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TRANSCRIPT

Mr. Kraut As we mentioned, we're reorganizing this to accommodate our next speaker. My name is Jeff Kraut. I have the privilege of calling to order the annual meeting of the Public Health and Health Planning Council for June 24th, 2026. I want to welcome members, participants, and observers. I'm going to introduce Mr. Amir Bassiri, who directs the Office of Health Insurance Programs to provide a council with an update. Once Mr. Bassiri makes his presentation, we will then suspend the annual meeting and we'll go back to the Codes meeting and then after the Codes meeting concludes, we'll come back to annual meeting. If you followed me, it would be good for you. Mr. Bassiri, and he's on through Zoom right now. Watch the screen.

Mr. Bassiri Thank you, Jeff.

Mr. Bassiri I hope everyone can hear me okay.

Mr. Kraut We can hear you.

Mr. Kraut If you could turn up the volume in the room, please. Thank you.

Mr. Bassiri Thank you.

Mr. Bassiri Good morning straight to be speaking with the council. Apologies, I can't be there in person but thank you for accommodating virtual attendance. I'm joined today by Mike Ogborn, the Deputy Medicaid Director and I believe Amanda Lothrop, who's our Chief Operating Officer is also on. There's two topics we wanted to go through today, both of which have been requested by members of the council. Starting with the more esoteric concept being disproportionate share hospital payments or the payments and specifically getting into the indigent care pool. We're going to go through very briefly at a high level what the program entails, the three supplemental fee for service payment programs underneath it, what comprises it. We'll likely open it up to questions because I know the council members have asked specific questions about methodologies under these programs.

Mr. Bassiri If we go to the next slide, we'll start with the indigent care pool. This should be familiar to members of the council. This is a methodology authorized in our state plan amendment that establishes payments for both voluntary and public hospitals, primarily voluntary, based on the number of hospital services that each facility provides to uninsured and Medicaid beneficiaries. It's based on service units. It is a very prescriptive and formulaic program and methodology that we have tweaked with over the years with the legislature. A few years ago in 2022, Mike will correct me, but we had actually made a substantive number of changes eliminating what was then in place known as a transition collar and making some reductions and reallocations to the pool. Currently, the entirety of the indigent care pool is $825 million and that includes federal and non-federal amounts. The public portion is very small, and it's related to an ICP, a swap that we can get into later, but not a very large portion of this program. The majority goes to our not-for-profit

voluntary hospitals. As I mentioned earlier, the program was larger before. It was almost a billion dollars. There was a reduction. There were actually two reductions in the last few years that have resulted in the pool going down by about $235 million. The legislature and the executive did put in place an enhanced safety net pool, which is based on a definition. The legislature had put forward several years ago to target more of these dollars to safety net hospitals. But all in all, the total amount of this program is $825 million. The key point to remember here is that it's really based on the service units that each hospital provides for uninsured and Medicaid patients.

Mr. Bassiri Mike, anything you want to add to this?

Mr. Ogborn I think you covered it, but you're right. It's based completely on Medicaid units of service. I think the last slide notes that it's Medicaid units and uninsured. I believe bad debt was a question that folks had asked about and that is not included here.

Mr. Bassiri If we go to the next slide, there's a second supplemental payment that is made called the indigent care adjustment or the ICA allocation. This is also fixed in terms of the total allocation. It is $412 million and for public hospitals only. This payment is based on what we call and what the federal government has called DSH caps, disproportionate share hospital caps. That is the limit established under federal law and regulation for what a hospital can be paid from Medicaid. Anything above that DSH cap is not eligible for federal financial participation, meaning it's not eligible from match. The nuance is that DSH caps are not audited on a real-time basis. They're audited on a lag. It's usually two or three years. The timing of the ICA payments and the time period of the ICA payment is based on a historical period. As you'll see here, the way that these payments are allocated is a proportional allocation based on the state's total DSH cap. And then each respective public hospitals share of the total cap. In this case, and it's usually the case, New York City Health and Hospitals Corporation is the largest beneficiary followed by SUNY and then the county-run facilities. There is a non-federal share, of course, with this payment. It is, with the exception of SUNY, I believe it is funded through intergovernmental transfers from the other public institutions. There is the primary public hospitals put up the non-federal share.

Mr. Bassiri Next slide.

Mr. Bassiri The third supplemental payment---

Mr. Kraut There's just a question before you go off that slide. Hold on.

Dr. Soffel Thanks.

Dr. Soffel I was wondering if you could give us a little detail on the funding that goes to counties. What is that for, how is it allocated, etc.? Thanks.

Mr. Ogborn Those are county run hospitals. You're talking like you're your Westchester. Those are the facilities that received that funding.

Mr. Kraut Those would be public benefit corporations by and large. They're all hospitals though.

Mr. Bassiri The final portion of the disproportionate share hospital payment supplemental programs is what we call DSH reconciliation. If I were to just step back a level, we have a DSH allotment the state gets each year. New York has a very favorable allotments as

compared to other states. The two programs I just mentioned are part of that allotment. The remainder is paid out through reconciliation which is the majority of it. What happens is, as I mentioned, there's a DSH audit. That audit concludes, and in effect, it's a retrospective analysis. We will be looking at how many hospitals were paid above and below those final DSH caps. Just a reminder that the DSH caps are established based on uninsured and Medicaid losses. There is zero factor from bad debt or charity care. That was a federal change made several years ago that we can talk about in a minute, but that is the basis of how the DSH cap is set. If we have overpaid facilities, we try to resolve that as soon as possible. There are some nuances in how we handle over and under payment, respective to the discrete programs underneath DSH, but for the indigent care pool... That is the program I mentioned that is primarily for not-for-profit voluntary hospitals. When we overpay, we shift that overpayment to a state-only obligation, meaning there is no federal share associated with the amount over the DSH cap. We do that intentionally for compliance purposes and to make sure we are never claiming federal match on a dollar that is not eligible for match. ICP is very straightforward. There are practically no overpayments that have a federal dollar tied to them. Same with ICA. That's the Indigent Care Adjustment that goes to the public hospitals and the county facilities. We recoup all overpayment for the ICA. We use this final reconciliation payment to ensure that we pay our public hospitals, with the exception of Health and Hospitals Corporation up to the maximum DSH cap limit we can. They pay the non-federal share through an intergovernmental transfer. The primary purpose we have structured the DSH programs this way is so that we can pay our public hospitals as much as possible. And even though Health and Hospitals Corporation is not guaranteed a payment up to that DSH cap like the other publics are, they are receiving well above and they are getting paid the maximum as well in recent years and it's related to things we've done in managed care supplemental payment programs where we're getting more dollars to hospitals through state-directed payments and higher payment rates and managed care. That is resulting in facilities, for lack of a better phrase blowing through their DSH caps well in excess of it. There are some financial ramifications of that, but the underlying message is that we are paying them the maximum we can.

Mr. Bassiri Mike, anything you want to... I know that's a lot, a lot of words, not that easy to follow. Is there anything you want to fill in? Because I think we're going to open it up for questions after this slide.

Mr. Ogborn I would just say that the change in bad debt and charity care came at about 2013/2014 in that range. That was based on a federal government change that said we could no longer base any of our payments for DSH on bad debt. And charity care. We shifted to completely Medicaid and uninsured losses. There was the first of initial DSH work groups with the stakeholder community to come up with the methodology that we pretty much have in place now. That was the change that Amir was speaking to in the first bullet.

Mr. Kraut Is that the last slide?

Mr. Bassiri For this portion of the presentation. We can open it up for questions.

Mr. Kraut I'm going to open it up to questions. Let me just kind of set up some of the questions maybe because we've had discussions here on, so you've explained how the funds are put together, but the source of the funds beyond the state matches the federal contribution, we have surcharges on covered lives assessment. We have the HCRA public goods fund that come in. Just talk a little about the revenue and also what the intent of the

indigent care pool is. It was supposed to pay, you know, we're going to talk charity care, bad debt, and Medicaid underpayments. If you can comment on that, and I'll open it up for questions, because those were some of the questions that had repeatedly come up in the room that we were unclear about. First, the sources of the funds, that there's taxes or surcharges, whatever is politically acceptable, and then what is supposed to pay for.

Mr. Bassiri Mike, do you want to take the sources, or do you want me to take that?

Mr. Ogborn I mean, the sources are really general fund revenue. Getting a little bit of feedback. There are surcharges in taxes in the state for HCRA and cover lives assessment. However, from the perspective of the financial plan, the non-federal share comes from the general fund. The amount is matched against the federal share to then dispersed to the facilities. That's when we're talking about the state funding programs. The local share that we're speaking about when it came to the county facilities was related to when they put up the non-federal share associated with DSH payments for instances like the care adjustment or the reconciliations around this slide. Those come directly from the counties or the public hospitals in their area. As far as the secondary question related to bad debt, that had to be removed from the equation in 2013, as I noted a little bit earlier. While that was an initial attempt when DSH came into play back when this came to the federal government back in the 80's, it had to pulled out in 2013. The payments are completely meant to reimburse facilities for additional uninsured and Medicaid losses.

Mr. Kraut Okay, so no longer for bad debt?

Mr. Bassiri No.

Mr. Kraut Okay.

Mr. Bassiri No, and just to be clear, Jeff, and for members of the council, CMS at the time, very clear about changing our safe amendment to remove that debt and charity. Bad debt and charity here have not been a part of this program for some time now.

Mr. Kraut I'm going to open it up.

Mr. Kraut Ms. Soto.

Ms. Soto Nilda Soto, council member. I like clarification in particular on this last slide. What differentiates the uninsured Medicaid losses versus bad debt and charity care?

Mr. Ogborn There are different definitions in the federal calculation of what bad debt and charity care is versus what uninsured and medicated losses are. It's definition from an accounting perspective. Anything that the hospitals would classify as bad debt in charity care in their cost reporting cannot be included when the payments are being made or when the dispatch are being calculated.

Mr. Bassiri And just to add to that, Ms. Soto, the Medicaid and uninsured losses are calculated based on the cost the hospital is reporting for delivering that service to the Medicaid member and or the uninsured member and then the cost of reimbursement that they received. In Medicaid's case, that's typically the fee for service reimbursement or a managed care payment. In uninsured, it could be zero. As Mike said, there are some clear definitions that segregate the cost by bucket and bad debt and charity here are very clearly segregated from Medicaid and uninsured losses.

Mr. Ogborn Actually go through a process with the KPMG as well, pursue the federal regulation where they audit our DSH caps and ensure that things are not included as well.

Mr. Kraut Anyone else?

Mr. Kraut Dr. Berliner.

Dr. Berliner There's a proposal that I guess will be coming to us soon that would switch a major voluntary hospital in New York City to become a public hospital. Will that just result in a... You know, just switch off the money or will, in other words, will the voluntary payments to voluntary hospitals be reduced or will the payment to public hospitals be increased? Have you thought about that or has that been discussed at all?

Mr. Ogborn I would say it depends, right? The volunteer pool is going to stay the same as far as the amount that's currently in statutory requirements. However, the facility that if they were to become part of the public facility, they would be included as part of their overall DSH allotment. They will probably get paid additional funding on that third slide here that we're looking at the final reconciliation payments. That said, it will also depend on what the ultimately their DSH caps are and what the amount is that we can pay up to the federal limit. There's many factors that are going to have to go into it. It's difficult to determine without having all of the cost information in front of us and going through the process of understanding. The amounts for voluntary pools and public pools still stay the same in the engine clear pools that you saw on slides one and two.

Dr. Berliner Thank you.

Mr. Kraut Ms. Farrell.

Ms. Farrell Nancy Farrell, member of the council. The Trump Administration CMS has issued new rules very recently. I know there's changes to state-directed payments. I'm not sure if there are other impacts that will threaten funding to the state's facilities. Can you comment on those rules? They were issued within the last month, I believe

Mr. Bassiri Yes, absolutely. The rules that are being referenced are subsequent guidance or proposed regulations from the federal government following the enactment of H.R. 1 last Summer. Some of those provisions included a moratorium on state directed payments and a cap on the payment amount in a directed payment at the Medicare limit for states like New York that are expansion space subject. The proposal rule is pertaining to that. There are significant changes. What it really is doing is that it's closing off an opportunity and a potential pathway that we had to use to target resources to facilities for specific initiatives or for the underlying financial condition of the facility. There are a lot of changes that are happening. There are also some transitions, or CMS is calling grandfathered state directed payments that can exceed that Medicare limit for a time period up until 2028. Following 2028, those payments that are already above the Medicare level will have to be reduced by a minimum of 10% each year until that payment rate is equivalent to the Medicare rate for the hospital service. We do have grandfathered state directed payments. Those are the state directed payment or are financially distressed hospitals downstate that are not for profit. We have a state directed payment for critical access hospitals, and we have a credit state directed payments for community hospitals. Those are all grandfathered. We received approval for the and hospitals state directed, payment to be paid at the average commercial reimbursement rate and that is grandfathered. There is

some solace in the fact that we have a little bit of time to transition before these payments are getting reduced, but they will, it will start to become a major problem in subsequent years because there's essentially no new vehicle that the federal government has established to provide supplemental payments to providers and particularly hospitals and state directed payments were our vehicle for doing that in the last several years.

