. Those will do that as well. Now that the important part of the council meeting is over, could I have a motion to adopt the June 18, 2025, PHHPC minutes?

Mr. Kraut I have a motion.

Mr. Kraut I have second. Mr. Thomas.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut It is now my pleasure to hear from Dr. McDonald, who's going to update us about the department's activities.

Dr. McDonald Thank you, Jeff.

Dr. McDonald Good morning, everybody. Great to be with you today. Just a couple of starting points. Just so people know, the Advisory Committee and Immunization Practices is meeting today and tomorrow. Be assured that I have plenty of my staff actually watching the meeting. I'm being updated in real time. Please be assured too that we're well aware of what could happen today. We've planned for this. We'll just see where this goes and go from there. I just think it's important to understand that no matter what happens, we will respond to it and protect New Yorkers' ability to get vaccines. I do want to also just talk a little bit about something else going on that I'm kind of encouraged about, which is the Northeast Collaborative. You might have read a little about this, but there's a press release coming out, I think in about four minutes that we'll talk about this. I'll just tell you now. There's this voluntary coalition of states, Connecticut, Maine, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, New York City. Some others are coming on board, just really working on common public health concerns, you know, and it is vaccine related, but it's more than just vaccines. We're talking about how do we coordinate more? How do we protect evidence-based public health? We have work groups that look on just a public health emergency preparedness. How do deal with data? What other infectious diseases can we do? What other things we do with laboratory sciences? You know, I think this is something to actually be a little bit encouraged about. As much as you see a lot of discord in this country right now, public health people do talk to each other respectfully. We get along well. We really do enjoy working with each other. I think this is something that we should maybe have a little bit of optimism about. I've enjoyed these last few months working with these folks. I've really been thrilled that many of our team members have been part of this and really leading the way in this. It just seems to me like as much as the public health conversation federally is getting a little bit different, perhaps even unusual...there does seem to be a great deal of coherence in many of the states right now. I think that's something to be thankful for. I want to talk a little bit about COVID vaccine and September 5th, Governor Hochul issued an Executive Order and why was that important? One of the things you saw is just because of the revoking of the emergency use authorization because of limited FDA approval, many people are just used to their COVID vaccine in a pharmacy like CVS or Walgreens or any drug store for that matter. What

people are finding is there was so much chaos and confusion that people really just didn't know what to do. The pharmacies didn't what to. So, Governor Hochul, one of the big parts about the Executive Order was allowing a pharmacist to actually prescribe and administer a COVID vaccine. Keep in mind when the Governor issues an Executive Order, the Governor can't create something new. What a Governor can do is suspend an existing law. That's what happened. It's a thirty-day executive order. I expect to be renewed as needed. You know, I did my usual standing order. Thank you for my team for helping me get those standing orders done for not just the Moderna vaccine, the Pfizer vaccine, the Novavax vaccine. We sent those up. I think one of the key points to remember is my standing order is only good for what's considered FDA-approved indications. In other words, when you prescribe a drug off-label, which doctors do every single day. It is very common. When you do something off label, New York State law doesn't allow me to do what's called a non-patients specific standing order. This is really part of why the Executive Order was necessary. It's been well received. I'm very thankful the Governor did that. I think this is another example of how the Governor is stepping forward and really helping protect New Yorkers. And just to give you a ballpark number, over 7 million New Yorker's were disenfranchised from a COVID vaccine. This mitigates that. Part of I think that's important when you look at who's really at risk... Totally agree with the federal government, people 65 and older are at risk, no doubt about it. Totally agree that people with underlying health conditions are at risk. We sent out a provider advisory to people who take care of people who are pregnant. Pregnancy is an independent risk factor in and of itself. There's an enormous amount of data that just shows that. When we sent our provider advisory out, you included forty-seven scholarly references I'll see you in the next one. It was much longer than the usual provider advisory, because what we're doing is making sure the health care providers in your exam rooms understand what is the case, what is data, and why do we do what we do? We're doing what public health people do all the time. We do our research, put our facts together, put it in a way that people expect. We did the same thing for children. We sent out a provider advisory and fifty-four scholarly references attached to it, included all the data, but came up with our recommendations. Everyone six months through twenty-three months should get immunization, just so people know, yes, the group that ends up in the hospital, the highest rate is people 65 and older, but the third highest group is people in that six month, the twenty-three-month group, and keep in mind the majority of those children don't have an underlying health condition. Our recommendations aligned with the American Academy of Pediatrics, and just to put a little bit of context in the room, the American Academy of Pediatrics has been giving recommendations for children's vaccines since roughly 1930, a good thirty years before the Advisory Committee of Immunization Practices was even informed. You know, when we did our recommendations for people who are pregnant, we did look closely at what the American College of Obstetricians and Gynecologists put together. You know but again, we had done our own research, but we came to the same conclusions that COVID vaccines were recommended for people are pregnant. Just recognizing pregnancy is an independent risk factor. One of the things about getting a COVID vaccine when you're pregnant is there really another way to pass on protection to your little one who's in the first six months of life because there's no vaccine for them. Again, just want to make sure we're on top of these things. Shift the conversation a little bit from infectious disease to our 1332 waiver. And by the way, I don't know how many people follow the difference between a 1331 to 1332. I just think the whole thing is just a little confusing. Maybe I can just refer to this as the Affordable Care Act or Obamacare. I tend to call it the Affordable Care Act, because that's what the law is called. What we did last year on April 1 of 2024, we got approval for what's called a 1332 waiver. We got that approval so what we could do is expand coverage for people who earn between the federal poverty level between 200 and 250 percent of federal poverty levels. What that meant is those individuals could get really

nice health insurance at no premium. That was a really good thing. Why that's important is these are people who otherwise would have had to pay for health insurance through the exchange. I think just keep in mind that's expensive. You know, even a simple plan is well over \$9,000. If you think about how much money people make in that area, that's just a lot for people to absorb. We had a revert back to what's called the Basic Health Plan, which is now. It's also been known as the 1331. With the Basic Health Plan, we opened a thirty-day comment period starting September 10th. Once that comment period is done, we then wait for Center for Medicare and Medicaid services to give us their determination on this. They have a nine months to do that. This starts that ten-month process. You know, if something happens on the federal level where people literally do the right thing and reverse these changes, then we still have a chance to go back. You know, the federal government so far, as much as our conversations with them have been progressing, we have to wait and see what they're going to do. You know just to put context around this, when that House Resolution 1 bill passed that took away \$7.5 billion from us, which is a lot. It's not something we can just simply absorb. Just to give you a different number on this as well is 450,000 people who work for a living are losing health insurance. This concerns me deeply. We are preserving health insurance for 1.3 million, which I think is great, but I think there's real consequences to what the federal government has done. We expect to see over \$10 billion in annual losses to New York's healthcare system at large. There's a ripple effect to this, right? Like hospital systems are going to face increases in uncompensated costs. There'll be healthcare job impacts as well. There's harm to local economies. It's really clear the impact of HR1 is not insignificant. There's also some changes that are occurring to Medicaid. I just want to highlight that a little bit. There's guidance that will come out from the Center for Medicaid and Medicare Services June of 2026. We have to be ready to implement by January 1 of 2027, although there's kind of a provision for an extension of three months if you're making a good faith effort. The thing that just really is clear, I want to just go through what happened here. There's this now work requirement that will be going into place. It's been done in other states, not shown to be incredibly successful. There are some exemptions to the work requirement. I don't expect people to read the 870-page law that was called HR1. You might wonder why I read it. It wasn't because I had all the free time in the world. It was just that part of the way I learn is at some point I just need to see all this stuff for myself and see if it is what it says it is. It is in there. It's somewhere between 629 and 633, where you see what the exceptions are. There are exceptions. Some of the exceptions to the requirement being a parent or guardian of a child who is disabled or under the age of 13, foster youth or former foster youth under the ages of 26, medical fragility, such as blindness, disabling mental disorder, physical and intellectual disability, substance use disorder, or complex medical conditions. Another one is participating in substance use disorder program. Another is someone who meets the SNAP work requirements. Another requirement, an exemption, is if you're American Indian or Alaskan native. Another exemption is if you're a disabled veteran. Another exemption if you are an incarcerated people or those who have been released within ninety days. There are exemptions here, but it's really quite a significant change. Our team is working on what we can work on at this point. There's only so much we can do getting ready for this, but we're spending a lot of time on our Medicaid team to be ready for this. Keeping on the theme of what went on with House Resolution 1, I want to just touch base on the Rural Health Transformation Program. Very thankful to my team that's working on this. The Rural Health Transformation Program is something we're applying for. Just nationally, it's a \$50 billion program. It's allocated to states over five years with \$10 billion of funding available each fiscal year, beginning in the fiscal year 2026 and ending in the fiscal year 2030. Half the funding is distributed equally if you're in approved state. The other half is allocated by the Center for Medicare and Medicaid Services based on a variety of factors, including your rural population and the proportion of status of rural health

facilities in the state. The application submissions are going to close in early November. The notice of opportunity to apply, the notice of funding opportunity was announced Monday. Our team has already been meeting with stakeholders ahead of time to get some input on this. We've met with hospital leaders, the associations, rural health people, the federally profiled houses. We're trying to really get ahead of this as best we can. We anticipate applying for both ends of it, the part that you get just because you're a state that is rural, but also the competitive portion as well. Unless you think New York is not a rural state, I just think this little factoid might be interesting to somebody in this room today. New York has a little under 20 million people, but to your surprise, perhaps, we have over 25 million trees. I assure you, I travel New York all the time. I do enjoy coming to Manhattan. I really enjoy coming downtown. Really, most of New York that I travel through is just green and a lot of ruralness. Internet reception is what it is. We are a rural state, for those who are curious. If you haven't been to the rural part of New York, I do invite you to get out there. Not just some great sceneries, but some of the best soft ice cream you will find. There's that. The Hospital Transformation Grant. Last month, Governor Hochul announced nearly \$300 million in awards made throughout the statewide health care facility transformation program. This was version four. The funding support more than fifty different projects very much across the state aimed at expanding access to inpatient, primary care, behavioral health, and long-term care services. This is a nice project. There's a lot of great projects. I'm really excited to see that we're able to finally get this done. There was a lot. In case you're curious, why do these take so long, we get a lot of applications. Very complex. It's a rigorous review process. We're trying to distribute things as equitably as possible. There's a lot of work that goes into getting these approved. I'm very thankful to my team for all the work we did so we can make these awards. That was great. Another thing I want to just make sure I thank you for is our prevention agenda. You were very helpful with our prevention agenda. I want to make sure you know, I appreciate your gratitude in that regard. In July, with the Department of Health launched it's 2025 to 2030 prevention agenda. You have to thank Dr. Boufford in particular, who's right here next to me. This was an enormous amount of work, a lot of stakeholder activity, hundreds of community-based organizations, all local health departments, health care associations, non-profits. It was just great to see this. When you think about our state health improvement plan, it's a blueprint of coordinate state and local action to improve the health of everyone's standards. This is one of those things where it's really a nice menu of evidence-based public health interventions that we know are effective. how do we eliminate health disparities? How do we recognize that health is shaped by many factors, including our social determinants of health? It really allows for a proactive focus on actions that address the root cause of injury and illness. Really, it dovetails very nicely with something else we released in June called the Master Plan for Aging, which again is just, I can't thank the team enough for just meeting the deadline of the Executive Order. Val Deitz and her team just did an amazing job with Dr. Heslin and Greg Olson from the State Office for Aging and the Department of State just really getting this done. Hundreds of meetings, hundreds of organizations helping with us. We really were more than just a convener, but did a lot to really find out how do we make New York a very age-friendly state? How do we get so New Yorkers can age in place in New York? This was a plan very much built by New Yorkers for New Yorkers. You know, just for context, 3.2 million New Yorkers are over 65. I'm not in the group yet, but well on my way. This has just been a wonderful project. There's a lot of fabulous ideas here. We'll see where all this goes here. I think that's just great. Another thing that we're really happy to announce, going to be announcing in the next week or so just to let you know now is the Living Donor Support Program. You know this has been a really significant project for the department. It's been over two years in the making because, quite frankly, some things are complicated and need over two year to put together. The Living Donor Support Act needed us to start from

