

NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
FULL COUNCIL MEETING
SEPTEMBER 17, 2026, 10:15 AM
ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY
TRANSCRIPT

Mr. Kraut Good morning. I'm Jeff Kraut. I'm calling to order the September 17th meeting of the Public Health and Health Planning Council. I'd like to welcome members, Commissioner McDonald, department staff, participants, and observers. As Mr. Holt had indicated, this is a public meeting via webcast. There's a form that we ask you to fill out. You can get that form on the department's website, or you can write directly to Ms. Colleen Leonard, the Executive Secretary of the council for filing your attendance here. In addition, as part of the Open Meeting Law, we're broadcast over the internet. We use synchronized captioning. It's important that we don't speak over each other. The first time you speak, please state your name, identify yourself as a council member or staff person. This will be helpful to us. It turns out I can't say this enough, although we say it at every meeting, after every meeting we get a note or an email or a comment saying, I didn't know that was going to be on the agenda. Well, if you'd like to be aware of what's on the agenda, please join the Department Certificate of Need Listserv. The PHHPC Unit regularly sends out important council information, our notices, our agendas, our meeting dates, policy matters. There's printed instructions at the reference table on how to join the Listserv or again you may contact Ms. Leonard who will provide you assistance in joining. I'm going to announce as I did at the previous meeting, we have three new members that have joined the council, Jon Van Valkenburg, Dr. Christina Gerdes and Kathryn Haslanger. We're now going to appoint them to committees. You heard Mr. Holt, appoint Dr. Gerdes and Jon Van Valkenburg to the Codes, Regulations and Legislation Committee. Jon was also appointed to the Establishment and Project Review Committee. Kathryn is going to be serving on the Public Health Committee. Kathryn and Dr. Gerdes will be serving on the Health Planning Committee. Dr. Gerdes has taken on, volunteered I might add for the Committee on Health Personnel and Interpersonal Relations. We really thank you very much. We all look forward to working with you as well. I may have to change the order of the schedule today to accommodate staff people as part of the comments.

Mr. Kraut We're going to start off by welcoming Dr. McDonald who will give the report of the commissioner. Ms. Donald will also give the report of the Office of Public Health. Ms. Sheltry will report on the material transaction program, which I think you'll find interesting as point of information. Dr. Boufford will provide us an update on the activities at Ad Hoc committee to support the prevention agenda. That will be followed by Mr. La Rue and Mr. Holt who will present the nursing home Certificate of Need Ad Hoc community final recommendations for the endorsement of the council. Mr. Holt will present the regulations for council action and then Mr. Robinson will present a report of the Project Review and Establishment committee. Just to remind you with respect to that last item with the certificate of need, we're batching the applications for discussion and approval. If you please take a look at the batch that we have proposed, if there's any issues and you want to remove or change a project that's in a batch, please let us know.

Mr. Kraut I'd like to begin by having a motion to adopt the June 24th, 2026 Public Health and Health Planning Committee minutes.

Mr. Kraut May I have a motion?

Mr. Kraut Thank you, Mr. Torres.

Mr. Kraut May I a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Any comments on those things?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Kraut It's now my pleasure to turn it over to Dr. McDonald who'll update the council about the department's activities.

Dr. McDonald Thank you, Jeff.