Mr. Kraut It just shows the complexity of the reimbursement system that gets patched together on all these different streams.

Mr. Kraut Yes, Dr. Soffel.

Dr. Soffel Good morning---

Mr. Kraut If I can hold the questions after Dr. Soffel, I would like Amir to finish his presentation and then we'll come back.

Dr. Soffel Good morning. Denise Soffel, member of the council. My question is about the enhanced safety net pool and how many hospitals are currently receiving funding through the enhanced safe net pool. Are the criteria explicit and what happens then if more hospitals meet those criteria? Does the average payment per hospital then start going down? Because it feels to me like given the crises that we're seeing across the state that more and more hospitals could certainly be called Enhanced Safety Net Hospitals or Critical Need Hospitals.

Mr. Bassiri Thank you for the question, Denise.

Mr. Bassiri What I would say is actually, interestingly, we have seen that the number of hospitals meeting the definition of a safety net increasing year over year prior to H.R. 1. This criteria that was established in legislation is pretty broad. If I'm not mistaken about seventy hospitals that met the definition, it includes a lot of other hospital types that are in... it includes critical access hospitals. It includes some community hospitals. It includes the hospitals with average payer mix. I think over 30% met. It's a pretty big list. It has all publics. If hospitals get added, there will be proportional impacts on the transition collar, but I think... We have seen it stay pretty consistent year over year. There's maybe one or two hospitals that have come in and out over the years, but it's pretty consistent just based on the prescriptive statute.

Mr. Bassiri Mike, I don't know if you have thoughts to share.

Mr. Kraut I'm going to ask Mr. Bassiri to turn his attention now to the other question we asked him was to give us an update on the New York State Health Equity Reform, the 1115 waiver. I apologize. We got the slides a bit late. We will get these slides to you. They'll be posted to the public as soon as this presentation is over.

Mr. Bassiri Thank you, Jeff.

Mr. Bassiri I'll try and be brief to ask for some questions and Amanda's joining me here. I know there have been questions. There's a lot happening with our 1115 waiver, also known as the New York Health Equity Reform Amendment. It's very exciting. This was one of the bright spots. We love talking about our success here and excited to share a little bit of where we are. Just a brief overview to illustrate the importance of our programs. A third of New Yorkers are covered under one of our public health insurance programs between

Medicaid Child Health Plus and the Essential Plan. We cover half, largest program in the country, second largest population of dual eligible in the county, two million primary payers for long term services and supports behavioral health care. While the figures on the right-hand side of the bar chart are lower today than they were in 2025. As you may have heard or seen, there've been a number of changes to the Essential Plan that were directly a result of H.R. 1. About 450,000 of that 1.7 million may receive coverage elsewhere but will not be enrolled in the Essential Plan. We've seen our Medicaid enrollment go down as well. The 9.2 is really closer to like 8.4 right now, but still sizable, sizable growth in the last decade.

Mr. Bassiri Next slide.

Mr. Bassiri What is the waiver doing, our 1115 waiver? That is our vehicle for innovation. That is a vehicle for testing different models and ideas in the Medicaid program with federal funding. That is what we are doing with this amendment. There's sort of three major pillars of the amendment, starting with the establishment of social care networks and social care infrastructure to address health-related social needs and integrate the social care services with physical and behavioral health care. We have the most ambitious program in the country. We've taken a lot of unique approaches, and our scale is just leaps and bounds above other states. We're very eager to continue this work. When we received approval for the waiver, we were actually in the middle of our five-year demonstration. Our waiver runs between 2022 and 2027. We received approval for the amendment in 2024. We had essentially half the time to implement, we had twenty-seven months to implement a five-year demonstration. We are hoping to get as far as we can. We've seen really tremendous progress recently, but it just goes to show that we had less time to do this than we had anticipated. Along with the social care infrastructure, there is an IT overlay and underlined data and encounter process that allows us to establish social care encounters and actually measure who is receiving what service at what time after which referral. It's given us very good visibility. We've set up infrastructure that is built to last even beyond this waiver. Two other pillars are also very critical to the Medicaid program workforce. Only New York and Massachusetts got workforce approvals in 1115. We established a very innovative career pathways training program to help people move up the career ladder in advance and have the supports they need to get trained in advance. There's also a loan forgiveness program we'll talk about and then more broadly the overall goal is to improve population health and population health outcomes and what these three pillars really structured to do.

Mr. Bassiri Next slide.

Mr. Bassiri Our social care networks addressing health-related social needs. They're doing an incredible job, especially as of recently. I think we should all be there. I know the Medicaid program is super proud, but all the stakeholders should be really proud about where we are and what they have done in their communities and in an appendix slide we have more details about who is where and which organizations are serving which regions, but they've really identified unmet needs and added capacity to their communities to help residents and members access services they previously have not had access to. Things like food and nutritional supports, housing supports, transportation for non-medical purposes, as well as navigation to other local and federal resources. They have developed targeted outreach mechanisms working with health plans and CBOs to really reach broader and harder to reach populations in the Medicaid program and helping them receive an integrated enhanced services. They have facilitated reimbursement to community-based organizations. This is something that was a very large pain point in our

last waiver, the program, where there was difficulty getting dollars downstream. This is an area where the seat social care networks have done a very good job working with health plans on a premium basis and then reimbursing providers on a fee-for-service basis. While we're not fully there yet...we are seeing improved outcomes and health equity across the state. It's very early. It's encouraging based on the premise of our waiver and what we're hoping to see at the end of the demo.

Mr. Bassiri Next slide.

Mr. Bassiri How are the SCNs targeting and who is essentially receiving these new health-related social needs services? Both the state and CMS were very keen on measurement and demonstration of value and outcome. We really narrowed the targeted population who would be eligible for these enhanced screenings to include our highest-needed members. These categories will be very familiar to the council. They are consistent with categories we've used to stratify high risk elsewhere. They include things like people who are actively receiving substance use disorder or have serious mental illness, anyone who has an intellectual developmental disability, any person who is pregnant or in postpartum care, children under 18 were all considered to be a high risk as well as populations receiving health home services or something we call high utilizers, frequent utilizers of hospitalizations, recurring hospitalizations and healthcare, indicating there's a lack of care management and case management. These are the populations that receive these enhanced services. It's about two million of our six and a half million Medicaid members.

Mr. Bassiri Next slide.

Mr. Bassiri This is the detailed subset of health-related social needs services that we received authorization for in our 1115 waiver. It's more comprehensive than most other states that have waivers to provide HRSN services, and I'll go through it at a high level. Every member, regardless of whether you have, whether you meet one of those criteria on the prior slide or not can be screened using our standardized accountable health communities screening tool and then navigate it to existing services or county or locally led services if they are not one of those populations that are a higher need. For those that are, they have access to a very, very comprehensive list of nutritional housing and social care management services. Some of these are familiar to you, like medically tailored home delivered meals. That's something we have provided in our managed long-term care programs prior to this waiver. We now have nutritional counseling and courses. We have food prescriptions and pantry stocking, as well as cooking supplies. There's differing utilization of these underlying services, but by far and away, the highest need that has been identified in our screening of members is nutritional services and a lack of access to them. This has been something that has been reaffirmed since the beginning of our waiver, and we're seeing it continually. Housing a lot of these services we provide in different waiver programs, whether it's an HDD and TBI program, whether it is our Enhanced Supportive Services Housing Initiative that is done with in coordination with OTDA and OMH, but these are very much targeted to helping people remain in the community in the home or move from institutional settings to the home. There's been navigation, but then there's also support for six months' rent and utilities and a host of other housing supports. It is dependent on the availability of supportive housing such that it's not as though we are paying for six months' housing for someone to get evicted. It's very much integrated into the transition of individuals from an institutional setting to the community. Due to the lack of supportive housing availability, there has been a mixed uptake in these services. Same said for transportation. While we were excited about it, it

has been difficult to see a large uptake in that benefit. The social care management has been incredibly helpful. We have seen existing care management agencies and organizations like our health homes, like the CCBHCs and other entities come together and provide social care management in an integrated way, working with CBOs and health systems. This has been a very strong point of success of the waiver thus far.

Mr. Bassiri Amanda, I don't know if you want to add anything further to this slide or we should just keep going.

Amanda I think we should keep going because they're best illustrated by the stories which we have to highlight coming out of that's really the impact.

Mr. Bassiri What has been the impact thus far? Bear in mind, we are in month twenty of the twenty-seven that we have essentially, so we're not yet done. We have seen tremendous progress. All the credit goes to the social care networks and the stakeholders in our communities to drive this work forward along with the great work of our team, our waiver team. There's nine networks. We have over 1,400 HRSN service providers, all of the health plans are engaged, and they've established over 3,000 social care navigators who are actively working every day to connect new members to services. We have reached over one million screened members. That is a huge milestone for us. Given where we were in the beginning, we're very excited about the momentum we're currently seeing. There's about 2x screening rate each week. We're seeing a huge, huge uptake. A big part of that is because we've brought in and created opportunities not just for CBOs but for health care providers to work with social care networks and ensure that each member in the delivery system is helping reach members where they are. The data backbone has been great. There's been mixed performance depending on each social care network's technology partners but what we have confirmed and we're proud of is that the data backbone works. We've leveraged the state health information network as a critical resource to bi-directionally exchange health-related social need information to social care networks plans in the state. All of the work we did to set up the piping, it actually does work, which gives us confidence for the infrastructure lasting post-waiver. We're reaching members where they are and seeing a lot of, as Amanda mentioned, really nice stories in different parts of the state from families, from members, particularly those with high needs and for where we're hoping to see better outcomes.

Mr. Bassiri Next slide.

Mr. Bassiri As I mentioned before, I think a big reason we've been able to scale quickly in the last six months has been the organizations between traditional healthcare providers, hospitals, FQHCs, pharmacies, working with community-based organizations and care management agencies on the ground to really leverage and scale up the access points for where members can be screened. We wanted to highlight one example, and I'm going to take this one because it's a great one in the Southern tier, but it really highlights where some of these infrastructure dollars have gone and how they've leveraged capacity building for the future.

Amanda We see these all over, but the social care networks are really taking innovation to heart, which was the goal of this waiver to begin with, and testing out different models. We have a few of them here, but even in the Southern tier, they centralized a behavioral health hub so that members can get access to critical services quickly, off hours, in maybe odd settings and in crisis stabilization immediately to reach the high needs cases as quickly as possible. We see that across the board. We've seen that in other examples.

Amanda If you go to the next slide, you can see that in other examples with another social care network addressing a maternal health initiative.

Mr. Bassiri Can we go to next slide?

Amanda There we are.

Amanda Another social network addressing maternal health efforts really partnering with New York City to create stress-free zones and bring a comprehensive set of benefits to maternal health families to get access to really the continuum of care as early an intervention as is as is possible or one of the Staten Island providers putting forth a concerted effort to address asthma through a really interesting model that creates both a technology hub to have an interactive platform to attempt behavioral nudging to address those interventions, as well as some of those traditional environmental remediation or modifications to support the member.

Mr. Bassiri If we go to the next slide. These are some of the stories Amanda was mentioning. We're not going to read them necessarily, but we really just want to highlight it's not in one place. It's from different...whether it's members, navigators, providers. We are starting to capture some of the impacts of this work. It's very powerful and meaningful. And to the point Amanda raised on the prior slide, especially Staten Island, we have to give them a shout out. They've been leading the way since the waiver kicked off. This is not easy work at all. Getting health and non-health providers to work together and all collaborate towards the common goals, very challenging, and it's also complicated from a technology and reimbursement standpoint. Staten Island and the SIPs is the name of the SCN. They've really done a fantastic job building from their success and the community network and partnerships that they've established to really both screen, assess, refer, and follow up. Their workflows are fantastic. We've seen incredible performances from them, and they've been sharing best practices with the other SCNs. We are hitting our stride for lack of a better phrase.

Mr. Bassiri Next slide.