scratch with building a program that allows someone who wants to donate an organ to somebody a way to get compensated for that. There's an estimated over 8,000 New Yorkers who are living with organ failure. Some 7,000 are waiting for a kidney and more than 500 are waiting a liver. This new program, operated by our department. The fund can pay up to \$14,000 for certain expenses related to the living donation process when both the living donor and the ultimate recipient of the donor are recipients of New York. Those regulations have been approved by the Transplant Council. There are other approving entities beside you, but they have been improved. Getting those regulations created from scratch was really a very significant effort for the department because really just hadn't been done before. Excited to see that's going on. I just want to remind people we did do a standing order since I saw you last Respiratory Syncytial Virus. It really just reminding people that part of why we do these standing orders is to reduce barriers to people. Our hope is that people can avail themselves to everything they need in healthcare. The nice thing about the RSV standing order, it's really everyone 75 and older is supposed to get it. It's a one and done vaccine. If you're 50 to 74 and you have an underlying medical condition, it's recommended. Folks who are pregnant in that 32-to-36-week period that can help. You get that vaccine to protect your newborn. One of the things that's interesting I've enjoyed traveling. I was at the Children's Hospital last week. It was fun talking to him. He was just talking that RSV vaccine we do for babies has really been a change and how we're just not seeing so many kids with RSV in a children's hospital. I can tell you as an old pediatrician, I didn't enjoy seeing kids with RSV, because there's precious little I could do other than oxygen, ivy fluids and just watch them suffer. I think this really speaks to, we are living in a wonderful time. You know, I'm an old pediatrician who remembers when rotavirus was a problem before we had a rotavirus vaccine, and now we just don't see that so much anymore. I remember we used to see Haemophilus Influenza Type B Meningitis. You see where I'm going with this, don't you? I don't take for granted the talents and gifts of the scientists and researchers who create these wonderful vaccines that we have. I do not take that for granted. I'm very thankful for the work. I don't take for granted the hard work that goes into distributing vaccines and even to the regulators who approve them. It's odd to me that we're spending so much time defending things that just quite frankly make everyone's lives better. I think just to underscore and maybe point out the obvious, we live in unusual times right now. I've seen this in the department quite a bit. The federal government isn't making our job harder. It was already hard. They are making it more important than ever. Very pleased to have a very robust, solid, strong health department that, quite frankly, does not get discouraged no matter what gets thrown at it. Many of them are here today. Just can't thank them enough for the hard work they do. With that, let me see if folks have questions.

Mr. Kraut Thank you, Commissioner.

Mr. Kraut Questions for the Commissioner?

Mr. Kraut Ms. Soto.

Ms. Soto Good morning. Nilda Soto, council member. Thank you for your remarks. My question is, with the Executive Order for COVID, what has been the response of insurance companies? Are they going to cover the individuals that now come under the Executive Order?

Dr. McDonald Yeah, so when you think about the insurance companies, keep in mind, they want to cover the vaccines because they know there's benefit, right? The Department of Financial Services issued a circular telling the insurance company they were expected

to cover it. Keep in mind where we were in the underwriting cycle, the insurers were expecting to cover anyways. It is going to be covered by Medicaid. We expect people to be able to get this COVID vaccine traditionally the way they should through the third-party payers. I can't speak to every single insurance company out there. If someone has a question, they should talk to their insurance company. Our expectation is every insurance company should be covering it like they traditionally do. I am not hearing about challenges. Quite frankly, this is something that we're doing as much as we can do to make sure that the insurers to cover this.

Dr. Kalkut Thank you, Dr. McDonald, for the comments, thoughtful comments. I had a question about the ACIP committee and several votes today. Do we anticipate that that would affect school immunization schedules or mandates in our state?

Dr. McDonald It's sad that you had to ask that question, isn't it? Right, you know? You know, the short answer is I have people watching it today for a reason. I don't think it will affect any requirement in school because that's governed by state law. I don't want to underscore the epic weirdness we're living in right now. I can't predict everything they might do. I think just to be kind of blunt about the advisory committee, it took seventeen objective experts that were well respected and replaced them with twelve people who, quite frankly, there's legitimate questions about their qualifications. When you look at what's on the agenda today, there's a reason for people to pause. Having said that, we have to wait and see what comes out today. The state health law is the state health law. Never confused about where the Governor is, quite frankly, on protecting the health and safety of New Yorkers. And just so you know, my team has been table topping a lot of different contingencies, and we'll just see where this all ends up here. I'm optimistic New York will come out okay with all this.

Mr. Kraut Dr. Soffel.

Dr. Soffel Good morning, Commissioner. It's always a pleasure to see you. I have two questions. And the first is, now that mandatory reporting on COVID is no longer required, what is New York doing to understand the spread of COVID and where there are problems and where we should be alarmed? My second question is, can you say something about measles?

Dr. McDonald Regarding COVID, we do track deaths, and we track hospitalizations. We do not track cases that well. We track wastewater, which isn't super helpful when it comes to COVID, quite frankly, because it's too late a signal. When you look at what our strategy with COVID right now is really it's focused on the public messaging about the importance of immunization or also our interventions to actually make immunization available and to make sure the provider committee knows exactly what to do. A lot of what we're doing is focusing on giving people the tools they need to succeed. The treatment is still available. That hasn't been threatened, quite frankly. It's nice to know that if you need treatment for COVID that's still available. I think when you think about COVID in general, and I think there's just something in the back of your mind. Yes, we are seeing less hospitalizations over time, but I want to put some context in the room. COVID is more of a health impact than flu. Just to give you a little bit of a number, I know it's a little early for numbers. In 2024, we're a little over 21,000 hospitalizations related to flu. We're a big state. If you look at COVID, there's over 51,000 hospitals related to the flu. For every one person admitted to the hospital related to a flu, yet over two people admitted related to COVID. When you look the vaccine numbers, they're much less. Now keep in mind, I don't have good data when it comes to adult vaccines like I do for kid vaccines. Because if a kid gets a vaccine

in New York, anyone under 18 that gets reported to me. If an adult gets a vaccine over 18, it only gets reported to me if the adult chose to share the data. Our estimates are when you look at COVID vaccination for New York last year, maybe 12%. Part of why I don't put context around that is the COVID vaccine uptakes are way less than the flu vaccine uptakes. I think there's a reason for that. I think it's because the public quite frankly is exquisitely confused about what is what when it comes to this. And of course, natural immunity is helpful, but there's a reason why you still get the COVID vaccine to boost your immune system. Just to put another number around this, we think about deaths last year in 2024 related to COVID. There was 2,775 deaths related to COVID, not anywhere near what you saw in 2020 or 2021. Just to context around that number, if we heard about seven different 747s crashing in New York State, we would be, oh my gosh, what is going on? 2,775 people is about what you'd put in seven jumbo jets. I still think this is a big number. Kind of my message to folks who are listening is COVID is still a significant threat to New Yorkers. The best protection out there is to get your COVID vaccine. I'm getting mine at the end of this month. The way I'm going to do it is going to get it with the flu shot at the same time. Just because of me and who I am, it'll be a media event just because I want to encourage the public to do it. I don't get to go to my brother's drug store anymore and do it like I used to when I was younger. I'm going to do that just to make sure people understand I'm doing it in a purposeful way.

Dr. McDonald Now, you asked if I could say something about measles, and I can. Measles is really spreading right now in Texas, Ontario, Canada, and parts of Mexico. You're seeing isolated pockets along the United States. There was a case here in the city or two, there's been four recent ones. You know, what I'm seeing in New York though, right now, when you look at New York State right now, I think we're probably not going to see widespread measles in New York. Why I'm saying that is our vaccination numbers are pretty good. If you want to make sure we don't have widespread outbreaks in New York, we really need to get the vaccine numbers to be even better. People are supposed to get two different measles, mumps and rubella vaccines. By the way, just in case you're curious, if you're born before 1957, you're considered immune from measles because it was that common. In 1989, we started having two doses. So just to help you with the math, if you're between 36 and 68, you might not have had two doses if you want to check with your doctor. There you go, don't get titers if you aren't sure, just get the extra dose. It really is a fine thing to do. I think when you look at the national conversation about measles, it would have benefited from a coherent federal message, which right now has been absent from all this. Earlier this year, I issued a travel advisory for people in New York when they went to Ontario, Canada, because as much as people worried about Texas, the outbreak in Canada was literally over the bridge. That's still an area that we're concerned about. There is a lot going on with measles. I think it's important to understand that it is a serious disease and people do it up in the hospital with that. For people who are telling you that it's a minor childhood illness, they're either selling you something or misinformed.

Mr. Kraut You know, your point is New York State is, we're in the 80's in most of the counties except for Rockland.

Dr. McDonald By the time you get to school age, we get a lot better. You know, if you look at that under 2 crowd, 81 percent, I'm not loving it. If you get the school age we get to 97 percent. There's pockets of the state I'm more worried about. Some of those counties. We have our team working with those counties. The way you build bridges with people is you establish relationship, build trust, and you help people understand what the concerns and answer questions are. Vaccine hesitancy really is very one-on-one relationship building

right now. There's only so much mass media is going to do in that regard. We're doing a lot with individual groups of people just to help bring people along. I think we're making some progress there.

Dr. Berliner Commissioner, thank you for your remarks. This is a weird question, even for me. Is there a reason why the rule about COVID and drug stores didn't go through the Rules Committee here for us to pass an emergency rule? Because it was an emergency.