Dr. McDonald It's good to be with everybody this morning. I want to first acknowledge our new Deputy Commissioner of the Office of Public Health, Cheryl Donald. You'll hear from Cheryl a little bit later this morning. I want to just make sure you know, really thrilled Cheryl came to join us from Health and Human Services. Cheryl was with Health and Human Services for twenty-five years, knows public health well and knows the interface, I think, quite well of how state government and federal government interact as well, and really knows New York pretty well. We've been on a few events together. I've been introducing Cheryl to whoever I'm meeting. I've be surprised to see Cheryl already hugging the person because it's been a bit of a reunion. I think that's just really wonderful to have Cheryl at the New York State Department of Health. I want to thank Laura, who did just an amazing job as acting deputy for so long, and I really appreciate all the work Laura did. Of course, it's great to see Dr. Whalen from the Office of Public Health here as well today. We really do have a really good team in the Office of Public Health. I'm very thankful for the hard work they do for us all the time. One of the things about public health is... You know when public health works well, it's often unnoticed. I think the Great New York State Fair is a bit of an example of that. I just want to talk a little bit about the Great York State Fair. You know, they had almost a million visitors this year. I think on the peak day there was 114,000 visitors. Just for the type of trivia that some people appreciate, on days like that when there's 114,000 visitors, the great New York State Fair becomes the fifth largest city in New York State. What's interesting is that isn't an accident that everyone can go to the fair and safely enjoy. There's a lot that our team at the State Health Department does, many from the central regional office that Maria McPherson leads to make the state fair just a wonderful event. We do a lot in environmental health. There are over 300 food vendors. There were 50 new vendors this year. We did over 550 risk-based food inspections. You know, if you'll notice, everyone goes to state fairs, enjoys the food. I didn't say it was healthy food, but you go enjoy the food, and you have a great time at the fair. I love the fair for a lot of reasons. And by the way, if haven't been to the fair, you know, I just think it's one of those things that's really enjoyable. The maple ice cream is really one of the things that is unique to New York State that I just think is amazing. We have really good maple in

New York. The maple syrup is something my wife asked me to get for her every year and I bring it back. It's just wonderful. You can find healthy food at the great New York State fair. It just takes a little bit of digging. I think it really was a great fair. I want to say there's some other things that our team does as well. You know, Brian leads our Bureau for Communicable Disease Control. You know it's in the Division of Epidemiology that Dr. Emily Lutter leads, but you know it was great to see Dr. Jennifer White there talking about tick-borne illnesses. Our team passed out over 5,000 tick removal kits. Some handouts about why you should do this and how to do it effectively and how to do it correctly. Passing out 5,000 tick removal kits is great. We have all this information there. They really do interact with the public a lot, talking about insect repellent, which is really another good public health intervention. I thought that was great as well. Of course, our Office of Drug User Health was there as well, as well as our partners, passing out naloxone kits. It was interesting just talking to our team as they passed out naloxone kits. Now last year, they passed over 4,400 naloxone kits, that was a record for us. You know, when I was there this year, we had already exceeded that by quite a bit. We gave out over 7,500 naloxone kits this year which was interesting to me. One of the things the team said to me which I thought really quite compelling was that there were a lot of people who just came to restock at the fair. They're coming back to the fair not just for the fair, but to refill the naloxone. One thing that surprised me about this was over fifty people had come to them and said they had used the naloxone and saved someone's life from that. You know, I think that's just fascinating to me. It's the state fair. It's turning out to be an important public health intervention. Saving fifty lives by having people at a kiosk educating people about naloxone that's a pretty powerful public health intervention. I think what's important about that is not just passing out the over 7,500 kits of naloxone, but just the way we educate about naloxone. In other words, they're not just here's your kit. We explain how to use it. We go through what to do, how to understand that. I think it's really we're seeing a real shift in people embracing how to actually help people overcome an overdose. I think this is just an example of all the great work that the Office of Drug User Health does in that regard as well. I'm very thankful for the team as well.

Dr. McDonald I want to acknowledge some of the work Karen and her team are doing with the Rural Health Transformation Program. I see Dr. Fish here as well. Karen is our principal investigator. I think many of you know, on September 4th, Governor Hochul announced our 76 plus million-dollar investment in the community health integration, which is one of the four initiatives we're doing in the \$212 million cooperative agreement we have with the Rural Health Transformation Program. I don't want to put too fine a point in this, but the Rural Health Transformation Program is a cooperative agreement with us and the Center for Medicare, Medicaid Services. A cooperative agreement is a little bit different than a grant. With a grant, you generally get the money, and you go do what you're going to do and with your grant deliverables. What cooperative agreement is what it sounds like. It's an agreement. There's partnership. The CMS team works with us. They were just here last week very pleased with how our team is performing in this regard. It's wonderful to have this partnership with CMS, how they're helping. It's great to see the emphasis on rural health and how important it is. Community health integration is what it sounds like. It's really helping rural communities integrate. What's nice about the ninety different awards to these fifty-six different organizations is you're allowing customization. Recognizing all of rural New York is not a monolith. Rural New York is not simply small urban centers. Rural New York is rural New York. It is unique. It is different. There are unique needs. It allows customization for rural communities to really partner. Is your concern more of a mental health need? Is it more of a substance use need? Is it more of emergency medical services? Is it more of trying to help people integrate behavioral health with primary care? So, it is really a wonderful initiative. It was great to see some awards go out to some really