Mr. Bassiri One thing we haven't taken a victory lap on, but that the teams work really diligently on is on our workforce programs. Like the health-related social needs where there is a regional entity, we are working with three workforce investment organizations in different parts of the state to really help lead that work, partner with academia, partner with employers, outreach to students, work with their communities, and help people get upskilled, trained, or retrained with the social supports they need while maintaining their existing employment. We've seen really wonderful progress thus far. Some of these training programs are multiple years, so they're not all complete. Many things are in flight. We have over 13,000 residents enrolled in some form of workforce training that will be complete either at the end of this year or at some point in 2027. The fantastic news is that they have also signed up for a service area commitment to participate and after they complete their training they'll work at an employer in the state that is serving Medicaid and other public health insurance program patients, a minimum 30% payer mix, so they're going to stay in New York and continue delivering services to employers. We're seeing the most activity in nursing titles really moving up into different nursing titles or receiving a Master of Social Work and other licensed credentialing. So, I'm very excited about that. We've seen really exciting progress there, mostly nursing titles. There's a really good success story just to show you what those are actually doing to help people. In the citation

on the left side of the screen, FLPPS is the Finger Lakes Performing Provider System. They are one. They've been providing so much support to students through their training that the average increase in the grades for students during that training session has gone up by over 20% year over year. It's simply due to them supporting members and making sure they have the social support while they receive educational and academic training. The last slide is on the loan forgiveness or loan repayment program. Only us in Massachusetts had this. We were very targeted at the types of health care professionals we wanted these dollars to go towards. They are areas where we have a dearth of access, either statewide or in rural parts of the state, starting with dentistry, psychiatry, primary care and nurse practitioners. We've received nearly 900 applications, which is great. We won't be able to win all of them, probably. We do have a cap of a little under $45 million for the awards that we can make. We are seeing really wonderful potential outcomes in the area of psychiatry and dentistry in particular, which are areas that are not just challenging for Medicaid, but for all payers. We're almost ready to finalize those awards, but there will be... We're hoping psychiatry and dentistry are the largest number of awards we make, and we expect them to be.

Mr. Bassiri I just want to give you an update on where we are from a public and timeline standpoint on the next slide, just so you are aware of where we are. While the slide is loading, as I mentioned, we're in the last year of this waiver. Our waiver ends on March 31st of 2027. The renewal process starts much earlier than that. We are working very hard right now. We'll be preparing some public stakeholder engagement in July and August, which we wanted you all to be aware of and encourage you all to attend. We'll be talking about what we plan to request in our waiver renewal that is due to CMS on September 30th. Not breaking any real news here, but we're really going to be applying to renew the waiver that we have and continue the work that we're doing. We didn't get the full five years to do this. We've seen tremendous progress in the twenty-seven months we've had. I think we will have the evidence and the justification we need to illustrate that more time is needed. Very unclear. There's a lot of things changing. The waiver space, you may have heard of a proposed rule that came out on budget neutrality. Not going to get into the details of that, but there's no short-term implications for that with respect to our renewal. There will be implications for that in the future. A lot is TBD right now, but it should not impact our renewal application that is being submitted at the end of September. Ideally, we would have this done by the end the year. We do have to work with our federal partners and their timeline, and so some of this will be dependent on their capacity and ability to meet with us on the renewal. We've had great conversations thus far. I am cautiously optimistic that we will get what we are asking for.

Mr. Bassiri The last slide is really just some next steps for you all in terms of ways that you can support the waiver or participate in the renewal. To the extent you haven't already, please activate your providers. We are seeing great progress. We know that providers and SCNs are working much better together, but to the extent not, we encourage and appreciate your outreach augmentation. To the extent you haven't met with or talked to, please work with your regional social care networks. They're doing really fantastic, innovative work in their communities with plan and CBO partners and other community-based organizations. They have public meetings. Reach out to them. You will appreciate it if you have. Finally, we welcome your voice input and feedback in the way of a renewal process. We will have public feedback sessions in July and August, and we encourage you and your partners to participate. Thank you.

Mr. Kraut Thank you. We really appreciate that comprehensive overview of where you're at with the waiver and what's coming next.

Mr. Kraut Are there any questions from councilmembers before we let them go?

Ms. Soto My question is regarding the loan program. You listed that there were 889 applicants at this time. So, the first part is... How many will be awarded? Secondly, is there a designation for the particular categories you happen to have listed for? How many will be rewarded? Is there any designation set aside by the type of provider?

Mr. Bassiri Great question, Ms. Soto. There is no allocation by provider. There's no set amount for dentists, psychiatrists, primary care, or nurse practitioners. There is criteria used to prioritize the applications. That includes whether or not they're serving in a rural community, whether or they're not serving children or adolescents, whether or not they serve in a health service area for blanking on the term professional shortage area. We obviously take into account statewide representation of the various provider types, knowing that access is needed everywhere. Can't tell you right now how many will be awarded. We're going to award as many as we can that meet the needs. The largest applicant pool is nurse practitioner followed by a primary care physician, psychiatry and dentistry. We are definitely prioritizing psychiatry and dentistry given the evidence and the knowledge of the dearth of availability of those providers statewide. I would expect those to be the largest allocations of award, but we're going to work as much as we can up to the amount we were authorized under the waiver, which is forty-three million dollars.

Mr. Kraut Dr. Soffel.

Mr. Kraut No, you're okay?

Mr. Kraut I really appreciate that. I think that was a great education for the council. I'll just underscore your opening point that one third of the state residents of about twenty million are covered under these programs that we talked about, Medicaid, CHIP, Child Health Plus, and the Essential Plan, which as you know is under review. We often think of Medicaid as only people living at or below the poverty level. The federal poverty level in New York is $31,800 for a family of four. Substantially more, one third of our population is really at 200% of the federal poverty level, which is still living in poverty in New York to a great extent. It's an important program. You understand now the complexity of some of the things that we see here when we're dealing with Medicaid and why we're advocating for applicants to make sure there's a commitment to treating Medicaid. It's not treating 14% of the population. It's treating over 30% of population. I would say that's an important role that we play here. Thank you so much and your colleagues for presenting. We'll see you back after you submit the application. We wish you well and good luck and thank you so much, all of you, for the work you do for the state and the people of New York. I appreciate it.

Mr. Kraut I'm going to now ask for a motion to suspend the annual meeting.

Mr. Kraut Hold on. Oh, I'm sorry.

Mr. Kraut The Commissioner's on. We will continue with the mission and Mr. Holt will keep his bookmark in place. The Commissioner is joining us, obviously, remotely.

Mr. Kraut Commissioner, welcome.

Dr. McDonald You know, normally I'm with you in person.

Mr. Kraut Okay.

Dr. McDonald I'm in Midtown Manhattan. I'm going to do the best I can from my car here. Thank you.

Dr. McDonald A couple of things. I'm just going to do a little bit of a budget overview just to put a little context around the budget. It's a $277 billion budget. The Department of Health's allocation is $126.4 billion, and that's a $12.8 billion increase from last year. It was thrilling, by the way, to have Amir represent us. I tell you, I'm so thankful to have him leading our Medicaid program and Amanda as well as our Chief of Staff. Medicaid's $106.1 billion, and that's up from $93 billion for the fiscal year 2026. The Essential Plan is now at $11.4 billion. The Essential Plan is $11 .4 billion, but that's a decrease of $1.8 billion because of changes to do with H.R. 1. That means I have $8.9 billion for everything else the Department of Health does. That's just the high-level numbers. I'm just going to talk a little bit about some of the healthcare stability fund investments. The Healthcare Stability Fund, a lot of you know it as the MCO tax. We did that a couple of years ago with the Medicaid program. It's a state level financing mechanism to generate deployed, targeted Medicaid and managed care funding. We're trying to expand health services in New York. It's a legislative tool to provide fiscal flexibility and protect access to care during these periods of uncertainty. The hospitals will be able to get up to $706 million. Now, keep in mind that number includes a federal match. That means you need to get a state plan amendment approved by center for Medicaid and Medicare services. Nursing homes will be to get up to $480 million dollars. Federally qualified health centers get up to $80 million and assisted living programs up to $20 million. I know that's a lot of dollars out there, but it's all contingent on us getting state plan amendments, which we have every reason to believe we would be able to do. We have every reasonable belief we know how to do this, and we'll get them approved. The safety net transformation program, I'd just like to mention this one. This is a different program. I just want to make sure you guys keep track of all of our programs. The safety net transition program is financial support and regulatory flexibility to encourage partnerships that strengthen safety net hospitals that care for the most vulnerable New Yorkers. Since its passage, Governor Hochul has been awarded more than $4.4 billion to support fourteen different transformation partnerships. This year, the Governor has secured $1.3 billion in additional capital and operating funding. The Governor's identified special focus areas, including partnerships that focus on regional planning to improve coordination of care and reduce duplication of services. And now, in addition, this is another little pot of money that it's important to keep track up. This budget includes an additional $500 million, an additional funding for the Vital Access Provider Assistance Program. That's to support distressed facilities that are experiencing financial emergencies. Now, keep in mind, Vital Access Providers Assistance Program, which is sometimes called VAP app, is only state money. Not to be confused with other tools like the VAP program, Vital Assistance Program. I admit they sound the same. That one has a federal match as well. The vital access provider assistance program really for emergency financially distressed institutions. It's generally meant to be one time funding with a transformation plan just to find sustainable paths forward. I'm going to move on to other investments in critical healthcare services. So, to support hospitals, nursing homes and assisted living, the budget includes an additional 1.5 billion in support in addition to the billion investments that are continued from last year's budget. You know, I want to just shift now to talk a little bit about the medical indemnity fund. The medical indemnity fund. There's only three states who have a fund like this. This is a neurological birth injury fund. It's an alternative fund. It provides for the future healthcare costs of eligible individuals. This budget invested $155.5 million, an increase of 103.5 over the base appropriation of $52 million to sustain the medical indemnity fund. That was the increase that occurred

there during the budget process. Just keep in mind, the fund started in 2011 and just gives you, that's just sort of perspective. Some of the new public health investments I just want to talk a little bit about. One of the public health investment is a cardiopulmonary resuscitation readiness program. This is a new program. It's a little over $3 million a year, each year for five years. The whole point of it though is that, you know, sudden cardiac arrest, which can be a leading cause of death in New York state, often depends on whether the person who's next to you decides to do chest compressions, really cardiopulmonary resuscitation. This is about training as many people as possible to understand how to do CPR, also to make sure there's easy access to automated external defibrillators. I'm really excited that Ryan Greenberg, Steve Dessour and others from our EMS team are leading this initiative. It was a great idea. Another nice public health investment, this one was near and dear to me was improving vital records. We got $7 million just to improve what we're doing about our records. You know, the department's Bureau of Vital Records. We have great people doing great work there. For the first time in five years has halted the growth of backlog of requests for records. We really want to get closer to just helping people get records they need in a reasonable period of time. We're going to be able to recruit more staff. It's just something we've really done we can with optimizing the technology. We just need more people. It's great to see that. And then, I was thrilled about the artificial intelligence investment. That's going to be $1.5 million. Great to see that happening as well. I think it's just important to know that we all know artificial intelligence is here to stay. I think most of us are using it every day, whether we know it or not. It's really important for us to be leading in this space with healthcare. I just want to mention the Rural Health Transformation Program. That money came from Center for Medicaid Medicare Services. It was really probably the most virtuous aspect of H.R. 1. It's $212 million. What we needed the legislature to do, and they did was give us an exemption from state financing laws. We already have RFAs out there now. Moving forward as far as that goes. I want to mention a little bit about food. I don't know that many of you realize how much the New York State Department of Health does in food. We have ten different food programs around $1.1 billion a year in meeting food needs. This year, we saw a nice increase in the hunger prevention nutrition assistance program, up to $72 million. Nourish New York got $55 million, which is a program we do with Ag and Markets. This year there was a new investment again of $10 million that we just launched with the Dormitory Authority of the State of New York for really capital improvements for food banks. It was over 2,700 food banks and they need capital improvements as well. Sometimes it's something as simple as industrial size refrigerators and freezers, and good to see that as well. I'm going to stop there because I really do think it's important just to have time for questions here. Thank you again for the flexibility to do this remotely here. As you often know, my life isn't my own, but I try to make it available to you as flexibly as I can. What questions do you have for me, my friends?

Mr. Kraut Thank you very much, Commissioner. We appreciate the effort you made to join us today.

Mr. Kraut Questions for the Commissioner?

All (Laughing)

Dr. McDonald I'm not driving.

Mr. Kraut You're not driving, I know.

Mr. Kraut Any questions for the Commissioner?

Mr. Kraut Commissioner, we really will thank you. We'll let you go. We do want to make one observation. I'll do it on behalf of the council. You heard Amir describe the impact of the 1115 waiver and the significant amount of dollars that we're investing in focusing on social determinants of health. It seems to us that one of the most impactful factors on improving the mental health of New York is a Knicks championship. I think those are one of the things you think we should be putting under the purview of the Department of Health next year.

Dr. McDonald I absolutely think so. I really think we need to focus as much energy on the Mets as possible.

Mr. Kraut Yes.

Dr. McDonald If we had a Mets championship, oh my gosh, the health benefits for that one.

Mr. Kraut I believe we would see a decline.

Mr. Kraut We would see a decline in mental health if all of our sport teams would win.

Mr. Kraut Now, I'm going to have a motion now to suspend the annual full council meeting and reopen the Codes Committee. May I have a motion?