Dr. McDonald A couple things, one is you couldn't change a law no matter what you did because the thing we had to address. I'm thrilled you asked this, because what we had address was a pharmacist can't give a drug off label. That was the issue. No matter what we did with you, and we looked at every different option, like I know it's interesting like all of a sudden an Executive Order appears. You'd be amazed on how much work goes into doing that. Late night weekend work, the kind of stuff that you're like, oh my gosh, I can't believe we got this done finally. What we needed to do was actually get a law suspended. That's why it's an Executive Order. That's hard to do. State Ed was a good partner with this. They helped us with this. I think this really gets to the point where people got it. One of the things CVS and Walgreens were telling us was like, we don't know what to do. It wasn't just us. There was all these states. This was something they really were saying. This really helped them quite a bit. We would love to do this. Like I remember when I was here last time, you know, Jeff Kraut said, call us if you need us. We're ready for an emergency meeting. I know that. I appreciate that. I'm very thankful for that. We might need you. It depends on what weirdness happens today and tomorrow. We will see. I know you guys are ready, willing and able. Appreciate it.

Mr. Kraut I made it clear that if something comes out of the federal government that requires a change in regulation that's under our purview, we will meet in between the cycles to address that.

Mr. Kraut Any other questions for the committee?

Ms. Farrell I'm not up to speed on the federal vaccine for children's program. I'm assuming it's all going to be tied up with everything that's happening in Washington. Will the state be doing anything for low-income children through the local health departments, for example?

Dr. McDonald I want to unpack that just a little bit. If a vaccine comes off vaccine for children, which is something that would be a problem, right? How does anybody get that vaccine? It puts the onus on the state to find the money to come up with that vaccine. I didn't bring my checkbook today. We've had those conversations. We know what those numbers look like. They're a lot. I'm not going to commit to spending money today because that's not what we do. We've done our homework to know that if things happen, not just today, tomorrow or in the future, what does that mean? I think it just gets to a larger issue, right? Like in other words, everyone benefits when everyone's immunized, right? Just to make sure that's really clear for folks is like, you know, Florida did something a little bit odd. It was in the news. I'm not really going to get into it, but like if you're going to Florida now, when if they do remove vaccines for everybody like... You start putting everyone at risk. I think one of the things about vaccines is they're a victim of their own success. When you think about how awful polio was, that people who are much older than I are just banging their head against the wall. How could you even entertain this conversation? It was so miserable and so awful and so tragic. Because I practice in so many rural areas, I've seen all these vaccine preventable diseases because I'm it. When you're the pediatrician in a rural area they come to you in your office... Right in your office.

You're doing your spinal tap there, blood culture and taking care of things right. In other words, you're it. Same thing everywhere I've been, right? I think the problem that we're seeing is people are choosing a real just a dangerous path. I think Florida chose a dangerous path really to step backwards in public health.

Mr. Kraut Ms. Monroe.

Ms. Monroe Thank you.

Ms. Monroe I read just briefly that the three Western states have come together to pass some legislation in each of their states to address this. You mentioned early on that you're a member of a group of Eastern states. Is there a conversation about some collective action that you all might take that would get us to kind of blanket the East Coast with a policy that makes sense?

Dr. McDonald The answer to that is yes. Just to really put a little bow on that, the Western Care Alliance is California, Oregon, Washington, and Hawaii. They haven't really done legislation. What they did is they restarted their own immunization committees. Their governors have all gotten together and have done that. What I talked a little bit about this morning is the Northeastern states have been getting together for several months. We're not just talking about vaccines. We're talking about a host of different issues. Part of why we're doing that is there's a lot more that we can do and as important as vaccines are, a lot more we should be talking about like for disaster preparedness. Part of this is just recognizing the federal government that was once our strong partner just isn't there anymore. There aren't as many people as possible in there anymore. The expertise is left. There's just not as much that we can count on from our federal partners. What we really need to do is collaborate amongst ourselves. Just to give an example, we have Wadsworth, one of the best public health labs on the planet that's ever known. We do a lot to support seventeen different states. Quite frankly, there's things that we do at Wadsworth that other people can't do, and we do it. Money, it changes hands, but we actually do the testing for people because we can do things other states can't. That's a good example of how you do rational things. I do talk to California often. I talk to Illinois from time to time too. If you're noticing a little bit of a trend, the states that are talking to each other are the states that generally identify of a certain direction. We are open to talking to every state. I do meet with all the state health officials throughout the entire country every Tuesday afternoon. I'm going down in October to meet everybody again in D.C. for a couple days. People have different political persuasions. The state health officials generally want to do the same thing. They just aren't always allowed to because their leadership doesn't allow them to actually do the things I can do. I enjoy a great deal of freedom. My Governor's very supportive of everything I do. It's just a delight to work for Governor Hochul. She really is a thrill.

Mr. Kraut Commissioner, I thank you for spending time with us and appreciate that very informative report.

Dr. McDonald Thanks, everybody. I hope you have a good rest of your meeting this morning. Thank you.

Mr. Kraut Thank you.

Mr. Kraut I am now going to turn and ask Dr. Fish to give us a report on the activities of the Office of Primary Care and Health Systems Management.

Dr. Fish Good morning. Thank you, Mr. Kraut. Doug Fish, Deputy Commissioner for the Office of Health Care Delivery. Welcome everyone this morning to today's meeting and please let me welcome Mark Hennessy, who was just appointed as our new Deputy Director for the Office of Primary Care Health Systems Management. Mr. Hennessy's worked nearly a decade managing a statewide and regional healthcare regulatory system for the department and has been overseeing regulatory activities, standards development, investigations of patient safety complaints. Prior to his leadership role as the Director for the Center for Healthcare Provider Services and Oversight that's within the Office of Primary Care and Health Systems Management, Mark was Deputy Medicaid Inspector General, and before that worked in a leadership role in the New York State Assembly for eleven years. I'll continue in my current role as Deputy Commissioner for the Office for Healthcare Delivery, which includes the Office of Primary Care Health Systems Management, the Office of Aging and Long-Term Care, our Office of Health Facilities Management, which has our state-run Veterans Homes and Helen Hayes Rehabilitation Hospital and then our Office of Medical Provider Management. I'm just grateful to Mark for accepting his new role.

Dr. Fish I'd like to speak from the written report on two things here at the public meeting. The first is on charity care. I'll speak to the certificate of need streamlining efforts and where that stands. Regarding charity care at the recent Establishment Project Review Committee meeting on August 21, questions were raised about hospital charity care, and the department was asked to provide an update. In New York, charity care refers to free or discounted medical services provided to individuals and families who cannot afford to pay their medical bills, often based on income and lack of insurance. New York's Public Health Law and the Internal Revenue Service both mandate and regulate hospital charity care, but with different focuses. New York State Public Health Law requires hospitals to establish detailed financial assistance programs, including specific eligibility levels tied to the federal poverty level and maximum patient charges, while the Internal Revenue Service ensures that nonprofit hospitals meet specific operational and community benefit requirements under Section 501R to maintain their tax-exempt status. To report hospital charity care, a hospital organization must complete and attach Schedule H, Form 990, Hospitals, to its annual Internal Revenue Service, Form 990. On Schedule H, charity care is referred to as financial assistance, and organizations report the reimbursed costs of free or discounted services provided to individuals who meet the hospital's financial assistance criteria. This information is then used to demonstrate the hospital community's benefit activities and is subject to Internal Revenue service instructions and requirements. The New York Attorney General's Charities Bureau handles charity care oversight for non-profit hospitals. The Bureau supervises the administration of charity care and ensures hospitals follow state laws and it monitors the use of charitable funds. On the New York State Institutional Cost Report, eligible charity care includes the full charge for patients who have no third-party payer coverage and are determined to have no patient or guarantor responsibility based on the hospital financial aid law policy. It also includes reduced charges for patients whose income or assets after applying the of financial aid law result in a partial or total write-off of their medical bills. It's not a write-off of uncollected debt, but rather a predetermined discount offered through the hospital's financial aid policy. Some certificate of need applications may reflect a difference between percentage of inpatient and outpatient charity care projections, largely due to uninsured patients' eligibility for emergency Medicaid on the inpatient side. For hospitals submitting full review certificate of needs applications, hospitals do report the amount of community benefit spending. In the community health improvement services category that supports local prevention agenda goals. This information is depicted in the staff report for the Public Health and Health

Planning Council's consideration. In the fiscal year 2026 budget, pleased to report that New York State then enacted a provision regarding a general hospitals to report their community benefit they provide to the state on an annual basis. Lastly, regarding certificate of need streamlining, the New York State Department of Health adopted amendments to its Certificate Of Need Regulation as part of 7.10 of Title 10 of the New York Codes, Rules, and Regulations to update, modernize, and streamline the certificate of needs review process for health facility construction projects. The updated regulations took effect August 6th, 2025, and apply to all applications filed on or after the effective date. The state's Public Health and Health Planning Council approved those regulations at its June 18th, 2025, meeting, but these did not become effective until the Department of Health's formal publication of its notice of adoption in the state register. In general, the changes increased the cost thresholds for health care facility construction projects to reflect increases in construction costs, thus subjecting many projects to less intensive levels of review. They also reduce the level of review required for many services, equipment, and projects now considered routine in today's healthcare environment, and they expand the ability to file both written notices for certain non-clinical projects and architectural and engineering self-certifications. The department has prepared a guidance document to assist in this implementation of the new regulations, and that's available on our Certificate of Need website. With that, I'll conclude my remarks and happy to take any questions.

Mr. Kraut Are there questions of Dr. Fish?

Mr. Kraut Mr. Lawrence.

Mr. Lawrence Harvey Lawrence, member of the council. You are collecting the information about the data about the charity care. Do you also do an analysis across the state to see how, what hospitals are contributing in terms of charity and whether it is equal balance across the state?

Dr. Fish Thank you for the question. Right now, what the statute requires is us to collect the information that currently is reported. It is publicly available on the federal website on the Form 990s that the hospitals submit. It's extremely time consuming. The first step here will be for the state to collect those forms. That's what's required and will be putting into implementation. And then, you know, subsequent to that in terms of looking statewide across, I mean, ultimately I think the goal is to have a better understanding of charity care and what that looks like at a regional and statewide level. The first step was to collect and require the collection of this information so that we could begin to get a handle on it. It is certainly categories that we look at and there are published national reports of states in terms of their reporting on charity care, and in particular the community benefits spending allotment. We do look at those as well.

Mr. Lawrence Do you have a plan in place that at some point you will be generating a report a year, six months?

Dr. Fish So at this point, the requirement is to collect the information at a statewide level. That's phase one, and then we'll take it from there in terms of follow-up reports.

Mr. Lawrence I don't know what's the appropriate time frame for a follow-up in terms of the...

Mr. Kraut Yeah, I think once the data is available, it will be available to us as well when it's collated.

Mr. Kraut How long will it take? I would also say there are numerous organizations that collect and publish this data and do comparative analyzes. The difference is, just like quality ratings, everybody uses a different methodology. Those that follow the IRS tax methodology, which it's very prescriptive, you get audited, make sure you're doing it right. Some organizations will discount certain categories, say, that's not really community benefit that you're subsidizing Medicaid or behavioral health or that. There isn't an organization that I am not aware of. That doesn't collect, particularly on charity care, people's ability to pay, discounting the bills or writing them off. There is a lot of that information from other parties other than the state that does this. I guess you're basically saying when the database is ready, it'll come. Now, everybody is filing at the end of this year the community service plan, or do they have to file...or the implementation plan? All of that data is going to be available in some way. If you're looking for comparative analyzes, if we don't have the Department of Health, maybe there's a third party from the IRS and stuff. The Institute is one of them. Again, there are ones that they have a methodology that ignores the methodology that the federal government and the state holds us to. There's all of these different ones. No, I would say the difference of opinion because their perspective is their perspective, and I can't say it's wrong. It's just not what others might think.

