

STATE OF NEW YORK
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

HEALTH PLANNING COMMITTEE

Minutes

November 12, 2025
1:00 p.m. – 4:00 p.m.

90 Church St, 4th Floor, Conference Rooms 4 A/B, NYC, 10007

COMMITTEE AND COUNCIL MEMBERS PRESENT

Dr. John Ruge, Chair	Mr. Hugh Thomas
Ms. Ann Monroe, Chair	Ms. Lindsay Farrell
Dr. Marcus Friedrich	Dr. Lawrence Eisenstein
Dr. Anderson Torres	Dr. Denise Soffel
Mr. Peter Robinson	Mr. Harvey Lawrence
Dr. Mario Ortiz	Dr. Sabina Lim

DEPARTMENT OF HEALTH STAFF AND GUESTS PRESENT

Dr. Eugene Heslin, DOH
Dr. Douglas Fish, DOH
Ms. Marthe Ngwashi, DOH
Ms. Abigail Harabarovici, DOH
Mr. Jacob Bintz, DOH
Ms. Colleen Leonard, DOH – Zoom
Ms. Rachel Smith, DOH – Zoom

I. Welcome Remarks and Meeting Overview

Dr. Ruge opened the meeting reminding the committee that the goal of this discussion is to develop recommendations on cardiac procedures and ambulatory surgery centers. These recommendations need to be forwarded to The Department by December 2025.

The Committee approved the July 1st meeting minutes with no amendments.

II. Summation of Learned PCI Information and Data

Dr. Ruge provided an overview of the information and data received to date. Ann Monroe added that the committee had heard from a variety of sectors and perspectives at our public comment session in September.

Dr. Heslin provided an update from the November 3 Cardiac Advisory Committee meeting. He noted that the Cardiac Advisory Committee received the same presentations that the Committee received in October. The Cardiac Advisory Committee has developed some thoughts, but no specific recommendations yet. Their discussion included the following topics:

- Quality and safety
- Relationships to hospitals
- Limited data and need for more data
- Recognizing data is only collected for PCI procedures
- Consideration for a measure approach around patient selection and backup hospitals for support

- Concern with hospitals losing business but also an acknowledgment of the expansion of Ambulatory Surgery Centers going forward.

Dr. Heslin concluded with the Cardiac Advisory Committee will bring more formalized recommendations to The Department soon. The Department will take both sets of recommendations for consideration as the Department moves forward.

III. Committee Discussion

Ann Monroe expressed the desire to achieve consensus within the committee. She asked that each member consider everything they have learned, listened to, and share where they are right now in this process. She hoped to get to a preliminary recommendation at this meeting. She acknowledged a clear lack of data but she urged members not to let that prevent our recommendation from developing.

Discussion and comments provided by the members can be summarized by the following topic:

1. Patient Eligibility
 - a. Concern with patient eligibility numbers presented by DOH previously. 5,000 patients of 50,000 patients, 10 percent for percutaneous cardiac intervention is a low number. Would like to see need criteria and a metric for this. Note: this did not include the potential diagnostic catheterization candidates (approx. 90k available).
 - b. Don't want excess cases (bad actors) being done but would want quality reviews on cases (similar to hospital quality review process or for appropriateness and outcomes).
2. Access to Care (around patient eligibility)
 - a. In consideration of level of patient support post-procedure for discharge to home and eligibility requirements- from what we have learned, those with no social support get screened out for outpatient procedures done at a hospital and require inpatient stay to have cardiac catheterization completed.
3. Need to keep health equity lens in place to make sure that appropriate access is achieved for all populations. Access to care (geographic)
 - a. Need to clearly define access. Low density population risk, aging demographic, other socially vulnerable indicators.
 - b. Suburban areas already have a lot of ambulatory surgery centers. How will we improve access to more vulnerable communities.
4. Cost and Financial Implications (System Level)
 - a. If demonstration/pilot is done, operators should be nonprofit.
 - b. No need methodology exists to determine the appropriate level of procedures. Excess procedures could drive up cost (this is not measured at this time and data presented to the committee suggests wide regional variation in the number of procedures per population. No study that has been done to determine the appropriate level of procedures, rather clinical decision drives the process.)
 - c. Initial phase rollout should be limited to non-for-profit entities, there is a concern about venture capital and private equity profiteering.
 - d. There are concerns about financial harm to hospitals by reducing what is a lucrative procedure from the hospital portfolio.
5. Cost and Financial Implications (Patient Level)
 - a. Need to consider social vulnerability for Medicaid and low-income commercial patients as part of the initial phase rollout.
6. Nursing and Staffing Shortage
 - a. Appropriate nursing staffing and credentialing for ambulatory surgery centers are critical considerations.
7. What is the problem we are trying to solve?
 - a. The Department clarified that it had been approached by hospitals as well as physician groups about Percutaneous Cardiac Intervention being allowed at ambulatory surgery settings in New York State. Some have expressed concern about capacity of the current system as more complicated and time-consuming procedures are being performed in cath labs, effectively reducing capacity.