Mr. Kraut Mr. Robinson.

Mr. Kraut May I have a second?

Mr. Kraut Mr. Hughes.

Mr. Kraut Mr. Holt.

Mr. Holt Good morning. I'm Tom Holt, Chair of the Committee on Codes, Regulations, and Legislation. I have the privilege to reconvene the Codes Committee meeting. We have two other items on our agenda this morning. These are both for information, the first being communicable disease reporting definitions and specimen collection. This regulation is being presented to the committee for information only and will be presented to committee and the full Public Health and Health Planning Council at a later date. Dr. Lutterloh and Mr. Riegert from the department are available and will provide us with information on this proposal.

Dr. Lutterloh Thank you.

Dr. Lutterloh I'm going to tell you about Section 2.1, which is the list of communicable diseases that must be reported. Section 2.2, which has definitions, and Section 2 .5, which specifies those diseases and conditions for which a specimen must be collected for lab analysis when a specified illness is suspected. All three sections are to be repealed in their entirety and replaced with revised content. The proposed amendments basically update and clarify the list of reportable communicable diseases along with the definitions and those for lab analysis to address public health preparedness and surveillance of emerging communicable diseases and conditions. Before I move on to the details of the proposed changes, I do want to emphasize the extent of the outreach that we've undertaken in the

course of developing these proposed regulations. Over the past three and a half years, we've had over literally 280 meetings with parties involved, and that doesn't even include email conversations or the work that was begun before the pandemic interrupted our efforts. We've talked to various programs and subject matter experts throughout the department, other state agencies that might be affected. NYSACHO, which is the New York State Association of County Health Officials as the representative of most local health departments, which we spoke with multiple times several individual local health departments in New York City, the Greater New York Hospital Association and the Healthcare Association of New York State. An important point is that as part of this outreach, we didn't just describe our proposed amendments and explain the reasoning behind them, which we certainly did, but we also carefully considered the feedback and in fact, we did make several modifications to these proposed regulations based on that feedback, particularly from NYSACHO. We also conducted outreach via email with several laboratory associations. The limited feedback we got from them was that they were supportive of the changes. The result here is that the regulations I'm going to tell you about have been crafted to give us the information that we need for public health surveillance and response activities while particularly importantly minimizing additional burden. I will go into more detail about burden after I summarize the proposed amendments.

Dr. Lutterloh So, now to get to the regs themselves. I'm going to try to strike a balance here between giving you enough information and giving you too many details that are included in the written material because there is a lot here. I'm going to start with Section 2.1, which includes the list of reportable conditions. The biggest change here is that we want to create two lists rather than one to improve the clarity of reporting requirements. One list would be the list of conditions and diseases for case reporting. Typically, these would be things that physicians and other providers would call into the local health department. The other is a list of organisms and other agents for positive laboratory test result reporting. We also would like to make some minor edits for spelling and consistency of formatting and gender neutrality. There's one definition in Section 2.1 that we want to move to Section 2.2, the definition regulation. We would like to group tick-borne diseases that are currently listed separately under a single tick-born disease category that will now be based on these proposed regulations include Alpha-gal syndrome, which I will talk more about shortly plus Rickettsia. We want to align reporting of influenza, COVID and Respiratory syncytial virus as much as possible including simplifying and updating COVID reporting. We're proposing to remove hospital associated infections from the list, which actually will not change reporting requirements because of other laws and regulations that mandate the reporting that we need. It's present on the list for historical reasons, which no longer apply. We also would like to make some minor updates to three conditions to reflect advances in knowledge or laboratory technology. An example of this is changing E. coli O157:H7 infections to E. Coli Shiga Toxin producing. We also would like to add three agents. Select agents are organisms or toxins that are defined by the federal government as having bioterrorism or other high-consequence public health potential. There are, like I said, these three that are not covered elsewhere; hendervirus, nepovirus, and epidemic typhus. There are also several other conditions that appear to be emerging in New York State, or otherwise in need of better public health surveillance. Examples of those are blastomyces species in the Mohawk Valley, Candida auris, particularly in the Metropolitan area in hospitals and nursing homes, carbapenem-resistant organisms, which seem to be spreading throughout the state and Vibrio species. That's Section 2.1. Section 2.2, again, is the definition section. We would like to remove the reference to hospital-associated infections, which is not needed with the term being removed from the list in Section 2 .1. Frankly, It was defined in a confusing way anyway. We would like to slightly modify and

align the definitions of a case and a suspected case, particularly to explicitly include epidemiologic considerations. We want to clarify the definition of an outbreak to explicitly state that it includes both community and healthcare-associated outbreaks, and also to include single cases of disease that may reasonably be considered to portend an outbreak of public health importance. Lastly, for Section 2.2, we would like to update the definition of unusual disease, which in the current regulation only includes emerging diseases or syndromes that have an unknown etiology. We would like to add conditions with no etiology, but demonstrating new, unusual epidemiologic or clinical characteristics that might have public health significance. This really addresses improved lab capabilities. I mean, in decades past, something could be of unknown etiology for quite a while, and now we tend to know pretty quickly what the underlying cause is, if not the reasons for the new presentation. This change is also consistent with what is, for example, New York City and other jurisdictions. For Section 2.5, now this is not technically a reporting regulation. I want to make that clear because it's very easy to get 2. 5 and 2. 1 confused. Section 2.1 defines a list of conditions that physicians are expected to send off a lab test for if they see a suspected case. The biggest change that we're proposing here is to expand the applicability of the beyond physicians to include other types of independently practicing licensed healthcare provider whose scope of practice includes the legal authority to diagnose disease via laboratory examination. Just to give you an example, under the current regulation, if someone walks into a physician's office and the physician thinks that they have, say, measles, which actually, technically, measles is not on the list right now. That is one that we propose to add. With it only being applicable to physicians...You know, when we put measles on the list, the physician would be required to send off the very critical laboratory test information. If we did not expand this and the same patient walked into, say, a nurse practitioner's office, that same requirement would not apply. That just plain does not make any sense. That's why we want to expand the applicability of the regulation. We did work with the State Education Department on this. They are aware and provided us with the appropriate wording. We also want to add several new conditions to that list. Most critically, Hepatitis A, influenza caused by a novel influenza virus and measles, and a few other vaccine preventable diseases. Lastly, for 2.5, we would like to remove some individually listed conditions and consolidate them into groupings, mainly because often it doesn't make sense to list the individual condition separately when the whole point of the regulation is to require testing for conditions that have public health importance that really can't easily be diagnosed down to the... You know, like say the organism level without the lab test. To that end, we would have arboviral infections, tick-borne infections, and acute infectious non-viral diarrhea. When those entities are suspected, then the physician or other clinician would be required to send off the appropriate laboratory testing. I mentioned earlier Alpha-gal syndrome, which there's been increasing legislative and public interest in recently. Alpha-gal syndrome is an allergy that can occur after tick bites, particularly from the lone star tick. It does it by causing sensitization to a sugar molecule that's just a normal part of the tick's saliva and that is transmitted during a tick bite. Unfortunately, that same sugar molecule is also present in mammalian meat. People who are sensitized from a tick bit thereafter can suffer allergic reactions after eating meat. The proposed amendments include reporting of lab tests consistent with Alpha-gal syndrome. For those of you who are familiar with Alpha-gal syndrome, we recognize that clinical correlation beyond the lab test is needed to diagnose Alpha-gal syndrome. We plan to use the lab tests reporting really as a starting point and then use additional data sources such as claims data and our tick surveillance data to really to hone in on the burden and spread of this condition. We didn't include case reporting in these proposed amendments for several reasons, primarily because we felt that it would impose a potentially large and we felt unnecessary burden on local health departments in the most highly affected areas. There are some conditions where it is really

important to have an exact case count typically because of the public health follow-up that's needed such as say contact tracing. That obviously would not be the situation here. There are other conditions such as this one where... You know, we need it. We need the reporting because we need to be able to follow trends and spread and get an estimated burden and that's what we need for this one. We think that is sufficient. Therefore, we think laboratory reporting plus... You know, the additional work we can do based on that is sufficient. We also think that it will give us the information we need while minimizing burden to the local health departments because accepting a lot of physician reports can be a burden. Speaking of burden, I want to talk about that a little bit more and discuss the issue of burden associated with these amendments because we all know that we're somewhat in somewhat fiscally challenging times both for the state and local health departments. My main point here is that we've done everything we can do to minimize burden in the extreme. This is much less than the extent of the and these amendments might at first imply so Mr. Kraut a few years ago back in 2023 when we added RSV and Vericella to the list of reportable conditions. You made an offhand comment that you wanted us to carefully consider further additions to this list and. I don't know if you even remember that comment, but we do. We took it to heart. We took it seriously. It actually led us to conduct a comparison of New York and other states with regard to their reportable conditions. Now, of course the primary determinant of whether something should be reportable should the public health need, not just what other states are doing. I addressed the need earlier and in great detail in the written documents that you have. I nevertheless hope to be able to give you some numbers to reassure you that what we want to do here is on par with what other states are doing. Unfortunately, this turned out to be a lot more complicated than I thought because of the many different ways states group their reportable diseases and different age ranges and different subsets of which aspect of the disease is reportable. You know, differences, lab and clinician, and a lot of other complications. The bottom line is it just wasn't possible to tally these up easily and give you counts. After all the time I spent scrutinizing the spreadsheet that our team created, I can tell you that the regulation in its current form puts us well on the lower end of what states tend to require for reporting, and these proposed additions will us into the pack. So, another thing we did to try to minimize burden was eliminate clinical case reporting where it's unnecessarily redundant with lab reporting. Now, of course, there are some conditions where case reporting is important and necessary, even if it might be redundant, but we took case reporting out of the list where it made sense to do so because it's a burden for clinicians to report and its burden for local health departments to accept those reports. This doesn't mean we can't go to the clinicians for case information after we get the lab report. It just means that we'll first hear about it from the lab. Now, as far as the specific additions that we're proposing, for several of them, we actually expect zero or near zero burden. Examples of those would be the select agents that we really need to know about if they occur, but they should be zero or nearly zero. Quite frankly, if the cases of the select agents are not zero or near zero, then we have far bigger problems than case burden. For some of the other conditions, such as chrono bacterial leprosy and leptospirosis, we expect very low numbers, but they do each prompt important public health responses. There are some other conditions that are a part of this where we do expect cases, although generally low numbers. We have processes in place to minimize burden. If you recall back in... Let's see, in 2024, we amended Section 2.6 to give us some flexibility in what investigatory activities we expect from local health departments. That was a conscious decision to make that amendment before proposing these current amendments because we're making use of that flexibility for some of the conditions that we're proposing to add to minimize burden. An example would be with blastomycosis. Blastomycosis is a fungal disease that can cause a very severe pneumonia and can be difficult to diagnose if you're not looking for it. It seems to be emerging in the in the Mohawk Valley area. So, for

that particular case we had we had discussions with the likely impacted county health departments to kind of determine and come to a consensus about what type investigation would be both appropriate and feasible. For, say, congenital CMV, we have a federally funded program here at the state to follow up cases, which right now we use information from our birth defects registry, but adding this to the list of reportable conditions will substantially improve the data and allow for better follow-up, and follow- up is critical to ensure good outcomes for congenitally CMV. What happens if our program here ends? We also have plans in place to minimize burden on counties should that end, and this is an example where we would really only expect probably about eighty cases per year statewide. Let's see, I don't know if I need to go into a lot of these other ones. One more example.

Mr. Holt Maybe take a pause now and take some questions from the members.

Mr. Kraut By the way, I thank you for responding to offhand comments so thoroughly. I'll make another one, increase funding for public health and health.

Dr. Soffel You sort of touched on this, but I was interested with the U.S. withdrawing from the WHO disease surveillance system, some states have indicated a plan to continue to be involved, and the reason I raise this is because it may be you getting to local health departments to say there's been one case of X or one case of Y, which we've seen a little bit in the newspaper. Ebola is getting more familiar to us sadly. Is the state part of that new grouping? How does that work when you are sending it to somebody, we've had a case of X in some place, and you just should be aware of it.

Dr. Lutterloh We actually are a part of a WHO group that holds informational phone calls, it's called GOARN, and I'm so sorry, I can't tell you what that acronym stands for, but we do have people from the department listening to those phone calls and also participating in what's happening on our end when needed. We also have our Office for Science creating the Global Health Report, which is a weekly report available on our website. You're welcome.

Mr. Holt Thank you.

Mr. Holt Other questions from the members of the council or committee?

Mr. Holt Dr. Watkins.

Dr. Soffel I'd just like to commend you for the rigor with which you undertook this process. It's really quite impressive and I just wanted to add to say that.

Dr. Lutterloh Thank you.