Mr. Lawrence When we are looking at an application, charity care is always a reference point. I think in our last committee meeting, it was the question about charity care. It is very hard to be fair to applicants if there is no real standard upon which we are look at charity care.

Mr. Kraut I mean, Dr. Boufford will maybe touch upon that about in a second when we get into that. We do get information. You're trying to make comparisons between providers, but we're looking at the provider in relation to the community and to the service type they're giving. We don't have, I think, standard data if you're an ophthalmology surgery center and what was a reasonable expectation for charity care or Medicaid access relative to a multi-specialty or to a hospital based. You're right. There isn't good data here. We've used, I think, somewhat subjective criteria. It has served us well because what we've seen is a commitment increasing. Nobody comes in here saying I'm not taking care of it. What we don't know is after we approve them, we get a report, I think, once a year, am I correct, of the actual reported Medicare and charity care of every center, for example. We got that in February in our annual report. I think we got it in our report. We do get that data every year. The department is using data to follow up on that.

Mr. Lawrence It might be helpful, then, if the data is collected and there's some analysis, then we can then be able to have some comparative analyzes across regions and across different sectors.

Mr. Kraut Dr. Eisenstein.

Dr. Eisenstein Larry Eisenstein, council member. Thank you, Dr. Fish and Mr. Lawrence. I can comment on this as I'm ultimately responsible for community benefit in my system as I've come to learn good data is really important, but bad data or data without context can be really dangerous. I think this is a circumstance where there's no doubt we should be doing community benefit. There's no doubts it's a requirement regardless of what you feel about it, but absolutely we should be doing community benefit. I think all hospitals and Article 28's do a certain amount of it. Standardizing the evaluation is really complicated. It

sounds simple. It's not. We certainly aren't going to go into this today, but as I'm sure as the department knows, what qualifies and what doesn't qualify doesn't always line up, doesn't always make sense, and what's evaluated by one group looking at it. I've seen all the different reports is different than what's evaluated as another. I'm reiterating what you said, Jeff. Community benefit is not always looked at apples to apples. And if we're going to be fair, it needs to be. If we are going to hold people accountable, it definitely needs to be. I think it's great that we're collecting the data, but the proof is going to be in the analysis, getting that right so that we could say not just a number that doesn't have any context or, well, this hospital does more than that hospital. They may serve very different populations. They may offer very different services. There's got to be a context put to the numbers behind community benefit. I think this is a very large project that we need to get right going forward. It's important, but I urge everybody, don't just jump to a conclusion based on a report that might not be accurate context. That's my opinion

Mr. Kraut I mean, you're going to see the next round of these increase support for funding research, which is a community benefit, because of cutbacks in the federal dollar. You're going to have changes. Some people will argue, well that's not what we're talking about when we talk about community benefit and the prevention agenda.

Mr. Kraut Yes, Dr. Berliner.

Mr. Kraut Howard, just a little closer so the rest of the room can hear.

Dr. Berliner Mic wasn't on.

Dr. Berliner Dr. Fish, I wanted to ask you about the status of the Bad Debt and Charity Care Fund. How much do you know, ballpark, how much we collect? I ask this in part because one of the reasons we approve D&TCs, and ASCs is because they contribute to that fund. Just like to know how much that we're actually getting from it and how that helps that overall charity care and bad debt problem.

Dr. Fish I can take that back. I don't have that figure off the top of my head, but I got the question related to bad debt charity care. Thank you.

Mr. Kraut This is a good tee-up for Dr. Boufford's conversation.

Mr. Kraut Any other questions for Dr. Fish?

Mr. Kraut Yes, Dr. Soffel and then Mr. Lawrence.

Dr. Soffel Good morning. I have two questions about charity care. The first is, when the charity care regs were first changed in New York State, there was a lot of concern about hospitals' compliance with the new rules in terms of posting their charity care policies and advising patients about how to obtain reduced rates at hospitals. I'm interested in what the department does currently in terms of monitoring hospital compliance with the charity-care requirements. My second question is, I read periodically about hospitals that are more aggressive in pursuing collections on patients. I was just wondering whether the state looks at all at hospital collection policies against patients and those that appear to be more aggressive in their stance on patient collections.

Dr. Fish To the second question, we do take in those complaints, and we are actually working to establish a person whose kind of sole role would be doing that and looking at

that across the state more broadly. The monitoring of the charity care is something that the department does do to an extent. Again, this new person will be doing this from the more broad-level, widespread, comprehensive view and understanding of the charity care and how it's applied across the state. We do get complaints that come into the department, and they right now come into Mark's center, his previous center, and his team works to address those to the extent that we can with the expertise that we have. It is an ongoing work in progress. I don't know if there's anything that anyone else wants to say from the Department in regard to that, but if so, I'll just open it up.

Dr. Soffel Just to be clear, so it's the monitoring that goes on is in response to complaints and not sort of a routine looking at different hospitals and assessing their policies in terms of compliance.

Dr. Fish Mostly its complaint driven, I would say at this point, yes.

Mr. Lawrence I guess, Dr. Fish, I appreciate that it's pretty difficult to come up with a standard. I think at least if we were able to get a report that outlines what we don't know and what the issues are, and that might, you know, I know it would help me to understand when we're looking at charity care and someone comes in and they're at tenth of a percent. They're projecting that to understand what that means relative to someone else who's coming in and we're beating up on them and they're at 2%.

Dr. Fish Thank you for the suggestion.

Mr. Kraut Any other questions, maybe on a different topic, because I know Dr. Boufford is going to try to address that?

Mr. Kraut Before I introduce and ask Dr. Boufford to speak, I just want to make a, I want to reiterate something. Dr. Ortiz, I saw your name on the table, but I didn't realize you were here when I said this, so I'm going to say it again. Because I have to increase my field of vision, I, Dr. Ortiz, and some of you were not in the room yet when I said this, but who's Dean at the Decker School of Nursing in Binghamton has just been appointed the editor-in-chief of the Nursing Science Quarterly, which is a big honor. It's an impactful publication that focuses on nursing theory, practice, qualitative, and quantitative analysis. I just wanted to congratulate you. I wanted to acknowledge it. Basically, give this as another example of the expertise that's in this room and the diversity of that expertise as we address some of the issues. Congratulations on that honor.

All (Clapping)

Mr. Kraut I am assuming it's not going to affect your participation here, but you can multitask. It's still an honor to be acknowledged and it just talks about your professional competency and excellence. We're glad that you're sharing it with us. Thank you.

Mr. Kraut Dr. Boufford, we'd like to give a report on the Public Health Committee and the Ad Hoc Committee to lead the state health improvement plan.

Dr. Boufford Thank you.

Dr. Boufford I want to give a little bit of background, if I may, just for some new members of the council and others. We need to be reminding ourselves, because we have a lot of very diverse portfolio in this council. First of all, the PHHPC has statutory responsibility for

overseeing the prevention agenda. That's why we talk about it. It's not a sort of because it's interesting and side activity. It's that we have that responsibility. I think that's important to clarify. The Public Health Committee does that really on behalf of the PHHPC. The PHHPC approved the current cycle, 2025 to 2030, in September of last year. Between then and there were several meetings of the Public Health committee, the most recent one in June, Liza Whalen and her team, thank you so much Liza, you've done a terrific job, has been sort of setting up the infrastructure for implementation. The Commissioner noted that the prevention agenda was in fact released in July, and the guidance went out to local health departments, to hospitals, et cetera. It's underway, but it's been a little slower evolving than we originally had thought, the cycle originally thought. We're on top of it in terms of representing your authority. I wanted to talk a little bit about the Public Health Committee for a minute and then talk about the Ad Hoc Committee meeting which was yesterday. We had a really good meeting. The Public Health Committee has been meeting frequently over the last two years in terms of shaping what is now the 2025 to 2030 prevention agenda, and recommended to you, as I mentioned, the approval of the PHHPC, which occurred in the Fall of last year. The Public Health Committee itself is sort of tracks the prevention agenda and has identified two related activities. With Dr. Whalen's office and Dr. Fish, we've had some conversations about this as well, on an interagency vehicle for advising and engaging with other agencies in state government around implementation. The second issue is the community benefit, looking at the community benefits language. When we think about community benefit we're not talking about the entire schedule age. We're talking about one category, which is the community health improvement category. If you read the IRS definition of community health improvement category, it is almost the same as what the prevention agenda is asking hospitals to do in the context of our implementation process. In this conversation for prevention agenda, we are not talking about disproportionate share, we are not talking about Medicaid gaps, we are not talking about GME, we're not talking about research. We're talking about this one category which is very clearly defined by IRS linked to the prevention agenda and the hospital's investment in community. In the other two issues that the Public Health Committee always identifies one issue they want to work on for each year or two. Public health workforce is the one that's been picked. We've been getting regular reports on public health work force from the staff in the department. Because the council had been very active a number of years ago, I'm really looking at the issues of maternal mortality and prevention of maternal mortality. We get a report once or twice a year at our meetings on that. That's what the Public Health Committee is working on.

Dr. Boufford The Ad Hoc Committee was created initially as a, if you will, a public advisory committee for New York State's application to be accredited by the National Accrediting Body. In New York State is, but I think it's one of the first large states to get accredited back in the day, and a number of county health departments are accredited. That vehicle has continued since that time. It's sort of renewed with each new cycle of the prevention agenda. We invite those that have been on it to continue. It's kind of open engagement. The members of the Ad Hoc Committee are state level, non-profit organizations, professional associations, advocacy groups and sister agencies within government. I think we have between thirty and forty that have officially indicated interest and registered their involvement in that group. The idea of it is twofold. One is during the development of the prevention agenda, which did occur, there were several meetings of that group over the last couple of years. They advise we use that vehicle as for public discussion of some of the issues that are present, the design, the implementation strategy, et cetera. And then once the prevention agenda is approved, which it now is, that group becomes, if you will, a partnership network for implementation of the prevention agendas. The idea is, because they are state-level entities, they have constituencies. Some of them

have infrastructures at state and county level, at county and regional level. We ask them to engage their members and their constituents in education about the prevention agenda and especially getting them involved at local level around the table when the local health departments and hopefully hospital partners are developing their responses to the requirements of reporting on the self-service plans and the community health plan. That's what that structure is about. The core of the Ad Hoc Committee is, of course, the Public Health Committee. They do double duty. We had a, I want to just pause for a moment to say we're, to again thank Dr. Whalen, who's been with us for a little over a year now, who's taken this on as a point person for the prevention agenda of the department, who's has been incredibly helpful and collaborative. We were pleased to be introduced to a number of staff who were supporting the work of the prevention agendas yesterday. Two I want raise, one is Mark, who's taking over as the new director of the, what is the local health services office, and other colleagues that are assigned from different divisions of the department working with him. We were happy to introduce to the Public Health Committee had met her already, but the Ad Hoc committee had not, Dr. Michelle Williams, who's been recently appointed as the Deputy Commissioner for Public Health. I might give her an opportunity to say a word or two here to introduce ourselves to the council.