great programs. Hudson Health Headwaters, John knows well, had a really great proposal. They're doing wonderful work up there as well. Hudson Headwaters does wonderful work in rural New York as well, so I am excited to see that as well. The other three initiatives, strengthening workforce, building sustainable rural health workforce is really important. Also, advances in technology and strengthening primary care. We'll have more announcements as the year unfolds. We're very happy about that.

Dr. McDonald I want to pivot now just to highlight. You know respiratory season is coming upon us. It's just something I want to just speak to you about a little bit. Because between now and when I come see you again in November, it's likely somebody here in this room has had the flu or COVID or RSV. I'd just like to give you numbers on this. Like, if you think about last year, New York State had about 27,000 hospitalizations from the flu, a little over 13,000 from COVID, a little 14,000 related to RSV. When you think about mortality from that. We have just under 600 deaths from flu. Just a little bit under 500 from COVID. Just a little under 300 from RSV. You know, I've been a doctor for a long time right now, over thirty-six years. You know, the vaccines really have come a long way. When I started my career, there wasn't a COVID vaccine. There wasn't COVID. There wasn't an RSV vaccine. There was RSV. It's now great to see we have vaccines for flu, COVID and RSV. The RSV is a one and done vaccine. I got mine when it came out a couple years ago. I'm done with that. If you're in that age group where that's something you should avail yourself to, it's a really good idea. I think it's also important to put flu and COVID in perspective. In case you're curious, I'm getting my flu and COVID vaccine in about two weeks. Why in about two weeks? It's because when I get my vaccine, we tend to make a press event out of it. So, that's scheduled. It's easier for you. You can get your flu and Covid vaccine without scheduling a press event. I would just recommend you go ahead and do that. Go to your neighborhood pharmacy and avail yourself to that. I think it'd be great. I do want to remind people though, when we talk about mortality, it's also important to have a concept that it's not just adults who pass away from these diseases. We saw some pediatric mortality last year related to flu, COVID, RSV. With flu, we had fifteen pediatric deaths last year. I mean, it's important to remember that sometimes when little ones pass away, they're under six months old, so they can't get a flu vaccine, so those around them really it's really important not to bring flu into your home if you can. We did see four COVID deaths last year and seven RSV deaths among children for a total of twenty-six among the three. I think it's just important to note those are things that are really important. I think it's also important to call out there's a lot of things in New York State Department of Health does like Dr. Eli Rosenberg leads the Office of Science. We have a really good team in the Office of Science. One of the things they were able to do last year for me, you might have noticed the CDC has been a little bit different. Quite frankly, we weren't really getting the vaccine effectiveness information like we were accustomed to. I asked Dr. Rosenberg and his team to say, is there anything we can do understanding vaccine effectiveness? We have the All-Payer Claims Database at the New York State Department of Health. His team did evaluate the flu vaccine last year with our All-Payer Claims database. What they were able to show was that the overall, we saw a 42% effectiveness for the flu vaccines last year to keep children out of the hospital. 42% effectiveness at that. When it came to adults, the effectiveness was 27%. Keep in mind, that's the best protection we have for this. I think we just don't know what this year's effectiveness is going to be. You don't how effective a flu vaccine's going to be until the season is over. I think it's important to know we'll be looking at the vaccine effectiveness again this year as well. Regarding COVID vaccine effectiveness last year, the COVID vaccine was 40% effective against keeping people out of the hospital, 79% effective against mechanical ventilation among adults. Last year, the vaccine was rather effective at keeping children out of the Emergency Department, 76% effective. I thought that was quite impressive. While the RSV vaccine