Dr. Watkins I also want to thank the department for their efforts to minimize the impact of those to this proposed regulation to local health departments. We also greatly appreciate the willingness of the department to consider and incorporate the recommendations that was brought forward by NYSACHO during this developmental process. During that call with NYSACHO, I did have one question I'm not sure that I got answered. For those for those new requirements or impacts that will impact local health departments, for instance, on those conditions, such as blastomycosis and leptospirosis, and measles, and those unusual disease events that will have to be reported by local health departments or investigated by local health departments. Will the state provide additional resources like

training and investigative guidance for two local health departments for these new investigative requirements that you're asking for the local health department?

Dr. Lutterloh Yes, absolutely. In fact, we have a lot of follow-up already plans for these regulations. First of all, it's not just local health departments. Local health departments, of course, will be a big part of this, but there will be updated lab guidance for the laboratories, which is already in the works. We will need to update clinicians, and we plan to do webinars to educate the clinical community about the new reporting requirements. Similarly, we would expect to do similar education for local health departments about... You know, again, what, if anything, frankly, is required of them based on these new proposed additions. If I could, I have like one last thing to mention here that is actually relevant to your question, so I want to do that very quickly because that relates to the if any that I just said. You'll notice that we're proposing to add candida auris and carbapenem-resistant organisms to the list. Those we actually see in extremely high numbers in New York State. We have people here in the state who are working on trying to limit spread and reduce those. That is an example where these are mostly associated with Article 28 hospitals and nursing homes. The department investigates them rather than local health departments. We actually don't think that that will be an increased burden for us or for local health departments. We already hear about them because they're typically reported to us because they are considered part of outbreaks. We already here about them and investigated them. This is a situation where we would not even send those reports through to the local health departments unless a particular country wanted us to do so. That's another example. That's the one last example there is one where we do have a very high burden of both of those conditions. We're already dealing with it. We don't expect that to change. We really need to get them on this list

Mr. Holt Thank you.

Mr. Holt Dr. Eisenstein.

Dr. Eisenstein Thank you.

Dr. Eisenstein Dr. Eisenstein, council member. Thank you for that presentation. We hear a lot of about a lot a topics here. Maybe this is your self-serving as an infectious disease doctor with experience in this, but there's nothing that we hear as a council that more impact the day-to-day lives of new Yorkers that what you're discussing. We should all sleep better at night based on this presentation because we just heard words like carbapenem resistant antibiotics and most people don't know what that means. What that means is when our loved ones end up in the hospital, antibiotics that are used to work to save their lives might not anymore. That's the work that your unit is doing. During the pandemic, everybody knows of this work. The rest of the time, it's almost like a forgotten thing. It really impacts every single day, every one of us, that you're monitoring this, that you are watching this. Scary as hell that you can get a tick bite and then die of anaphylaxis if you eat a hamburger. I mean, that's literally what Alpha Gal has become. You get a tick bite, you become allergic to meat, you eat meat, and you can have an anaphylactic reaction. This is scary. The fact that you guys are watching this, monitoring it and providing this guide is vital. Thank you.

Dr. Lutterloh You're welcome. We're doing our best. I just have to get to the point that we are doing our best under constraints both on our side and on the local health department side. We remain very cognizant of those.

Mr. Holt, Dr. Lutterloh.

Mr. Holt Any other questions from members of the committee or council?

Mr. Holt There was nobody from the public who signed up to speak. Thank you.

Mr. Holt This regulation will now go before the full council for information.

Mr. Holt Finally, we have on our agenda today the nurse aid training program. This regulation is being presented to this committee for information only. It will be presented to the full Public Health and Health Planning Council for adoption to a later date. Jonathan Karmel from the department is available and will provide us with information on this proposal.

Mr. Karmel Hi. This is a regulation that's in our nursing home regulations. We proposed it on June 17th. We're in the sixty-day public comment period right now, which goes until August 17th, so this relates to the training programs for certified nurse aides or CNAs. There's a federal regulation that says that the training programs have to have no less than seventy-five clock hours of training. Our state regulation currently says that the CNA training programs have to have one hundred hours of trading. This is part of Governor Hochul's Express New York initiative to eliminate burdensome regulations. We're making our state regulations consistent with the federal regulations by changing. The training requirement is from one-hundred hours to seventy-five hours, same as the federal regs. That's it.

Mr. Holt Thank you, Mr. Karmel.

Mr. Holt Questions?

Dr. Soffel Yeah, I have a question. Was the federal regulation always seventy-five and New York decided to make our regulation higher, or has the federal regulation been decreased? What explains the discrepancy?

Mr. Karmel I don't know the history of it. Val, do you know?

Ms. Deetz Hi. Thank you for asking me for that question. The seventy-five hours has been consistent with the federal regulations for quite some time states can go. They have that's the minimum threshold. We have some states that go up to one hundred and twenty. Several states that actually coincide with federal regulations at seventy-five. I'm not sure why we went to one hundred, but in 2020 during the COVID pandemic, we actually waived that requirement and we stayed consistent with the federal regs of seventy-five. This brings that in line, like Jonathan said, with the Federal requirements.

Dr. Soffel What gets eliminated from the training if you're cutting it by 25%?

Ms. Deetz Hours. That's it.

Dr. Soffel Hours.

Ms. Deetz Yep, so the curriculum stays the same.

Dr. Ortiz I don't think they're teaching it faster. It's the number of hours they're spending in a clinical setting to demonstrate their proficiency.

Ms. Deetz Or the modules that are, there's up to seven modules that are usually contained in a nursery training program. Each of those modules are blocked for specific hours. Those hours can be tailored to accommodate to fifty-nine hours of classroom time.

Mr. Holt Dr. Ortiz.

Dr. Ortiz Dr. Ortiz, member of the council. Would the department consider language that would say at a minimum of seventy-five? Because of my concern is that over time, if a program or a nursing home that produces nurse assistant graduates find that they don't have the outcomes that they expected in their learning that it gives them flexibility to increase the hours without having to reapply to the state and be consistent with the recommendation from the department. The minimum says that they get at least seventy-five, but if over three, four, or five years they found out that the learning outcomes aren't meeting practice requirements based on feedback from agencies, I would like them to have that flexibility.

Mr. Karmel The regulations do it will be changed from at least one-hundred hours to at least seventy-five hours. They could do more than seventy-five hours.

Dr. Ortiz Would they have to reapply or give a substantive report to the state about why the change would occur, or could they just make the change?

Mr. Karmel Well, the Bureau of Professional Credentialing, you know, authorizes these certified nurse aid training programs in nursing homes.

Ms. Deetz The guidance will be written once the regulations and the comments are assessed so that we can see if there's any substantive changes or any changes that need to be made.

Mr. Kraut So I would just say, because this is information only, you're going to collect comment. Please take Dr. Ortiz's language suggestion into consideration. It'll come back to us. If you don't like it, you could tell us again. We can change it. It's better to change it than it doesn't have to go out for public comment again. I would strongly suggest you incorporate his suggestions.

Mr. Holt Are their other questions or comments from the members of the committee or counsel?

Mr. Holt And no one from the public has signed up to speak, so this will be presented to the full council for information and will be coming back to us at a future meeting.

Mr. Holt That now concludes this morning's or afternoon's meeting of Codes, Regulations, and Legislation.

Mr. Kraut Thank you so much, Mr. Holt and the department for that work. I'm reintroducing myself. I'm Jeff Kraut. I'm reopening the meeting of the annual meeting of the Public Health and Health Planning Council.

Mr. Kraut Do I need a motion to reopen?

Mr. Kraut May I have a motion reopen?

Mr. Kraut Mr. Robinson.

Mr. Kraut A second, Mr. Thomas.

Mr. Kraut Thank you very much.

Mr. Kraut I want to welcome members of the Department of Health, participants and observers. Just to remind you that everybody who is attending today and who plans to speak, we'd like you to fill out a record of your attendance. It's required by the Joint Commission on Public Ethics and in accordance with Executive Law 166 we've posted the form out at the tables outside. You can email Colleen Leonard at the Department of Health. You'll find it on our website under www.NYHealth.Gov. Mr. Holt talked about the rules for webcasting. I just want to remind the public and members who are listening in that the department's certificate of need listserv. They send out important council information, notices, our agenda, our meeting dates, policy matters, material that's available on our website. We would encourage everybody to if they are following of the PHHPC activities to join that listserv. There's instructions on the reference table outside or you can contact Ms. Leonard for assistance in joining. For the annual meeting today... We're going to vote on the appointment of the council's vice chair. I will also talk about our committee's assignment. We're going to follow that with a report we just heard from Dr. McDonald. Dr. Whalen will talk about the Office of Public Health, followed by Dr. Boufford with the activities of the Public Health Committee. Mr. Holt will present regulations for our council action. Mr. Robinson will present the activities of the Project Review and Establishment Committee. For those members of the council, we are going to be batching applications. Our Certificate in Need is applications include different categories. Take a look at what we're planning to batch on the agenda. If you have any concerns or want to remove an application from the batch, please let Ms. Leonard know before Mr. Robinson gives his report. I'd like to welcome three new members to the council. We have with us today Jon Van Valkenburg who's going to be filling the newly created category seat representing freestanding ambulatory surgery centers. Mr. Van Valkenburg is a seasoned health care executive with more than a decade of senior leadership experience in governance development operations of free-standing ambulatory surgery centers. He currently serves as the Executive Director of the Upstate Orthopedics Ambulatory Surgery Center and oversees all aspects of its administration, regulatory compliance, quality and fiscal management. Next to him is Christina Gerdes. Dr. Gerdes is going to fill in as our representative now from the Behavioral Health Services Advisory Council. Dr. Gerdes is a double-boarded certified adult psychiatrist with addiction to medicine. She's a physician executive with over fourteen years of experience in behavioral health, clinical leadership and clinical operations. She co-founded and is the former Chief Medical Officer of Willow Health, where she developed and oversaw the organization's evidence-based clinical care model and led the company through the Joint Commission. I want to welcome the two of you. We hope that members of the council will introduce themselves. We also sent your bio to members of council. I'm sure you're going to make great contributions. We also have another appointed member. It's Kathryn Haslanger. Unfortunately, she could not join us today. She has an extensive background in social services, regulations, and compliance. She most recently served as the CEO of the Jewish Association of Services for the Aged, also known as JASA. She led an organization with over 2,000 staff that were dedicated to enriching the lives of tens of thousands of seniors and New Yorkers throughout the area with housing, home health care and community-based programs. Please welcome her.

She'll be additionally another voice. If you think about the three of these individuals... It gives us another perspective here on the work that we have to do. I want to congratulate one of our members, Ms. Farrell, who has just celebrated her forty years of service at the Open-Door Care Network, where she began as a volunteer in 1984.

All (Clapping)

Mr. Kraut You know, she, here's an individual who kind of rose, you talk about starting in the mail room, rose through the organization, almost held every major job and position in it, and guided it, grew it, and it's one of the larger patient-centered care delivery systems in the Hudson Valley. Her dedication, her vision, and the leadership has impacted so many patients and families and frankly improve the health of the communities that we serve. We want to congratulate you, Lindsay, on the extraordinary milestone. Forty years, if you take a look around the room and we add up all the years of knowledge here. I'm looking at Dr. Rugge.

All (Laughing)

Mr. Kraut Yes, two years. It's quite impressive. It really does show when we engage in, based on our perspectives, in issues with codes, with the work the council does, and we appreciate it. Ms. Farrell, we wish you many more years of productive contributions to serving the people of New York.

Mr. Kraut I'm going to now propose the election of a vice chair. I am moving to the election of the council's vice chair to make a motion for Dr. Boufford to serve as vice chair. I make the motion.

Mr. Kraut May I have a second?

Mr. Kraut A second, Dr. Berliner.

Mr. Kraut Dr. Boufford, do you accept the nomination?

Mr. Kraut She does.

Mr. Kraut May I have a vote?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Anybody voting no?

All (Laughing)

Mr. Kraut Any abstentions?

Mr. Kraut The motion carries.

Mr. Kraut Congratulations, and thank you, Dr. Boufford.

All (Clapping)

Mr. Kraut For our new members, we're going to be meeting with them and assigning them to committees where we have some need for some manpower and based on their preferences and expertise. Right now, these standing committees on roles of the PHHPC will remain the same. Establishment and Project Review will continue to be chaired by Mr. Robinson and the Vice Chair, Dr. Kalkut. The Public Health Committee will be chaired by Dr. Boufford with the Vice Chair of Dr. Torres. Health Planning will continue to be chaired by Dr. Rugge, with the Vice Chair, Ms. Monroe. Codes, Regulation and Legislation will be shared by Mr. Holt, and the Vice Chair is Dr. Yang. Health Personnel and Interprofessional Relations will be chaired by Dr Thomas. The Ad Hoc Committee to lead the State Health Improvement Plan will continue to be chaired by Dr. Boufford as well. I'd like to thank all the members of the council for the hard work and time and the commitment you made to the respective committees. We look forward to another productive year, keeping our minds on the challenges that we have to confront in improving and strengthening and maintaining access to healthcare for all New Yorkers and improving that.