Dr. Williams Good morning to everyone. Thank you so much, Dr. Boufford, for the introduction. I know I've met a number of you and some of you I haven't, and I look forward to meeting you. I can tell you I am enjoying my position as the new Deputy Commissioner for the Office of Public Health at the State Health Department. This is my second time with the Health Department, so I'm actually glad to be I got good training earlier in my career from the New York State Department of Health, and I hope to use my experience at the federal level as well as executive positions at the state and local level, including serving as Health Commissioner for the U.S. Virgin Islands to continue to improve the health of New Yorkers. Thank you very much, and I look forward to working with you.

Dr. Boufford Thank you very much.

Dr. Boufford As I mentioned yesterday, we had the first meeting of the Ad Hoc Committee for the Prevention Agenda in this new cycle. It was very well attended. Thank you, very much, by the Public Health Committee. They're always stalwart, so I wasn't surprised. We had a number of members of the council who attended as well, which is great. And also, were introduced, as I mentioned, a number the staff. We had representatives from several agencies, most prominently Office of Mental Health, OASAS, Office of Disability Services, and AG and Markets, who have been regulars. One of our regulars from the Department of State wasn't there, so I'm going to track him down after this Paul Beyer, who is well-known to everyone, who's been incredibly helpful. Yesterday's meeting was largely a very rich briefing by Liza Whalen and her team. We heard about the overall design of the prevention agenda, the data, the implementation strategy, and also the mechanisms for monitoring progress and evaluation, the sort of setting up of a new website, revising the dashboard, et cetera. Everybody got to learn about those. The Public Health Committee had heard much of it already, but the Ad Hoc Committee had not. Talking about the resources available to their members for disseminating information about the prevention agenda. It was a really rich discussion, although a lot of it for good reason was presenting to the group and getting questions answered. There were a few questions asked, which will be on the table for the Public Health Committee. We're looking for another meeting of that committee at the end of October, beginning in November, and the Ad Hoc Committee again in December, so that we're all geared up to. Hit the ground running in the new year, as the local health departments and the hospitals are. A couple of the questions that came up. The degree of collaboration historically between the goal is for hospitals and local health departments to

work together in sharing the community health assessment and community health needs assessment and their plans over the last, I would say, decade or more of several cycles of the prevention agenda. It continues to be voluntary. We've had about 45% alignment of that. Again, I think one of the things we're looking at is the degree to which we may need to be a little more directive, I guess. There's been a reluctance to do that. It's even more complicated than it used to be, because now the consolidation of a number of hospital systems and smaller hospitals relating to a local health department or some local health departments not having a hospital any longer in their patch. That was a really important issue that we're going to talk about. The second issue was that we had spent a lot of energy in the last cycles to align the timetables required of hospitals for submitting their reports that Jeff alluded to, as well as the local health department. Because of some of the delay, really, and getting some of it had to do with the agenda. We're a little off cycle. The hospitals legally have to get their reports in. We were advised by Dr. Whalen that the plan is for the local health departments to meet the schedule they have and then to look at the plans of the hospitals in their geographic area and talk about how they're going to align. We're trying to let everybody do the thing they have to do but connect the dots sometime after the new year. See if we can get back on cycle for the sort of year three or four of this particular phase. We were also advised that there was an RFA out to hire a consultant to work on equity, capacity building on equity for local health departments, and that will be awarded shortly. We'll hear about that more. Our colleagues from OMH and OASIS were mentioned the notion, and I like to think some of it had to. They've been very active in the shaping of this, but that some of had to do with their deep involvement in previous iterations of the prevention agenda. Each of them has a prevention strategy and a lead person at a senior level in the leadership moving prevention in OASAS and OMH. Those folks were with us yesterday and again talking about aligning their strategies with the strategies that emerge that have now been outlined for the prevention agenda. Issues of language use. It was a really good discussion there. I think to the degree that some of the areas are interested. Obviously, the aging issue is fundamental. It's built into the prevention agenda. There was a discussion also of the inter-agency group that is currently is going to be used, the members being the group that's been convened to work on health equity within the department and across the department. I know Dr. Whalen's made one presentation to them now that the prevention agenda has been issued. She's going to be meeting with them again in the next weeks and seeing how effective, if they can address the interagency angles of the prevention in addition to their other responsibilities, then there may be other agencies in state government that need to be involved. What we'll be doing between now and the Public Health Committee meeting is sort of following up specifically with information for the Ad Hoc members about how they, that was last question, was one of them saying, how can we get involved and help? We talked about it in general terms, and we'll make some suggestions and see how that goes. Also aligning, making really clear to them how they can access the resources of the department for technical assistance, to give talks to their constituents, all of this has gone on in the past. We're finding ourselves that a lot of the staff that are leading the prevention agenda now, nobody was around for the last cycle, so we're sort of putting together a lot of the institutional memory and history, but since it's a new cycle and newly designed, there's no huge problem except we don't want to reinvent the wheel if we've already invented it. We want to be able to use it when we can. Anyway, I'll stop there, and we'll have more to report to you at the next meeting of the PHHPC.

Mr. Kraut Are there questions for Dr. Boufford about anything or that followed through from the previous conversation?

Mr. Kraut You know, the local departments of health, I'm assuming statewide, they're under-resourced to do a lot of the things we need to do. I'm going to go out on a limb here and say you don't have enough money. Dr. Eisenstein wrote, or Eisenstein led the Department of Health for Nassau County, Dr. Yang was involved in New York City. Dr. Watkins, I just assumed everybody knew Dr. Watkin's Commissioner there. It always struck me, yesterday I saw a presentation of the capacity of the state health information network that is being formed under the New York Health Collaborative and the Rios. They are now creating a massive data lake of all these different feeds from individual cases that you can really visualize public health issues, I think, in a more granular way than we've ever been able to do. You may have a single source of data, and I would just suggest that at some point in the future. It's not only for identifying health needs, but for the kind of things Mr. Lawrence was talking about, his response to it, where people are focusing. It just gives us, I think another tool that may produce a thing once that database gets matured and is accessible. I know that's a project that the Department of Health is focused on and is leading a lot of the data in the department. It has enormous, I think, implications for some of the things that you've discussed. It's exciting.

Mr. Kraut Go ahead.

Dr. Boufford Yeah, no, I think historically when the investment has been a significant investment made in data and IT consolidation integration over the years, public health data has not been included. Population level public health has been largely coming from hospitals. I'm glad you mentioned it. Hopefully, it is now going to be part of this database. If not, we can meet with the folks that are doing it to make sure it is.

Mr. Kraut Because in the 1115 waiver, the hero, you know, we're doing all these social determinants screenings that are chock full of information that also help, and that's going into this data lake. You're right, because I've spent a lifetime using data, but reverse engineering it from community perspective, not hospital perspective. I think we have more powerful tools if they can be harnessed that would just be good data drives good policy, and good policy should drive good funding decisions.

Dr. Boufford I just want to, because you opened the door, I'm just going to clarify, and this is really important to both Ann and Jeff, and I'm glad you mentioned it. The use of social determinants is, again, subject to definition. I think in the clinical arena, social determinacy is largely about the social supports for an individual patient with the diagnosis. I think that has been, unfortunately, to some of us the waiver focus has been, and Lord knows there's plenty to do on those individual populations that meet certain categories. I think from a public health point of view, the social determinants focuses on the conditions in communities in which people live that affect their health status. The bridge is... You know, the asthmatic comes into the clinic or to the emergency and gets treated, but goes right back to the housing, you know, the sort of---

Mr. Kraut Mold.

Dr. Boufford Exactly, exactly, and I think that's the data set. You're correct. They can be looked at together, especially if one, as one normally does have zip code data or other in New York City neighborhood-level data to begin to look at place-based analyzes of where this clinical work aligns with where the conditions in communities are aligned. I hope to get there. I think it's a very exciting possibility.

Mr. Kraut I just think with the data, with the advent of generative AI and new AI agents, the ability to access that data is. I guess we say this every five years. It's such an exciting time to be in healthcare. I don't mean that in a sarcastic way. It is exciting about what's on the horizon.

Dr. Boufford One example of AI, which is real as opposed to, you know. There's a lot that are real. There's project going on now in New York City with Cornell NYU and the New York City Health Department and the public hospital system looking at having analyzed the social determinants of individual patient groups of hypertensive, looking at preventing hypertension heart disease and stroke early on in the City of New York, getting access to the health and hospitals data after a year of appropriate legal concerns. And then analysis of, because New York City, the data from other agencies in terms of housing stock and greens. All of that is publicly available. You don't have to get permissions and go through a process. They are using AI now, having brought that together, look at the goal is to see which risk factors are most determinative of cardiovascular disease, clinical ones or the ones in community. The social determinants are showing to be much more strongly aligned with patients being at risk for cardiovascular disease, stroke, hypertension, and stroke than the clinical ones. What AI has allowed people to do is look at enormous databases that were never available and also get involved in predictive analytics to say, if we know these are conditions in communities, how can we look physically in these places and then crosswalk it with patients that are at risk and get everybody working together on it. This is really exciting stuff. I want to give credit to the Novartis Foundation in New York City for funding this basic information and also bringing together a lot of donors, a lot of foundations, and others are very involved.

Mr. Kraut I'm just concerned because I could nerd out on this.

Dr. Boufford It's really happening.

Mr. Kraut Look, just knowing the housing that has mold and giving an alert if a patient shows up that lives at that address would be beneficial. I'll spend the whole day doing this. It's my favorite thing. Thank you, Dr. Boufford, for that discussion.

Mr. Kraut I'll turn it over to Ms. Monroe, who's going to give us an update on the health plan.