8. Hospital Affiliated/ owner-controlled Ambulatory Surgery Centers vs. Non-Hospital Affiliated/owner controlled
 - a. The initial phase should be limited to hospital affiliated facilities with existing cardiac programs so that patient safety concerns are lessened. The ambulatory surgery centers would function as part of the hospital's quality review and data reporting systems.
 - b. Make clear distinction of hospital affiliated versus owned.
9. Lack/Lag of Data
 - a. Shortage of any data nationally for performing these procedures in an ambulatory surgery center.
 - b. The Cardiac Advisory Committee has a data set for percutaneous cardiac intervention both at hospitals that perform thoracic surgery and hospitals that do not have thoracic surgery backup on site; the committee does not collect any information regarding diagnostic catheterizations.
 - c. The initial phase would be to gather data regarding percutaneous cardiac intervention similar to what is collected now for all hospital institutions. The expectation of the initial phase would be to gather data.
10. Doctor Discretion and Patient Selection
 - a. The Society for Cardiovascular and Angiography Intervention has patient selection criteria regarding appropriateness of patient selection for non-hospital sites.
 - b. Physician/Surgeon should decide if they feel comfortable doing the procedure for lower risk patients in this setting.
 - c. There should be consideration towards the credentialing necessary for a physician to be able to work in this type of site similar to what was established when cardiac catheterization moved from hospitals with thoracic surgery to other hospitals that did not have surgical backup.
11. Complications and Response Time
 - a. Northwell model of retrofitted ambulances is an impressive solution, but the model did not happen overnight
 - b. Concern with responding to complications when they happen (when done in an Ambulatory Surgery Center) it is recognized that hospitals that do not have thoracic surgery do not have retrofitted ambulances on site
12. Overall Safety of Procedures in the Ambulatory Surgery Center Setting
 - a. Committee members expressed concern about ongoing lack of data and evidence regarding safety.
13. Future Data Collection
 - a. Data collection should start after the regulation is promulgated adopted as these centers are established, to be able to make future state decisions period.
 - b. Data collection should include a wide variety of indicators including social vulnerability indexes, other social determinants of health, including aging.
14. Non-profit Ownership for Initial Phase Rollout (Vs. For-Profit and Private Equity)
 - a. General agreement that the Initial phase of the project should be open to non-profit entities.
 - b. Committee members expressed the opinion that when private equity steps into healthcare, the quality goes down, and the prices go up. Want to push back against this further entering in the market. The committee acknowledged we need to be careful about how this is defined as for example physicians get incentives in the form of productivity bonuses, despite the site.
15. Society for Cardiovascular Angiography and Interventions Ethical Considerations
 - a. The list of ethical considerations from the Society for Cardiovascular Angiography and Interventions (SCAI) presentation should be fundamental to our recommendations moving forward. They are thoughtful and address concerns about profit incentives in the healthcare setting that need to be grappled with upfront.
16. Additional Considerations for Initial Phase Rollout
 - a. Could consider a grant program that includes system testing to address equity, quality and access issues. Only way to do this is to lay out criteria we want to have met and allow folks to apply for it and have it funded.
 - b. Technology continues to allow us to move to a more ambulatory setting, many years ago all cardiac catheterizations were done as inpatients, and the industry continues to evolve most recently allowing outpatient hospitals without thoracic surgery to be able to perform percutaneous cardiac intervention.
 - c. Need to be able to communicate Industry and technology changes in an appropriate fashion to patients to make sure that they properly understand and can take advantage of the opportunities that

the health care ecosystem can provide.