Mr. Kraut I'm concluding the annual meeting. I'm now going to go into the regular meeting of the council for today on June 26th. I want to start by asking for a motion to adopt April 23rd, 2026, PHHPC meeting minutes.

Mr. Kraut May I have a motion?

Mr. Kraut A motion, Mr. Robinson.

Mr. Kraut Second, Dr. Berliner.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Kraut I now would like to introduce Dr. Whalen who is going to give us a report on the activities of the Office of Public Health.

Dr. Whalen Thank you so much, Mr. Kraut.

Dr. Whalen Good afternoon to members of the council and public. I'm Liza Whalen. I'm the Medical Director of the Office of Public Health. I'm going to be providing the update for the Department of Health. I'll start with communicable disease update. I'm sure many of you have heard of the Andes hantavirus outbreak that occurred on a cruise ship. The Andes hantavirus is a subset of hantavirus, which has a high mortality rate of about 30 to 40%. It's an unusual strain. There can be limited person-to-person spread, which is not normal with hantavirus. There were thirteen cases and three deaths. New York State became aware that three of the quarantined residents were New York State residents. The passengers were disembarked from the ship on May 10th and sent to the National Quarantine Unit in Nebraska. Conclusion of quarantine occurred on June 21st and there were no further cases. All of our cases were monitored closely, including involvement with local health departments when it was warranted. Hopefully, that's the end of Andes antivirus for the time being. We also have been monitoring the Ebola virus outbreak in the

Democratic Republic of Congo, which initiated in mid-May. This has occurred in a remote region with ongoing civil strife, so precise numbers of cases and deaths have been difficult to obtain. This outbreak, we know, spread to Uganda and has led to travel restrictions on non-U.S. citizens returning to the U.S. after having been in the DRC, Uganda or South Sudan. Currently, there is screening of returning travelers at certain airports among them including JFK. For both Andes hantavirus and the Bundibugyo virus, we did create and send out health advisory notices to clinicians. The New York State Department of Health Emergency Preparedness management system was activated. We met daily during this time. We updated our website. We coordinated with state and local partners as necessary. Updates from the Center for Environmental Health. Staff and the Center for Environment Health Bureau of Community Environment Health and Food Protection have been working with local health departments in implementing the lead rental registry in twenty-five communities of concern across the state. Landlords can now register their multi-unit rental dwellings in the lead safe database. As of June 1st, more than 11,000 properties have been registered in this database inspections and lead safety certificates will be conducted and are due every three years. The first round will be no later than December 2028. We look forward to providing initial numbers of completed inspections later this year. From the Division of Public Health Infrastructure, our Office of Local Health Services was involved with the New York State Division of Homeland Security and Emergency Services to plan and assess preparedness resulting from numerous mass gatherings scheduled to take place across New York State in June and July. We know estimated tourism is expected to exceed two million during peak times as a result of events. Centered around FIFA World Cup and the 250th anniversary of independence, the U.S Open Golf Championship among others. There has been a lot of coordination and preparedness to ensure that our counties and state is aware of addressing and monitoring potential risks and key strategic focus areas. We continue to have meetings on this and have been presenting to agencies, including the New York State Association of County Health Officials, sharing communication on potential risks, including health risks, such as heat dehydration, communicable disease outbreaks, risk, et cetera, to have heightened awareness for this. As Dr. McDonald said, all of this was prepared for the World Cup, and probably the biggest gathering was after the Knicks won. Nothing bad came of that so far. We're happy about that. Community Engagement and Outreach Unit of the Division of Public Health Infrastructure has provided significant operational coordination support towards establishment of a New York State Rare Disease Advisory Steering Committee, which is helping lay the groundwork for the development of a permanent New York State Rare Disease Advisory Council. This is supporting cross agency collaboration to support the future council. Rare diseases again are diseases that affect less than two hundred thousand people nationally. They're often genetic. Other diseases and increasing awareness of them and having an idea of their prevalence in New York is important. In addition to this building on National Public Health Week, there have been numerous initiatives to increase the awareness of the work of public health through the Community Engagement and Outreach Unit, including involvement in social media and other strategies. These have helped. Among other things, increase awareness and enrollment in the New York State Community Public Health Leader Training Program, which is a program that we run with Cornell in the hopes of increasing awareness of public health for local leaders and others across the state. This program recorded twenty-one enrollments in April and May, and we continue to monitor that.

Dr. Whalen I believe I'm also going to be providing updates for the Office of Science and Technology. The Office Of Science has worked to update several major data dashboards in late Winter, early Spring. We can, the links to those are provided in your packet. Among these is the new 2025-2030 Prevention Agenda Dashboard application. This includes data

from the Pregnancy Risk Assessment Monitoring System, vital statistics, BRFSS, and Youth Tobacco Survey. The Prevention Agenda Dashboard is interactive visual presentation and kind of keeps us up to date on how we're doing with metrics, important health-related metrics across the state. It's updated at least twice a year, so it is fairly current data. We are always working to make it more current. New York State Community Health Indicator reports. It's over 150 metrics organized by fifteen health topics. There's also New York State Leading Causes of Death Data Application, which provides interactive visual presentation for up to seven leading causes of all deaths and premature deaths across the state. There are additional topic-specific dashboards, including the New York State Pregnancy Risk Assessment Monitoring System Dashboard. This presents data from a national surveillance system designed to support research and guide policy changes to reduce infant morbidity and mortality. The New York State Asthma Dashboard, the Opioid Data Dashboard, Maternal Child Health Dashboard, and the Office of Science continues also to update several COVID-19 related dashboards on a weekly basis. I encourage all of you to look there. We know that data is the foundation of so much of the public health work that we do. Maintaining these data dashboards is a significant amount of very important public health work.

Dr. Whalen From the Wadsworth Center, I will provide updates there as well. They have been educating undergraduate students for several decades through research experience for undergraduates' programs. They have now launched and expanded the Public Health Laboratory Academy. They have nineteen new students who are doing two-week lab 101 training boot camp and work in the divisions in Wadsworth. There is a tremendous amount of teaching, mentoring, and organization for this program and hopefully leading to more involvement in that workforce as well. I'm happy to report that the Wadsworth Center scientists that are advancing the development of a Lyme disease vaccine. Scientists at the Wadsworth Center have made several important discoveries towards development of a Lyme disease vaccines. Dr. Nicholas Mantis, who's the Chief of the Laboratory of Microbial Pathogenesis and Immunology, and his team elucidated the immunologic mechanisms by which antibodies elicited by vaccination may prevent Borrelia burgdorferi from surviving in skin tissues. This is in collaboration with Moderna, Cambridge, Massachusetts, and Tufts University. The vaccine is now in human clinical trials. Also, the Wadsworth Center has identified Borrelia mayonii, which is an illness similar to Lyme disease. It is pretty novel and was first recognized as a human pathogen in Minnesota in 2016. They have identified this in ticks, not humans so far. We will continue to monitor that. And of course, with all Lyme diseases, it's important to notice geographic variability, particularly as we have a northward migration of these ticks and more disease as time goes on. I also want to share Wadsworth Center scientists who share advances in molecular newborn screening at CDC training workshop, Dr. Carlos Saavedra-Matiz and Dr. Denise Kay of the Wadsworth Center's Newborn Screening Program participated in the 2026 Newborn Screening Molecular Training Workshop. Dr. Saavedra-Matiz presented three lectures covering the fundamentals of DNA sequencing, laboratory mathematics, and case studies in severe combined immunodeficiency screening. Dr. Kay delivered a lecture on national molecular analysis for cystic fibrosis screening. The leadership of center scientists in this nationally recognized training program reflects the center's ongoing commitment to advancing newborn screening science and improving the early detection of serious genetic disorders across the United States. Lots of work going on.

Mr. Kraut Thank you so much for that thorough report and congratulations to you and all the staff and the stuff that Dr. Matiz is developing the vaccine. That'll be a big, big issue once it comes out of clinical trials. I hope it succeeds.

Mr. Kraut Any questions for Dr. Whalen?

Mr. Robinson I think we just really want to underscore that that Lyme disease announcement is just significant and terrific, and the department and the Wadsworth folks are to be congratulated. I am very happy it was done in New York State.

Dr. Whalen Thanks so much. I'll make sure to share that with them.

Mr. Kraut Thank you.

Mr. Kraut I'm now going to move on, and I'm going to ask Dr. Boufford to give a report on the Public Health Committee's activities.

Dr. Boufford Thank you.

Dr. Boufford Hello, everybody. Good morning. It's my pleasure to report on the Public Health Committee, which met yesterday. We addressed three topics. One is the prevention agenda. Second is community benefit. The third was public health workforce. I'm going to touch on each of them for you. I also especially want to thank Dr. Whalen, who's also our liaison to the leadership of the department for the Prevention Agenda. Mark Waldenmaier, who's Director of the Office of Local Health Services, and Bella Elogoodin and Doug Fish, who have been really, really helpful from their office, which is very involved in the community benefit work, and the Public Health Workforce and Infrastructure Group. Let me touch on each of these. One, just for new members to remind everyone, the New York State Prevention Agenda, the PHHPC has statutory responsibility for working to not only help create the Prevention Agenda but also oversee its implementation. We are doing that on your behalf and really happy to have many of the council members who've been able to join the Public Health Committee, even though they have not been members. We were given updates. The cycle, these are requirements by the federal government to hospitals to provide community service plans every couple, three years, I think it is, and Jeff will correct me. Local health departments similarly provide their own community health plans to the state. Even though we're a little bit off sync because they had been aligned and we lost the alignment in the last year or so. Those processes have been proceeding. Hospital Community Health Service Plans were due the end of December of this past year. Those were received. The local health department reports. We had originally hoped many of them would be due the same time, and they would be jointly done. About 40 percent, I think of the local health departments were able to do that. Because of the sort of sinking delay in some of our processes, there was extra time given to local health department with a due date of July 1st. We're waiting for those to come in with the Community Health Plans. The department encouraged health departments that had not yet submitted their plans to coordinate with their local hospital and other stakeholders to try to get as much of an integrated set of reports as possible. We're looking forward to seeing that data. I think that fact is the next.... Probably between now and the end of the calendar year there are going to be a big analytic period for the committee.... For the staff of the department and also for the community to see what their reports are, how progress is going and what they are doing for the coming year. There's been some nice data put out. Nice fact sheet put out to be more publicly available to the public. Liza mentioned that the website, which is terrific and really offers a lot of information the public. A lot of effort to get the knowledge and understanding of the Prevention Agenda out more broadly around the state. I think that one of the highlights of that presentation was that we had a meeting of the Ad Hoc Committee to advise the Prevention Agenda on May 6th. There was a miraculous production of the minutes of that meeting for this meeting, which is twenty-six pages long

and provided to the committee. We very much appreciate it. Just to talk just briefly a summary. This Ad Hoc Committee is an instrument of the council that was created originally as a public advisory board for the department's voluntary accreditation process. It is a part of it the core of course are the members of the Public Health Committee of this council, but also it is an instrument of the council and involves state-level nonprofits, advocacy groups, professional associations. In this round because of the focus on social determinants of health, the set of state agencies that have been invited to participate actively in that group. As I said, the meeting was... It was a very interactive meeting. We had thirteen state agencies represented on May 6th. We had over thirty statewide organizations represented. We were meeting in this room. We had tables in the back. We had two rounds of cycles of people really providing input. Couple of real highlights. We had our really first engagement by the state education department. We had a senior person in the department sent over and a regent was there together. It was really terrific to hear about their plans for healthy schools and others and how they might integrate with the Prevention Agenda. Similarly, some of our long-time core partners, Mental Health, OASAS, Aging were present as well as Ag and Markets and a number of others. It was very exciting. I think they're very dynamic and the minutes are very long. We had good facilitation thanks to the Office of Local Public Health and staff within the department. We've been deciding that probably some young students or our colleagues that are more into AI or Claude or whatever could distill some of these twenty-six pages into some key themes. Some of the work was done. The cross-cutting themes were identified, but some of the other activity. The meeting for that group will be September 3rd. It will be here in Albany and in the meantime Dr. Whalen and others will be looking to reach out to individual agencies that were part of it specifically to really talk about how they can add value and working on the five critical domains that were key parts of the newer version of the Prevention Agenda which are addressing poverty, unemployment, well actually let's see, housing, economic development, education, food, and one of the others. I can't find it on the page. Social and community contact, which is really isolation, loneliness, social engagement. These are the first time that CDC has issued, has included social determinants in the Healthy People 2030 report because there is now a good evidence base of the importance of, shall we say, health supporting agencies like transportation, housing, and others in creating community conditions for health. Each of these other areas, obviously there are other agencies that have the kind of leverage the department has leverage on access to care, but not necessarily on the others. These inter-agency partnerships are going to be really important. We're looking forward to seeing those emerge. The second topic was community benefit reporting. This is something that the Public Health Committee had wanted to follow, mainly one particular category of community benefit reporting, which is the category of Community Health Improvement which is a very small area of the overall community benefit which does include, these are the items that each, every voluntary hospital has to submit to the Internal Revenue Service called Schedule H, which is the things that we were talking about earlier when we heard the presentation around unreimbursed care, GME research, a lot of other areas that are much bigger parts of community benefit, but we've been quite interested in this community building, community health improvement category really is an opportunity because the guidance from IRS for reporting in that category is very aligned with what we're trying to accomplish at community level in the Prevention Agenda. Since hospitals are key anchor partners along with local health departments for local work to implement the Prevention Agenda... The idea of having evidence-based interventions for prevention that would align in that area is part of our goal, and I want to thank Dr. Fish for his group's engagement and active with this. The status of this is that all private hospitals, I think it was a message from the Governor's Office to the Commissioner advising the Commissioner a year ago to really request that the community benefit reporting be looked at by the department more