Ms. Monroe Well, it's hard to follow that level of excitement and joy. John Ruge's not able to be here today. He's in Iceland. Too bad for him. As Vice Chair of the committee, I want to give you a little report on where we are. We've kind of refocused and restarted with a lot of new members because the council had a lot of new members. When we first started, we have so many experts on that committee in the larger world of health planning that the initial thought was we can tackle why isn't primary care more used or what happens. It became clear that that was just not a place to start. After conversations with the department and with the leadership of the council, we decided that we would focus, John and I decided we would try and focus our work on PHHPC planning. In other words, things that PHHPC needs to decide that needs planning and research by a committee of the council. A topic that was extremely interesting to the administration and the department and bubbling up in the community was whether or not we should be shifting or allowing to shift from hospitals only to ambulatory surgery centers, diagnostic and interventional PCIs. There's a lot of arguments for it. There are a lot of arguments against it. Our committee met and really identified some key questions that we had. Tomorrow our meeting is public comment. In asking for that public comment, we listed a few very specific questions that

we wanted these commenters to address. Let me just tell you what they are because I think they're critical to a decision around this. Give me one second. One is, should it be allowed to move at all from hospitals to ambulatory surgery centers? If so, should those ASCs be only those affiliated with hospitals, or should they be ones that are self-standing, free-standing? Another question was, should it be only not-for-profit ASCs or for-profit ASCs? What is the impact on the community if you move things out of a hospital? What is impact on financials if you moved it out of the hospitals? There's no question that it's a relatively lucrative service that hospitals provide? What happens if you move it out of there to hospitals, particularly safety net hospitals? And then also, should we recommend to the council that perhaps there be a demonstration project where we can track carefully the impact of this kind of shift from hospitals to non-hospital settings? We ask those specific questions of the people who are going to testify tomorrow. Look at my committee, I think I covered them pretty well. We're very excited to hear what their opinions are about this. No surprise, we have hospitals speaking who have a certain perspective. We have ASCs speaking who have a certain prospective. We also invited community groups. Medicaid Matters, the group that...I don't mean it's her personal group, but Lois Utley's group that she represents that has had a long-time community perspective. We're hoping to hear from those folks tomorrow. Just briefly, our plan before we come to the council is our September meeting is public comment. Our October meeting is an informal educational session to fill in what we didn't hear from the community or from public comment and hear from the department the data that we have. November, we will meet to really begin to finalize our recommendation to the council and our December meeting will be before the December council meeting, so that we can present the collective recommendations to the council about how to move forward. Just a caution to everybody who's excited about this is that it still will have anything we recommend, if it involves regulation, we'll have to go through the department to write the regulation to the codes committee, back for public comment before it's implemented. None of this is quick action that we're working on. We think it'll be a good test for the committee to take an issue and really work with it. It seems to be an issue that's of great importance to a lot of actors in the system. Does anybody have any questions or added comments? Anything I missed from the committee or?

Mr. Kraut I have a generic comment, and it's to compliment you, Dr. Ruggie, the committee members, and the department. One of the things that struck me about the process is it's so well thought out. It has a roadmap. You've identified the questions you want to answer. You created a timetable for a deliverable. In my mind, that and to some degree with the Ad Hoc Committee who did a similar, these kind of templates is a great template for dealing with issues.

Ms. Monroe Well, now the pressure's on not to delay it.

Mr. Kraut Delaying is inevitable at some times because we don't control anything, but I just want to compliment you on how organized and thoughtful the process was, because I think it is a very good template to deal with difficult issues. We've always struggled at doing things that are substantively important to the work of the council, so congratulations.

Ms. Monroe Well, I just also want to say that Dr. Heslin and Abigail have been extremely helpful to us in this. We're working hand in hand.

Mr. Kraut Even if you're not on the committee, if you want to see it or participate, first of all, you can watch it online, you can be here, it's going to be tomorrow at 10:00am.

Ms. Monroe We have scheduled 10:00am to 1:00pm.

Mr. Kraut 10:00am to 1:00pm.

Ms. Monroe We don't know how many people are going to be there to testify. We have gotten a few letters, but whether the people are coming in person, we don't know. We'll play by ear tomorrow.

Mr. Kraut Please feel free to join even if you're not a member of the committee.

Dr. Kalkut Could you talk a little bit more about the for-profit, not-for-profit discussion for this? No, no, just what was the thinking.

Ms. Monroe If you want to move in that direction, if they're affiliated with a hospital, they probably won't be for a process. If you're an independent ASC, you may very well want to take this on, and we want to hear kind of a perspective of both on that. I would just say I don't think we have expectations of what we'll hear, but we'll know more after the meeting

Ms. Monroe Does that answer that?

Dr. Kalkut I realize it's early, but that's a big deal.

Mr. Kraut I'll now turn it over to Mr. Holt to give us an update.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt The PHHPC has formed an Ad Hoc Committee to review and develop recommendations for the nursing home Certificate Of Need application process. This committee was established in response to concerns that were raised during the April 10th, 2025, meeting where three nursing home transactions failed to gain approval. The committee's primary charge is to create uniform policies that can be applied consistently across all nursing home reviews, particularly focusing on the qualifications of proposed operators, the financial feasibility of those transactions and the oversight of services and related third party agreements and the appropriate use of conditional approvals to ensure quality and sustainability. To accomplish this work, this committee will be chaired by my co-chaired by myself and Mr. La Rue. I believe Mr. La Rue will be joining us via Zoom for our actual meeting probably this afternoon. It will be a small focus group comprised of members of the PHHPC, the department and the Department of Health. The committee has agreed to hold a total of four public meetings over the next 120 days, and at the conclusion of each meeting, the co-chairs will present their findings and recommendations to the full PHHPC. Written input from the public is encouraged and can be submitted to Colleen Leonard at the PHHPC. The first meeting of the Ad Hoc Committee is scheduled for this afternoon in New York City and will convene immediately following the full meeting. During this session, the committee will begin its focus review of key areas, including establishing a clear standard of adequate and relevant experience for new operators, assessing the short and long-term financial viability of projects, and evaluating the impact of consulting and related party transactions on operational responsibility. The committee's work is crucial for developing a more transparent and consistent CON process for nursing home establishment and ownership transfers.

Mr. Kraut Thank you.

Mr. Kraut Again, here's another example, very structured, very clear charge, what the deliverables are, series of four meetings. It's a good template, I think, much like the Planning Committee.

Mr. Kraut Any questions for Mr. Holt?

Mr. Perry I notice that there was no mention of owner requirements, simply operator requirements. Will owners be considered as a part of the work that this committee is undertaking?

Mr. Holt Yeah, I think the terms are somewhat interchangeable. Yes, by all means.

Mr. Kraut Any other questions?

Mr. Kraut Again, it's going to be following a lunch break after this meeting. Today it's going to be held. If you'd like to attend and listen in, please do so. You can also do so by Zoom.

Mr. Kraut I am now going to turn over to Mr. Holt to give a report on the Codes Regulation and Legislation Committee. Thank you for looking over my shoulder.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt Good morning. At the September 18th, 2025, meeting of the Committee on Codes, Regulations, and Legislation, the committee reviewed and voted to recommend for adoption the following regulations for approval to the full council first being the twelve-week rule for foreign medical graduate students and limited permit allowances. Dr. Heslin and Mr. Karmel of the department presented the twelve-week rule for foreign medical school graduates and limited permanent allowances proposed regulation to the Committee of Codes for Adoption. They're available to the council should there be any additional questions. I move to accept this regulation for adoption.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Watkins.

Mr. Kraut Any questions from the council?

Mr. Kraut Yes. Dr. Berliner.

Dr. Berliner Can you just explain what that means in late terms?

Mr. Kraut Do you want the department to do it

Dr. Heslin Dr. Heslin, First Deputy Commissioner, Chief Medical Officer for the department. That's about the first time I've ever heard that. In layman's terms, there's a rule in New York State that says that people who go to foreign medical schools that receive training more than twelve weeks outside the country that foreign medical school is in cannot practice in New York State. There's a rule in New York State that exists, been on the books for many years that says that people who go to medical schools outside of the United States and receive training outside of the country that that medical school is in.

Mr. Kraut Training, not education.

Dr. Heslin Training for more than twelve weeks, they cannot practice in New York State unless that medical school is accredited by the State Education Department. There are seventeen schools that are outside this country that are accredited by the state education department. What we have done here is we are changing the way the regulation is written to allow people that are in that category that do not go to those seventeen medical schools that do receive training and education in residency that is accredited by a United States accredited training program to be able to then practice in New York State. This is essentially taking a category of people that would be ineligible to practice in New York State and allowing them to become eligible to practice New York State.

Dr. Berliner Can you give an example of one of those schools?

Dr. Heslin There are schools in other countries that are currently accredited. For example, Singapore, one of the Singapore schools. There's some schools in Israel. There are seventeen around the country, around the world.

Mr. Kraut These are accredited by ACGME.

Dr. Heslin No, these aren't accredited by the State Education Department.

Mr. Kraut Because they're all internationally accredited by ACGME.

Dr. Berliner If someone went to Oxford for medical school and then spent twelve weeks in, I don't know, some, they would not be allowed to practice in New York.

Dr. Heslin This is state education.

Dr. Boufford I'm really kind of going where Howard's going. My impression was that people that were international medical graduates had to be accepted in an accredited residency program in the United States and be trained in order to practice in the U.S. I'm confused with the medical education part versus the residency training part.

Dr. Heslin You're correct. However, if you're in this twelve-week section of the rule, you can't practice in New York. That's where the problem was. We have now eliminated that, and people who are going to accredited residency training programs in New York State will now be allowed to practice in New York State.

Dr. Boufford Thank you. That's really helpful.

Dr. Berliner Can I just say, Jeff, I mean, in this very room, many years ago---

Mr. Kraut I know what you're going to say.

Dr. Berliner The late Tom from Columbia chaired a committee on graduate medical education. At that time, the concerns were largely in New York about accepting or licensing graduates of mostly the Caribbean schools. Tom raised the question, just, well, so what if someone went to Oxford? The reaction of the committee was basically as if. That's why I raised the issue of Oxford, just so I have a surprise.

Dr. Heslin Oxford could always apply to State Education Department and get that accreditation, which had been previously the path. The new path now is that upon

approval of this committee, essentially people who are trained in the United States for residency will be eligible to practice in the state.

Mr. Kraut For the public health hospitals, this is a very important issue.

Dr. Heslin Extremely important.

Dr. Berliner Roughly how many people are we talking about on a yearly basis?

Dr. Heslin We don't actually know because we haven't had this rule in place before. It's a subset of a subset people. It's only for people that are outside of their medical school in another country for more than twelve weeks. A routine Oxford person could come to New York State, but if you're thirteen weeks somewhere else, like it went to Africa, Nigeria, pick a country for thirteen weeks, you wouldn't be eligible. It's a subset of a subset that we're trying to close the loop for.

Mr. Kraut I have a motion.

Mr. Kraut I have second.

Mr. Kraut Are there any other questions?

Mr. Kraut Hearing none, I'll call the vote.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Holt Next for adoption, we had the expedited partner therapy for sexually transmitted infections. The department presented the expedite partner therapy for sexually transmitted infections, proposed regulations to the committee on codes for adoption and they're available to the council should there be any questions of the members. I move to accept this regulation for adoption.

Mr. Kraut I have a motion.

Mr. Kraut I have second Dr. Berliner.

Mr. Kraut Are there any questions of the council on this?

Mr. Kraut Hearing none, I'll call for a vote.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Holt Lastly, we had for information proposed regulation that was presented to the committee for information only and will be presented to committee and the full Public Health and Health Planning Council for adoption at a later date and that was the cyber security requirements for public water systems. This completes the agenda of the PHHPC Codes, Regulations and Legislation Committee.

Mr. Kraut Thank you very much, Mr. Holt.

Mr. Kraut I'm now going to turn to Mr. Robinson to give a report of the Establishment and Project Review Committee.

Mr. Robinson Thank you, Mr. Kraut.

Mr. Robinson As you mentioned, I'm going to be batching these applications. For any of you that wish to have an application taken out and discussed and moved on separately, please signal that. We can do that at any time. But if you know it now, please, it would be helpful.