Planning Committee Discussion regarding Cardiac Catheterization in Ambulatory Surgical Center Sites.

Question posed for discussion:

1. Should the Ambulatory Surgical Center Program initially be a demonstration project? If a demonstration, discuss the criteria for the demonstration project, including quality and other performance indicators.
2. Should the Ambulatory Surgical Center program be hospital affiliated (ownership controlled), a freestanding center or both?
3. Should the Ambulatory Surgical Center Program be single-specialty or multi-specialty?
4. Should the Ambulatory Surgical Center Program be for-profit or non-for-profit?
5. Regarding community benefit, what should be the benchmark regarding Medicaid and self-pay policies for these centers.
6. If this program was initially hospital-affiliated, what criteria would guide expansion to a larger statewide non-hospital affiliated program?

Dr. Ruge took a straw poll to determine if the Committee supported some sort of project involving cardiac catheterization at ambulatory surgical center sites. Overall, the group was in favor of moving forward.

Generalized summary of comments made by and through the Committee's discussion:

Committee thoughts:

- General consensus was that there needs to be some sort of initial phase to gather data as to the safety of this type of program in an ambulatory non-hospital setting.
- The Committee is concerned about how these centers might be funded, given the lack of resources that hospitals have for capital investments.
- There was significant discussion about whether this should be a demonstration, pilot or initial phase project. The Department pointed out that it would like to write a single regulation to move this type of program forward rather than having to update multiple times, given the significant time and staff necessary to revise regulations.
- It was generally agreed that all sites need to have the same data and quality requirements for comparison purposes to better understand the differences between sites. Sites include hospitals with thoracic surgery on site, hospitals without thoracic surgery on site, outpatient procedures at both of the previous sites and ambulatory surgical center sites that are independent.
- There was general consensus that there needs to be a limited life Certificate of Need (CON), similar to what is already done for ambulatory surgery centers. An overall goal is that any preliminary project will eventually grow into a larger program. There's was general consensus that these programs need to be located in different geographic and demographic parts of New York State to better understand the impact of using an ambulatory surgical center site.
- The department should consider start with the lower risk procedures similar to the way hospitals without thoracic surgery on site started doing with cardiac catheterizations a decade and a half ago.

Summary of subsequent committee discussion:

1. Data Points
 - a. Using public health data (burden of disease, aging, etc.) to help risk stratify geographic variation.
 - b. Consider using an academic center, those trained in data collection, to design a 2-5 year project and get enough patients for this to be statistically significant.
 - c. How will we decide the potential additional criteria based on data from select sites? What should the be the duration of data/ could some of the data requirements be sun-setted over time?
 - d. It will be important to evaluate regional variation and regional needs.
 - e. If this were to be considered a research initiative, consider using an independent evaluator, for example, a public health epidemiology group to evaluate the programs.
 - f. Consider the information and concerns that the hospital systems and health plans submitted regarding

cardiac catheterization procedures done in an ambulatory surgical center setting.

2. Criteria and Applicants
 - a. Need to decide what would be the criteria for entities to apply for CON consideration.
 - b. Build a model that can be duplicated.
3. Ownership
 - a. Would like this to be a non-for-profit model to try to meet public need.
 - b. This need to be a viable business model.
4. Site and Patient Safety
 - a. Ultimately, focus on safety is the most important thing as a starting point, understanding that safety is relative based on a number of factors.
 - b. The program will need to be evaluated for safety while continuing to monitor important outcomes.
 - c. Consideration regarding rural and other underserved populations.
5. Size and Geographic Distribution
 - a. Looking to make a decision about size and geographic distribution after safety and patient selection.

IV. Next Steps

- In closing Dr. Rugge mentioned that there will be a summary of this meeting to review at the December meeting. Dr. Heslin added that the Committee will provide edits to these meeting minutes which will be the bases for the criteria and recommendations
- Ann reminded the Committee that we promised to have recommendations by the end of the year.
- Next Meeting: December 3, 2025, NYC, 90 Church Street, 4th Floor PSC Board Room