carefully, potentially language added or changed in that reporting process. For this round the decision was that all of the private nonprofit hospitals that do report to the IRS will use a form that's been created by the department to report their Schedule H by the 1st of July. Public hospitals are not obligated to report to IRS clearly because they're public hospitals. The department has also carried out a survey of them to really find out in more granular detail what they are doing in some of these areas of community benefit, one of which we would be interested in is the community health improvement and community building area. They have also a deadline of July 1st. Again, analytic weeks are coming up. Our hope would be to really be able to take a more detailed look at the one category that we've been quite interested in. To see very specifically, we know hospitals are doing a lot in the community benefit area. We want to try to align it with more of an evidence-based intervention which have come up. One example would be screening programs with no follow-up. Screening programs, everybody used to... You know, it used to be a really good way of addressing community need and community assessment before we really found out that without follow-ups it doesn't make a lasting impression. That's just a simple example of an evidence-based intervention that we would hope could be modified in many cases. It's already being done. There are a number of those we want to check. We're also going to be looking at that over the next meetings of the Public Health Committee. I think in the next cycle perhaps, or maybe second cycle, we're waiting to see as we might be able to put more specific language into that community health improvement reporting request for the hospitals so that we can really begin to align that work with that of local health departments and other stakeholders, importantly at the local level. That's also another piece of work. Every year, the Public Health Committee on your behalf picks a topic area that we want to work on, and this passed. We picked the area of public health workforce. There's been a lot of development of staff, hiring, and activities in the department there. We've heard a good bit about that in previous reports. We're trying to home in now in those discussions on maybe two or three priority areas in which the Public Health Committee could work with Health Department staff to make some of the issues more visible to the public through our sort of bully pulpit, if you will, opportunities for convening and connecting across the department and also making some of these issues more part of the public conversation. We did hear from the department, from the Workforce and Infrastructure Group on what they have been doing going forward to really explore some of the areas that we had identified as potential areas of interest. We also heard a report from NYSACHO, local health department workforce enumeration study which was an update. It's an annual enumeration to really identify some of the quite significant shortages in public health workforce issues across the state. I think we all agree that one of the major problems is funding of public health workforce, which has not really been a priority area. It's our job to figure out how to get that higher profile need and understanding with the public and potentially with elected officials. That's one of areas we're going to look at. One of the other interesting, I'll just mention it because of the earlier presentation. One of the major areas of shortage is public health nursing. Dr. Lopez leaped up. We're going to put him on the spot dealing with helping to look at. He's talking about many of the deans of nursing. There's a deans of nursing group in the state to really try to bring the issue of public health nursing work to the fore with them and perhaps let us know about that next time. Similarly, I think one of the areas that we've been interested in and the department's interest in is strengthening the academic partnerships between the department, especially on the workforce issue, between the department and schools of public health. We've discussed as an example, potentially trying to promote a network of Deans of Schools of Public Health throughout the state that could really work in a more organized fashion with the state to look at pipeline issues, to learn what they're doing and look at how to take advantage of aligning those goals. We hope to have for the next meeting, which is going to

be on September 16th some candidates for the collaborative project that we'll go forward with in the coming year. I'll stop there. Thank you.

Mr. Kraut Thank you.

Mr. Kraut That's been a busy committee, both committees, and it's really encouraging to see the inter-agency cooperation and dialog. That's something, it's hard to do, and much credit to you and the department for getting that done.

Mr. Kraut Other questions for Dr. Boufford? Anything she spoke about?

Mr. Kraut Yes, Dr. Rugge.

Dr. Rugge I don't have a question, but I have some public health concerns that are not really inside the committee If that's okay. I've made some scribbles. I apologize if I can't read them right or they're mistaken. My idea is to suggest our making a resolution which is outside the usual scope and boundaries of this council. I have not had the opportunity given this busy morning to confer with our chair, Mr. Kraut, so let me give this a try and that is going back to this morning's discussion about social care networks and their importance. We appreciate the broad scope of the social care networks effectively providing and encouraging the use of healthcare services and so would suggest that we resolve at a time when in certain ways people are dealing with shortfalls in meeting financial and basic human needs. This council is giving its attention. I'm sorry. This council which is comprised of healthcare providers and leaders across the entire diversity of healthcare delivery Is expressing by unanimous vote its appreciation of the dedicated support of social care networks and understands the importance and the need for continuation of those services. Ordinarily, we would not require any such a resolution, I think, but at a time when our fundamentals and our dedication to underserved people, underserved by virtue of their economy. I think adding our collective voice to that at least feels like a good thing for us to do and maybe, just maybe, could be helpful in demonstrating how broad the support of these needs are within the state of New York.

Mr. Kraut first of all, I think that that's wonderful. I think there is a time when we could come back and do that. If you looked at the timeline for the renewal of the grant, I think that it might be a good time when they're doing the public comments for us to maybe just clean up the resolution a little and in the Public Health Committee. Because that would be something that we would encourage the department and team that's resubmitting the grant to have a resolution for us. I'm sure he might find that useful, or it's not harmful.

Dr. Boufford Yeah, I appreciate John's statement. I just want to add to it. I didn't mention this, but I think one thing that's really, really important I think is for us and it's a constant dialog we have is to make the distinction between personal health and social services to individuals and changing conditions in communities that make them sick in the first place. I think the nutrition area is a really important one. There's a lot of work on medicine...You know, food as medicine and prescribing for individuals. Again, dealing with the availability of fresh fruits and vegetables at an affordable price in communities... That's kind of where we are living. As I was listening to what Amir is saying and John's point, I would love to maybe put our heads together and come up with, I'm thinking, we were talking yesterday about the issue, why couldn't community, everybody's very enthusiastic and rightfully so to promote an increase in community health workers. What are they being trained to do? Could they also be trained to do environmental assessments of homes? Could they be also trained to look at risk factors in housing or in communities in addition to navigating

responsibilities or assuring that people take their meds or make their appointments? A number of the areas he mentioned the public health nursing is another area. The workforce work is largely focused understandably on clinical, what I would call clinical, meaning individual health and social services, which we all know are in great shortage and underfunded, but I'd love to look at some creative ways of getting public health or population-focused content into the renewal. I think it would be advantageous for the renewal as well, as addressing our support for Dr. Rugge's suggestion, so maybe we could come back with some combined recommendations to them for the renewal.

Dr. Berliner I think another aspect that could be considered, be careful how to express it is mobilizing the social care networks to assist people in understanding what they need to do by way of re-enrolling under new terms with new expectations.

Mr. Kraut Well, okay, as long as we understand the state has to navigate through the federal policy structure that they have to operate under, I think those are great things to have that discussion.

Dr. Berliner Very careful not to be alienating the federal staff that is necessary to support all this.

Mr. Kraut We need that federal match.

Mr. Kraut We'll bring that back through the committee. I just have to, before I go to Mr. Holt, I made an error in asking for a motion. What you ended up adopting was the minutes of the Establishment and Project Review Committee.

Mr. Kraut I would like a motion to approve the May 7th, 2026, PHHPC meeting minutes.

Mr. Kraut I have a motion, Mr. Robinson.

Mr. Kraut I have second, Dr. Boufford.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Kraut Those minutes are adopted.

Mr. Kraut I'll now turn to Mr. Holt, who will give us a report on Codes, Regulation and Legislation.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt Good afternoon. This morning, the Committee on Codes, Legislation, and Regulations heard four codes, two for adoption and two for information only. First one being certificates of qualification for clinical laboratory directors. Staff from the department presented the certificates of qualifications from clinical laboratory director's proposed

regulation to the committee on code for adoption. They were available to the council should there be any additional questions at this point. I am so moved.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second, Dr. Watkins.

Mr. Kraut All those favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Holt Thank you.

Mr. Holt Second was ionizing radiation. Staff from the department presented the ionizing radiation proposed regulations to the committee on codes for adoption. They're available for the council should there be any questions. I am so moved.

Mr. Kraut I have a motion.

Mr. Kraut I have second, Dr. Watkins.

Mr. Kraut Is there any questions from the council?

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 two items that were on for information only, those being communicable disease reporting, definitions and specimen collection. Lastly, the nurse aid training program. These will come back to the council at a future date. That concludes the meeting on Codes, Legislation and Regulations.

Mr. Kraut Thank you very much, Mr. Holt, members of the committee and the department who gave an excellent presentation this morning.

Mr. Kraut Mr. Robinson, I'm going to turn the meeting over to you to give the report on the activities Establishment and Project Review.

Mr. Robinson Thank you, Mr. Kraut.

Mr. Robinson Just an introductory comment. A few of the applications that we reviewed at committee meeting involved a request by the committee that the applicant provide

supplemental information to the department. That supplemental information was received, and I believe in the satisfaction of the department. In going through these applications in the minutes, certainly you can ask questions if you like, but I believe that most of you have seen those communications and can confirm for yourselves that that information was provided. As Mr. Kraut said, we will batch where we can, but a relatively short agenda at this time. First, an application with a recusal by Dr. Yang and an interest by Mr. Kraut. This is Application 252166C, Hillside Polymedic Diagnostic and Treatment Center, excuse me, in Queens County. It is to convert a multi-specialty ambulatory surgery center, certify CT scan MRI and medical services, including other medical specialties, and construct a six-story replacement building. Both the department and the committee recommend approval with conditions and contingencies, with an expiration of the operating certificate five years from the date of issuance. I am so moved by that application.

Mr. Kraut I have a motion.

Mr. Kraut Dr. Yang has left the room.

Mr. Kraut May I have second?

Mr. Kraut Dr. Berliner.

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 Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson We are batching now, beginning with Application 261138E, Saratoga Schenectady Endoscopy Center, LLC in Saratoga County. This is to transfer 6.667 ownership interest from the fourteen current members to one new member. Department and committee recommend approval with a condition. Application 252183B, Saint Mary Center Inc in New York County. Establish and construct a new diagnostic and treatment center at 73 Lennox Avenue in New York. This is a statewide health care facility transformation program grant. The department and the committee recommend approval of conditions and contingencies. Application 252210E, Amsterdam SNF LLC doing business at Wilkinson Rehabilitation Nursing Center. This is in Montgomery County to establish Amsterdam SNF LLC as the new operator of Wilkinsons Residential and Nursing Center, which is a 160-bed residential healthcare facility. The department and the committee recommend approval of conditions and contingencies. I moved that batch.

Mr. Kraut I have a motion.

Mr. Kraut May I have second, Dr. Torres.

Mr. Kraut Anybody has a question about any application, I'll move it out of the batch. If there are one, let me know.

Mr. Kraut Hearing none, I'll move it.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstention?

Mr. Kraut The motion carries.

Mr. Robinson Now, batching the applications for licensed home care agencies. Application 222245E, Family Respite Home Care Agency, Inc., which is transferring 90.1 percent ownership interest from one withdrawing shareholder to the remaining shareholder. Department and committee recommend approval with a condition. Application 231025E, Family Home Care Agency, Inc to establish Family Homecare Agency, Inc as the new operator of a licensed home care services agency currently operated by One Stop Home Care Agency at 108-1072nd Avenue in Forest Hills, Queens. Department and committee recommend approval with a condition. Application 242060E, High Standard Home Care, Inc transferring 100% shareholder interest from two withdrawing shareholders to two new shareholders. Department and committee recommend approval with a condition. I moved that batch.

Mr. Kraut I have a motion.

Mr. Kraut May I have the second, Dr. Torres. Thank you.

Mr. Kraut Any questions on any one of these applications?

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

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut Motion carries. Thank you.

Mr. Robinson I have a certificate next to Cayuga Ridge LLC. Cayuga ridge LLC is seeking PHHPC approval to file a certificate of assumed name to use the name Ithaca Nursing and Rehabilitation. The applicant indicated that he is seeking to use this name to reflect their services and location more directly. Department and committee recommend approval. I'm so moved.