Mr. Robinson This first batch is for acute care services, Application 251211C, North Central Bronx Hospital in Bronx County, expand and renovate the emergency department. In the process, the Comprehensive Psychiatric Emergency Program, or CPEP will be relocated with its own dedicated ambulance bay. The department and the committee recommend approval with conditions and contingencies.

Mr. Robinson Application 251281C, SBH Health System in Bronx County increased the number of its inpatient psychiatric beds from 49 to 72, obviously an increase of twenty-three beds, through the conversion of twelve inpatient chemical dependents, detoxification beds, and the certification of eleven new psychiatric beds. SBH will renovate the hospital's two existing inpatient-psychiatric units and create a new inpatient psychiatric unit on another floor. The department and the committee recommend approval with conditions. I move that batch.

Mr. Kraut I do have a second, Dr. Berliner.

Mr. Kraut Is there any questions on any one of those applications?

Dr. Yang I just need to belatedly declare interest on both.

Mr. Kraut Dr. Yang is declaring an interest on both, but she can still vote.

Mr. Kraut Is there are any other questions?

Mr. Kraut Hearing none, I'll call for a vote.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Robinson These are individual. Dr. Lim, this is your conflict and recusal. Application 231342C, Mount Sinai Hospital in New York County, convert forty-eight physical medicine and rehabilitation beds to eighteen intensive care and thirty medical surgical beds. Decertify forty medical physical medicine and rehabilitation bed and perform renovations to create a cancer hospital on the Mount Sinia Hospital campus. I will note we had a very extensive conversation with the new leadership team at Mount Sinai. I was actually impressed with their new commitment to effectively engaging the community in any future projects that they do. I think that was a concern that the community broadly has and certainly the council did as well. I just want to acknowledge that comment and with that noting the department and the committee's approval. With conditions and contingencies, I move the application.

Mr. Kraut I have a motion.

Mr. Kraut May I have second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Dr Lim is out of the room.

Mr. Kraut Are there any questions on this application?

Mr. Kraut Hearing none, I'll call for a vote.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson Noting Mr. Kraut's departure because he has a conflict and is recusing himself from this application. Number 251133C, Peconic Bay Medical Center in Suffolk County. Perform renovations to move the maternity unit and C-section suite to an expanded combined first floor space. Department and committee recommend approval with conditions and contingencies. I so move.

Dr. Boufford I have a motion.

Dr. Boufford Do I have a second?

Dr. Boufford Dr. Watkins.

Dr. Boufford Any discussion?

Dr. Boufford All in favor?

All Aye.

Dr. Boufford Any opposed?

Dr. Boufford Please have Mr. Kraut return. Mr. Kraut can come back in.

Mr. Robinson Application 251146C, Clifton Springs Hospital and Clinic in Ontario County. I have declared an interest but will participate and vote. This is to construct a new extension clinic at 833 Canandaigua Road in Geneva to be certified for multi-specialty ambulatory surgery, physical therapy, and other medical specialties. Department and committee recommend approval with conditions and contingencies. I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have second, Dr. Berliner.

Mr. Kraut Any questions on this application?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson Another application with a conflict and recusal, this time by Dr. Kalkut, who's leaving the room. Application 251287C, Cumberland Diagnostic and Treatment Center in Queens County. Construct a new extension clinic at 1720 Village Lane in Far Rockaway, providing primary care dental, mental health, and other medical specialties. As an FQHC safety net, the department and the committee recommend approval with conditions and contingencies. I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have second, Mr. Thomas.

Mr. Kraut Any questions on this application?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Robinson This next application I'm going to take separately, because it comes forward from the committee without a EPRC recommendation. This is application 251157C, Hospice Buffalo, Inc in Erie County. This is for the renovation of existing vacant space into offices, conference rooms, and educational space, while simultaneously decertifying the ten beds in that area. Patient care areas will not be impacted. The department has recommended approval with conditions and a contingency. The committee

is advancing this forward to the full council with no EPRC recommendation. I make a motion for the application.

Mr. Kraut I have a motion.

Mr. Kraut May I have second?

Mr. Kraut Dr. Berliner.

Mr. Kraut The reason that was brought forward without a recommendation is the committee had questions for the applicant who was unable to be at the EPRC meeting, and we felt that we didn't want to hold it over a cycle. What we asked the applicant to do is to respond to the questions in writing, which we all, I believe have received. Everybody got a letter from the hospice, just clarifying the question we had about the use of the space and the use the beds and why they were decreasing the number of beds, and that was due to kind of economics of that. Departing from our usual process, I did ask the applicant to come here in case there were additional questions that were not able to be answered. I just want to make you aware of that. If anybody has any questions on this application that the department can't answer, we do have the applicant in the room. The applicant is here, yes. Do you have questions? I hope it's just one of you, because there's only one seat. If you just sit there, yeah, sit there. If you could just introduce yourself, and then I'll ask Ms. Monroe to just pose the question she has.

Ms. Sisti Good morning. My name is Cary Sisti. I'm the Chief Clinical Operations Officer at Hospice & Palliative Care Buffalo.

Mr. Kraut The person next to you is?

Ms. Chirico Hi. I'm Jean Chirico. I'm the President of the Hospice and Palliative Care Association, sitting here at the request of Cary.

Mr. Kraut Thank you.

Mr. Kraut Ms. Monroe.

Ms. Monroe This is an unusual process, so if I ask questions that should have been asked last time.

Mr. Kraut No, no, you're free to ask any questions. There's no restrictions.

Ms. Monroe First of all, I want to say I'm from Buffalo, so I'm very familiar with the organization. I have nothing but good things to say about it. These questions are not related to the quality of care you provide or your impact in the community. When we got the report from the department, the detail was all focused on the office space, that this closing of beds was going to take place. There'll be a conference room. There will be a training room. It was all very nice. I looked at it and said, you have a total today of thirty-two inpatient beds. You want to close ten. That's a third of all of the hospice inpatient bed in Erie County. That concerned me. We heard last, at the last meeting and in the letter that you wrote, there was a reference to help me, GLP beds, is that it? I forget what those are called.

Ms. Sisti The GIP beds, which stands for general inpatient care, which is the acute care.

Ms. Monroe Right, which is what makes inpatient hospice difficult. The rest of the letter and the letter from, and then also the letter from the association talked about all of the competitors that you're seeing, kind of hospice-lite that are not really providing the full compilation of care, but you're feeling that competition. One other, just fact before I go to my question, in the letter that you provided, you said that your average daily census of people served, excluding inpatient care was 411. You're seeing 400 people a day outside of your inpatient here. Is that correct?

Ms. Sisti That's correct. In order to be able to come into the hospice inpatient unit, you have to be enrolled in the hospice program. With the inpatient being short-term acute care for patients already in the hospice program, those patients will come and go from the unit out of that total active hospice census we have. We've on average had between 400 and 450 patients enrolled in hospice Buffalo per day. To Jean's point around the competition in the community, so the big question is, obviously we all know that hospice utilization is the lowest in New York State, and that's a huge problem. It's a long-standing problem. Biggest issue that we see, so for us in Hospice Buffalo, we have full capacity to take on more patients. There are 100% patients in our community, in our county that are eligible for hospice and need hospice services. It's not because of a lack of ability to serve. It's really that referral that's not coming to hospice. And so, to Jean's point around the competition in Erie County, we've seen a huge proliferation of serious illness or chronic complex care programs pop up in Erie County, who often will say to us as a hospice provider, staff up, we're going to have tons of referrals for you. Unfortunately, we never see those referrals come. In fact, as we've seen those programs pop up in our community, we actually see less referrals. If they do get to us, the length of stay is incredibly short. That's the competition piece that Jean was speaking to.

Ms. Monroe Help me with that. All of the activities that you put in your letter are to increase referrals. What's your occupancy on the remaining... What would it be?

Ms. Sisti Twenty-two beds. It's sadly low. So, following COVID, we and many others across the state never saw the inpatient unit census rebound.

Ms. Monroe It was higher before COVID?

Ms. Sisti It was much higher. There was a time, I've been with our organization for over twenty-eight years, and there was a time in our twenty-two-bed unit where we had an average daily census of 2023 and 2024. It was that active. As we've seen things change in the community, a lot of that, some of it started with COVID. Post-COVID, I think the biggest impact we've seen is all of these other, some unregulated programs that are caring really for the same patients that are eligible for hospice and don't get to hospice because the programs are caring for them and really not referring.

Ms. Monroe What you're saying is that we're not getting referrals. We're not full of the twenty-two beds that we have. We could have a better use for the space that the ten beds occupy. Yet, you're doing all this outreach to increase referrals. That's where I get troubled. Don't you think you're going to need these beds if you're successful at all of the outreach you're doing?

Ms. Sisti We certainly hope so that would be the best outcome all the way around. Again, we're fully willing. The need has not changed for these beds. Our willingness to provide this care in these beds has also not changed. One of the biggest drivers in the decision

right now to change the use of the space and decertify these beds, we haven't done it up until now because of all of the work that we're doing. The main driver now is the auditing environment. There's significant auditing happening in the space, not just in our state, but across the country, really, where they're scrutinizing this general inpatient level of care, the acute level of the care. With conviction, I'm also a clinical person, I can tell you that the patients we're serving and caring for that we've had denied in auditing absolutely meet the criteria. These are patients that are seizing, patients that are hemorrhaging. Auditors are denying those patients. The denial goes through multiple levels of review. We appeal everything on principle, because these patients deserve that care. There's also huge dollars that are recouped that make it very challenging to operate. You have to fight these at every level that often takes years to get them all the way to the administrative law judge level, which we take it. It costs a lot of money.

Ms. Monroe You made that case very compellingly. Do you think the future of hospice is in the community as opposed to inpatient beds?

Ms. Sisti I do. There should be much, especially with what's happening in the hospitals and in long term care. We're kind of in crisis everywhere as I know this council knows very well. What we're seeing is that patients that need the care in the community who aren't getting it or aren't being referred are ending up in the emergency rooms or ending up at the hospital. It's very hard to get people into long term care so it's kind of the perfect storm. Yes, we should see more patients in hospice at home and then we should in turn also see greater utilization of the general inpatient level of care.

Ms. Monroe I see that Dr. Eisenstein has a question.

Mr. Kraut Ann, ask the questions that you want to share.

Ms. Monroe Using this space for something else does not affect your long-range financial plan of building your population in the community in more competition with these other lookalikes that your association referred to?

Ms. Sisti No, financially, so this space is coming, our proposal for what we want to do, the space is coming in large part due to a very generous donation to cover the cost of the proposed construction from a patient that had been in our care.

Ms. Monroe You're getting foundation or foundation funding to go to the offices?

Ms. Sisti Yes, and within that space we're also looking to create sort of an innovative simulation center. When we look at how we can also impact the community through the use of this space, we'll be able to actually use the space to provide caregiver training, not only for patients that are in the community or people that are considering coming into hospice, but for the patients that we do serve in our inpatient unit, we can actually use the simulation center to train caregivers in a much less intimidating way than trying to work with their loved one.

Ms. Monroe I think there are clearly people on the panel who know more about the specifics of operating hospice than I do. I'm just very concerned about a third of the beds available in a county disappearing overnight. While I appreciate you need a conference room, et cetera, it seemed like an insufficient trade-off to lose those beds, but I appreciate your comments.

Mr. Kraut Dr. Eisenstein.

Dr. Eisenstein You had it right.

Mr. Kraut Eisenstein.

Dr. Eisenstein I was one of the people that asked questions which you addressed at the committee meeting. My comments really are not, and thank you, you let her address the questions that I had. You mentioned that New York State is dead last in the United States in usage of hospice. This is really inexcusable for a state that's supposedly so educated and forward thinking. We spend so much money on end-of-life care that could be done more humanely, more effectively, and it's better for people. This is not on you. I mean, you can't walk the streets of Buffalo looking for hospice patients to come to your center. This has to be something addressed upstream in the provider community, through palliative care, through education of providers. For New York to be dead last to where we're closing facilities that is the proper standard of care is insane. One of our roles as members of this Planning Council is to make recommendations, and I think for me there's nothing that I can think of that makes more sense to be addressed by the department or government than the lack of use of hospice care in New York State. Now, I have a personal, both of my parents died in hospices. One of them, my Father, moved into my house. My wife's a critical care nurse. We had home hospice until we weren't able to manage it anymore and then needed inpatient hospice. There is a market for both, and it should be done as smoothly and in coordination as it was. The fact to me that, having had both of parents go through it. That we're dead last in the country in this. Is astounding to me. We really need to take on end-of-life care, and even if you don't see the humane side of it, the fiscal side of it is massive. I just think that's something that I would recommend for the committee or the department to look at going forward. I plan to vote in favor of this. I believe whatever the committee's recommendation is after they've done the work, I should be supporting and certainly don't think this is bad. I agree with Ann that if we get this better, hopefully we'll get you to capacity and in a few years I would love to see you back asking to expand.

Ms. Sisti May I add something to your point because I think it will actually add to it. There's two, and I think you may have been wanting to mention this Jean, there are two big pieces of legislative work that was done at the state level that specifically speak to this. One is the passing of the advanced care planning campaign in New York State and that is geared towards a statewide campaign similar to the quit smoking campaign to really bring awareness to the state and everyone in the state, caregivers, patients, providers what palliative care is, what hospice is, who's eligible, and how you access those resources in your communities. We're incredibly grateful that the Department of Health created the Office of Hospice and Palliative Care Access and Quality. It's a great team. They're also focusing heavily across the state in terms of bringing that awareness and clarifying services and program in order to help individuals, especially those that are chronically underserved in hospice.

Mr. Thomas Hugh Thomas, a member of the council. Very quickly, I agree with Dr. Eisenstein and of course Ann, have lived through home hospice, not in New York. I guess my question for you would be, and it was exceptional and really, really appropriate. My question for is, are there long-standing legal or cultural barriers in New York that causes the state to be last. You know, I understand the inpatient home hospice migration, but how do we accelerate that? I lived through a home hospices experience, as did others, but not in New York, and that's my question. Is there something uniquely legal or cultural? You

may not be able to answer it today, but I think, just following on the conversation, as these conversations evolve for this council, I think it'd be helpful to know that.

Ms. Sisti I do think that there are cultural issues within, and I can say that as a health care provider, like I think historically, people have been uncomfortable with the conversations. Honestly, even on top of that, I think people are very stretched in the work they're doing. It's very hard in the office setting and in a lot of the clinics and really every sector of health care to spend the time being able to have those intensive, advanced care planning conversations, goals of care conversations. Our program and many programs across the state are trying to combat all of those things. We've created embedded models where our staff are in the offices, an extension of their staff, to take the time to have those conversations and help make those linkages to programs. There's a number of things that we're doing, but I do think it has to be coupled with that statewide approach to that awareness and education and how to access those services.

Mr. Kraut We're just talking. I'm not going to do it. I'm going to get in trouble. Thank you very much. You know that if you've made a mistake and you need the beds, come on back. You'll get them.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Kraut Thank you very much.

Mr. Kraut I want to make this point before you go on with the next application. What we did should in no way be as a precedent. When applicants have an application before the Establishment Project Review Committee, we expect the applicant to be in that room when the committee is there to answer the committee's questions. The only reason we did this, partly because there was some unavoidable conflict, there was a question that wasn't answered, and we gave them permission not to hold them up because of the importance of hospice moving forward. I just want to make it clear for the public that this is not a precedent. This is the second time we've done this in ten years. I just don't want people to think that I don't show up, they'll just let me come to the full council. I will not.

Mr. Kraut Mr. Robinson.

Mr. Robinson Thank you, Mr. Kraut.

Mr. Robinson We'll continue with batching now. 242233B, Flatlands Access Center, LLC in King's County. Establish and construct the single specialty ambulatory surgery center for vascular access surgical procedures at 3839 Flatlands Avenue in Brooklyn. Department and committee recommend approval with conditions and contingencies with an expiration of the operating certificate five years from the date of issuance.

Mr. Robinson Application 251234B, Smithtown ASC in Suffolk County. Establish and construct a multi-specialty ambulatory surgery center at 61 Southern Boulevard in Wisconsin. Five existing private office-based surgical practices will be converted to an

FASC specializing in gastroenterology, pain management, general surgery, in vascular surgery. The department and the committee in this case as well recommend approval with conditions and contingencies with an expiration of the operating certificate five years from the date of issuance. I'm going to move that batch.

Mr. Kraut I have those two applications. May I have a motion?

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner, thank you.

Mr. Kraut Are there any questions on these applications?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Robinson Thank you.

Mr. Robinson This is a batch of home health agency licensures mainly focused around changes of ownership. 231129E, Serenity Health and Wellness LLC, transferring 100% membership interest from one withdrawing member to one new member corporation. The department and the committee recommend approval with a condition.

Mr. Robinson 232-065-E Mountain View Management LLC doing business as Mountain View Home Care Agency. This establishes Mountain View Management LLC as the new operator of a licensed home care services agency currently operated by Mountain Home Care Agency at 355 Fishkill Avenue and Beacon. Department and committee recommend approval with a condition.

Mr. Robinson Application 232147E, Elite HHCLLC, transferring 100% membership interest to a new member LLC, department, and committee recommend approval with a condition.

Mr. Robinson Application 232150E, Adept Healthcare Services, Inc. Transferring 100% ownership interest from a deceased shareholder to a new shareholder. The department and the committee recommend approval with a condition.

Mr. Robinson Application 232199E, Kingsway Home Care Services, Inc. Transferring 10% ownership interests from one deceased shareholder to one new share holder. Department and committee recommend approval with a condition.

Mr. Robinson Application 241300E Parkview Mansion LLC doing business as Parkview Home Care establishes Parkview mansion LLC as the new operator of a licensed home care services agency currently operated by Parkview HFA Inc. Located at 3200 Bronx Boulevard in the Bronx. Department and committee recommend approval of the condition. I move the batch.

Mr. Kraut I have a motion.

Mr. Kraut I have second, Dr. Berliner.

Mr. Kraut Any questions on any one of these home care ownership changes?

Mr. Kraut Hearing none, I'll call for a vote.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Robinson There's a batch of certificates, a certificate of amendment of the certificate of incorporation for the Nazareth Home for the Franciscan Sisters of the Immaculate Conception. The Nazareth Home for the Franciscan Sisters of the Immaculate. This is like word salad. Of the Immaculate Conception requests approval to amend their certificate of corporation to change their listed purposes, update the status of the entity and change their mailing address for purposes of service. The department and the committee recommend approval. A restated app certificate for incorporation for Arnot Ogden Medical Center. This transaction will allow Centralis Health Inc to manage Arnot Ogden Medical Center and is necessary to effectuate Centralis Health Inc.'s establishment. As the active parent of Arnot Health, Inc., which was approved in CON 241015. The department recommends and the committee recommend approval. The Ira Davenport Memorial Hospital, Inc, and this is the Ira Davenport Memorial Hospital Inc requesting approval to restate its certificate of incorporation to preserve management powers to its member, Arnot Ogden Medical Center, among other things. Arnot Ogden medical center's sole member is Arnot Health Inc. Arnot Health Inc's sole member is Centralis Health Inc. This transaction will allow Centralis Health Inc to manage the Ira Davenport Memorial Hospital Inc and is necessary to effectuate Centralis Health Inc's establishment as the active parent of Arnot Health Inc., which was approved in CON 241015. The department and the committee recommend approval. Young Adult Institute, Inc, the Young Adult institute, Inc, requests approval to restate certificate of incorporation. Remove the language permitting it to operate a home care agency pursuant to Article 36 of the Public Health Law, add language permitting it to operating programs for the mentally disabled pursuant to Article 31 of the Mental Hygiene Law, update the language used to describe its mission, and update its indemnification and tax-exempt clauses. The department and the committee recommend approval. Finally, certificate of dissolution for Flushing Manor Geriatric Center Inc. Flushing Manor Geriatric Center Inc request Public Health and Health Planning Council approval of their proposed dissolution in accordance with 10 NYCRR Part 650. The department and the committee recommend approval on this one. I move the batch.

Mr. Kraut I have a motion.

Mr. Kraut I have second by Dr. Berliner.

Mr. Kraut Any question on any of these certificate actions?

Mr. Kraut Hearing none, I'll call the vote.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Robinson That concludes the committee's report.

Mr. Kraut Thank you very much.

Dr. Boufford I just, I wanted to flag one thing. When I was looking at the Sinai application, which is fine, as it's already passed, but it struck me, we haven't talked about physical medicine and rehabilitation beds as such in a long time. I think as the population ages and other things are happening, it strikes me from just notional information. They've always been contentious, not well reimbursed, et cetera, et cetera. I wonder if we could just get some mini report from the staff about that next time, just in terms of adequacy of the number of beds.

Mr. Kraut It came up during the conversation because there's decreased utilization of those beds that permit the, because there is that application, there's another one making its way to us again to decrease PM&R beds and repurpose them because of the economics of it and the insurance companies.

Dr. Boufford I guess the question, I mean, if hospitals are getting out of that business, is the default position to freestanding entities, or we just don't know more about that. I think it would be really helpful, because some folks may be too ill, or they're not getting the attention they need.

Mr. Kraut A lot of them were going into home health. You do the hip, or the knee and you go right to the house. I know with stroke or neurologically. PMR utilization.

Mr. Kraut Thank all of you for being here. Thank you for participating yesterday, for participating today, and for participating tomorrow. The next regularly scheduled committee day is going to be held on November 13th in New York City, and the full council meeting is going to convene on December 4th in New York City.

Mr. Kraut May I have a motion to adjourn the Public Health and Health Planning Committee?

Mr. Kraut I have motion, Dr. Yang.

Mr. Kraut A second, Ms. Monroe.

Mr. Kraut I'm assuming we are adjourned.

Mr. Kraut Thank you so much.