Mr. Kraut I have a motion from Mr. Robinson.

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

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries

Mr. Robinson Next, an application for an ambulatory surgery center. 261080B, Hawkins ASCLLC doing business as Vanguard Specialty Surgery Center. This is located in Suffolk County, noting interest by Dr. Eisenstein, to establish and construct the multi-specialty ambulatory surgery center at 640 Hawkins Avenue in Ronkonkoma. That's how you pronounce it, by the way.

Mr. Kraut That's correct.

Mr. Robinson The department and the committee recommend approval with conditions and contingencies with an expiration of the operating certificate five years from the date of issuance. I am so moved by that application.

Mr. Kraut I have a motion for Mr. Robinson.

Mr. Kraut May I have a second, Dr. Berliner. Thank you.

Mr. Kraut Any questions on this application?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut Motion carries.

Mr. Robinson Finally, application 242277B, Hype Plus Care in New York County. Noting an interest by Dr. Kalkut, establish and construct a new diagnostic and treatment center to be constructed at 111 West 24th Street in New York. The department and the committee recommend approval with conditions and contingencies with an expiration of the operating certificate two years from the date of issuance. I will note here that we are asking that in that two-year period that that renewal come back to the committee and the full council for consideration. With that, I make that motion.

Mr. Kraut We have a motion, Mr. Robinson.

Mr. Kraut A second, Dr. Torres.

Mr. Kraut In this application, you may recall, well, for those of you who were present at the last meeting, there were questions that were raised of the applicant. They wrote us a forty-seven-page document that addressed, I think, many of the issues that were raised. As you heard, there's going to be a two-year contingency placed on this, and essentially the questions that came up dealt with how they were going to overview quality and utilization issues. Ms. Glock gave us a kind of memo of a summary of that where the department found those requirements acceptable. They were shared with the individuals. There were people who indicated that without that information they would be unable to vote. We had a number of abstentions at the last time. Hopefully, those documents and the department's review satisfy those people who ask for additional information.

Mr. Kraut With that, I'll open it up to questions. If there's any questions or concerns that have been raised.

Mr. Kraut Dr. Kalkut.

Dr. Kalkut Thank you.

Dr. Kalkut Gary Kalkut, member of the council. I'm an infectious disease physician and was concerned about the use of intravascular catheters for infusions. The original staff report says they're expecting the first year to have infusions of 4,985 or close to 5,000 infusions, so I thought the material that Ms. Glock and the applicant put together was quite good. I wanted to add some measures on intravascular catheters, which I have a lot of experience with, excuse me, and complications occur and thought that some of the measures should be met should include about catheter complications.

Mr. Kraut What would those be?

Dr. Kalkut I don't have them in front of me, Ms. Glock has them, but it would be about infection, occlusion, and malfunction in some way that can cause problems for a patient, including DVTs and pulmonary emboli.

Mr. Kraut Those would be measures of safety and harm.

Dr. Kalkut Right, and then there was a couple of questions that we posed about the infusions themselves, what they're treating and what therapeutic was in the infusion.

Mr. Kraut Ms. Glock, are those three or four criteria, how would we include that in the approval? Would it be just directing the department?

Ms. Glock Thank you.

Ms. Glock Shelly Glock from the department. We do have additional reporting requirements around the adverse events, including intravascular catheters. We also have information about the patients served annually and what services and the utilization of those patients. We will add an additional requirement asking the applicant to provide the total number of patients who receive infusion therapy by month, the number of infusion treatments that therapeutic agents infuse the duration of those treatments per patient and what disease or condition is being treated. I believe the rest of the additional we will add

explicit language. They will be incorporated into the report that was distributed to the members that the applicant will be required by the conditions placed on the application to report back to the department and PHHPC annually after both year one and year two. Of course, the limited life of two years is placed with the application having to come back to PHHPC with that information.

Mr. Kraut Hopefully, that will address the other individuals who had an issue.

Mr. Kraut Yes, Dr. Berliner.

Dr. Berliner So, most of the measures that were proposed seem reasonable. Certainly, I can't talk about clinical measures. I trust Dr. Kalkut at that. But things like, you, know, number of visits requiring EMTs or the emergency room, I don't know what we get from that number because we have nothing to compare it to. Is there a good number? Is six a bad number? I don't know.

Mr. Kraut I hate to say it. I'll use... I think it was Justice Douglas.

All (Laughing)

Mr. Kraut I'll use the pornography definition. You know it when you see it. Unfortunately, there's some numbers. You're right. There isn't a good baseline. You don't know if it's an aberration or it's a causation.

Dr. Berliner This leads to the larger issue, which is there are already around, certainly around New York City, I can't speak for the rest of the state but just walking around I've seen one on 6th Avenue in the West Village, I've seen one on 8th Avenue and Chelsea. I assume there are lots more. These are not set up as DNTCs. These are private practices, I believe. The real issue for me is not it's not worth getting into the validity of what they're doing, that's beyond our scope. But the real question is... What's the public value in providing both a professional fee and a facility fee when we have no idea, when it seems like all these other places are making it work without that? My fear is just that, at the end of two years... If that's what we said as a limit, we've now created the precedent.

Mr. Kraut I can't agree with you more, and it's exactly the issue Mr. Robinson and others have raised over the years where we've seen a doctor office converting to a diagnostic and treatment center that entitles them to get a larger fee than they would have from a commercial insurer that includes a facility and other costs, recognizing that some added expense of being DNTC, but questioning the value of doing that. I'll go back to my statement, where one third of New Yorkers are covered under the Medicaid program in one form or another. I think this is a major issue. Unfortunately, we've opened those floodgates for ambulatory surgery centers. We've opened them for diagnostic and treatment centers, conversion, and yet now we're presented with this. One of the other things, and this is separate from this application. This application came to us. We've developed a way. We've essentially created a de facto two-year demonstration program. Let's just call it what it is. I do not think if the department receives other applications for this, we are unlikely for the reasons, until we get some data on it, unlikely to consider it. The bigger issue, if we see a floodgate of these applications coming forward, I will bring this over to the Planning Committee and I would ask them to look at it in a more, I don't want it to do it as part of a vote, but in a measured way to see what the implications are of converting these type of facilities. This facility may be different than somebody who goes

on an alcoholic binge and gets an infusion in the morning. I see those in California when I travel.

All (Laughing)

Mr. Kraut I have not used one but came close.

All (Laughing)

Mr. Kraut I would say, Dr. Berliner, your concerns are well founded. I'm just making the statement to the public that we are not... This does not create a precedent. If we are looking at least for the next two years to get some data back and to see what the impact and the positive impact and hopefully there'll be maybe some published data that'll come out of this in peer review journals that would be helpful in informing this across the country, not only here. If we do see a floodgate of this, if we see a lot of these, they're going to go, I will ask the department not to move them to us without coming back and discussing it. I think the appropriate venue is the planning as we've done for other kinds of new approaches, if that's acceptable to anybody. Even if it's not acceptable, that's what I want to do.

All (Laughing)

Mr. Kraut Yes, Dr. Eisenstein.

Dr. Eisenstein Thank you, Jeff.

Dr. Eisenstein You addressed the oversight as part of this, but part of the discussion was the use of evidence-based medicine and a standard of care. My concern working in the field was more about that than oversight. We have a process. It is what you just described. The Planning Committee, when we endeavor new practices. This practice is open and operating now, so whatever the vote is doesn't stop them from functioning today, and everybody should understand that. The point is that there are literally thousands of practices like this in New York State, they all do slightly different things. As of now, none of them are diagnostic and treatment centers. We are the body that approves all the diagnostic and treatment centers. If I were any other one and saw this pass, I don't know how my first move is not to submit Article 28. My point is if we have a process, we have plans and council which includes, we did it last year with the PCI and ambulatory centers, we had expert testimony from all segments to guide us. I think that would be the prudent way to go.

Mr. Kraut I don't disagree, but here we are with the application, and I make the other point that most of these centers that are operating as a physician office may not make themselves accessible to Medicaid patients. There are elements of what they've proposed that I think has some basis for helping patients. I'm not going to say it's an experiment. It's a demonstration that provides... Let's see what happens with the access. I'm going to call a vote on the application then we could talk about the issues because I don't want to mingle, co-mingle the issues with the applicant, right? Because we're getting into a broader discussion beyond the scope, to be fair to the applicant to be on the scope of what the application's asking us to do.

Mr. Kraut Dr. Friedrich, if it's about the application, yes, go ahead.

Dr. Friedrich Thank you.

Dr. Friedrich I have a question for the applicants.

Mr. Kraut I'm trying to avoid that because of the precedent, but if it's critical to your understanding.

Dr. Friedrich Marcus Friedrich, member of the council and a practicing primary care physician in this community. When you think about complementary medicine, and this is what I feel this application is really about, and the scientific process, thinking about bringing the field and the field of this medicine forward and thinking about the scientific processes behind it. I'm seeing like a lack of really thinking about that because most major academic medical centers in the city are providing these services already. I feel that, again, going back to what was said and a hundred percent agree with that and also my colleague, Dr. Eisenstein, that this is really pushing the limit into an area where I'm, as a physician, not very comfortable right now at this point where we are in healthcare in this country because I feel and I fear also for the reimbursement and that part of this application is just the increase in reimbursement for this.

Mr. Kraut I'm going to call the question, but for all the concerns that have been expressed, that's why we made it a two-year limited life, where we will get information, hopefully answering the questions, and hopefully the applicant adequately answered the questions we posed last time, and then the inclusion of the new criteria that gives us additional measures about patient, of concerns to clinicians on the council. I hope that I can call the question now and then we can come back to this.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Anyone opposed?

Mr. Kraut How many opposed?

Mr. Kraut Four.

Mr. Kraut Any abstentions?

Mr. Kraut One abstention.

Mr. Kraut The motion passes. Thank you.

Mr. Kraut Going back to this...we'll hear back in two years. Two years after they get rolling. Well, we're going to hear back annually. Please let's make sure Colleen, Shelley, that we do get that information in the... I would call it our Summer meeting, or the Summer meeting of the council. We should get a report back, and hopefully the applicant who's present here hears that. Start writing in May, okay? Okay, fair enough.

Mr. Kraut Yes, go ahead.

Mr. Robinson We're now more on the general topic of this kind of Article 28 DNTC and not specific to this applicant. I do think that we as a council and the department, led by the

department frankly, really need to take a pause and look at what we are doing and what we intend to through the lens of both making sure that there is uniform access to very needed services, but at the same time balancing that against the risks of reestablishing essentially the Medicaid mills of the 70's and 80's, which is the counterpoint to what we're kind of dealing with here. I think we really need to pay attention to that. My recommendation to you, Jeff, and to the department is that we move now to Planning Committee and to a thorough look on this topic rather than waiting for the outcome because I do think there's enough data out there that we can be well informed and start to think in a comprehensive way about how we want to approach these applications.

Dr. Boufford Just to add, I think it was mentioned earlier, many of the mainstream academic health centers provide many of these services and have been for a while. Similarly, there is an NIH institute focused on complementary medicine. I think that there's work for the Planning Committee to get started on looking at what's going on in other venues where this has been happening and also some of the evidence bases around certain interventions or lack of evidence around others and then moving ahead. The other thing I'd say, you know, is for doing global health. There's a lot of data from other countries where we don't approve things. We want to take a look at some of the work in other countries where good data on quality improvement and quality assurances is available. There's lot of work to do to get started on Planning Committee right away.

Mr. Robinson Mr. Kraut, that concludes the report of the Establishment and Project Review.

Mr. Kraut Thank you.

Mr. Kraut Dr. Rugge, before we started the meeting, he said, you know, Jeff, my committee's bored.

All (Laughing)

Mr. Kraut Thank you.

Mr. Kraut Thank you, members of the committee, members of the council for coming. Welcome our new members. Our next regularly scheduled committee day is on August 27th. The Public Health Committee is going to be held on September 16th. The full council will convene on September 16th. Unfortunately, our space is not available yet. It will have to be held in Albany, I am told. That is the last time we're meeting in Albany for this year. We are going to then be in New York City afterwards, one way or the other. The Ad Hoc is on September 3rd. I just want to wish everyone in our country a happy 250th birthday. I'd like to also point out I don't know what's being planned. 2026 was the hundred and twenty fifth anniversary of the founding of the Department of Health. We started as the New York State Board of Health in 1880. Twenty-one years later in 1901, they established the Department of Health. Twelve years after that in 1913, they were the forerunner of this council, which is the Public Health Council in 1913. We're only a hundred and thirteen years old.

All (Laughing)

Mr. Kraut With that, may I have a motion to adjourn the Public Health and Health Planning Committee?

Mr. Kraut Dr. Yang.

Mr. Kraut Second, Dr. Torres.

Mr. Kraut We are adjourned. Thank you.

Mr. Kraut We thank members of the public