was 70% effective at keeping little ones out of a hospital as well. I think it's important to understand that these vaccines are effective. We should avail ourselves to them. I want to just shift my conversation a little bit to another vaccine preventable disease, which is measles. I'm very thankful to the team for putting out a Measles Dashboard. We wanted to be transparent with the public and just let you know what's going on with measles in New York State. I think many people are following the Pennsylvania outbreak, which is over 700 cases. If you look at our dashboard later on today, you'll see we're now at sixty-six cases. A little out of one out of five of those cases are ending up in the hospital. Underscoring that. Although measles might have once been a common childhood infection, it's not a mild infection. You know, if you think about a little under one out of five people ending up in a hospital, that should give everybody pause. What's a little surprising about what we're seeing this year is the cases are not generally coming in from outside the state. Last year, we had forty-eight cases, but they're mostly cases that were just quite frankly coming from outside New York into New York. We've only had eight cases that were outside the state. We're seeing transmission in New York. It's mostly in rural communities. Right now, fifteen rural counties have measles, and they're in various stages of where it is here, but it's really turning into a very rural area. What's interesting to me, though, is, and I think a bit surprising as well, two out of the three cases we're seeing so far are in people 18 and older. Now, if you're older than 69 in this room, or just older than 69 outside this room, I should say, you're generally considered immune from measles because that's when measles was that common. But if you're an adult between 18 and 69, and you're unsure of your measles vaccine status, you can get a measles, mumps, or rubella vaccine from your doctor. I think that's important to do it. I do say measles, mumps or rubella vaccines. You know that vaccine's been around for fifty-five years. I know there's been some recent confusion from the federal government about the measles, mumps and rubella vaccine. I can't explain why the federal government is being as confusing as they are on vaccines. I think we should just accept that this is the way they are right now. I'm not confused about anything ever, quite frankly. I think it's important to know that there was no new research or no new science when they did their executive order. Nothing changed in New York State. States determined what are the required vaccines. Governor Hochul was really supportive, and the Legislature was as well. Now the authority in what becomes a required vaccine risks with the Commissioner of Health, me. There's no changes planned here. I think it's just important to understand that. At the New York State Department of Health, we're really just trying to prevent people from getting infectious diseases. We'd also like you to stay healthy. I talked to people in Pennsylvania quite a bit. Their outbreak is ten times or more larger than ours. It's sad that there's been four preventable deaths that really concerns me. I will say this. One of the things I'm seeing in New York is the local health departments are doing a really good job responding to this. We've seen our local health department give over 700 doses of the measles, measles bumps, rubella vaccines to people. This is in populations that traditionally haven't embraced healthcare or vaccines. So, that's a really interesting success. I think that speaks to the beautiful relationship local health departments have with their communities. They're doing a great job at that. Many times, the community is reaching out to the local health department, which I think is good. We've done a lot with educating providers. I think Dr. Lutterloh gave a great webinar about how to recognize measles. I've made public service announcement. We've several health advisories. We issued a Dear Administrator letter to hospitals yesterday just to remind people about isolation, but I do think this is one of those things where we're following the measles outbreak in New York State very closely just to mitigate the impact.

Dr. McDonald I do want to draw some attention to the work we're doing in New York State about overdose prevention. I think it's really important to acknowledge Governor Hochul made an announcement on Overdose Awareness Day last month, just acknowledging that

since 2022 there's been a 45% decrease in overdose deaths. That's not accidental. There's a lot of reasons why that's the case. Part of it is the over \$500 million investment that's come from Opioid Settlement Funds. We're really seeing a lot of progress in New York, increasing the number of people of treatment, number of people getting naloxone, prescribing's getting a whole lot better. A lot of community-based organizations do a lot of magical work in that space. You know, and really doing great things to make overdose, quite frankly, less rare. We're trying to achieve an overdose-free generation in New York State. A lot of this occurs through harm reduction and just quite frankly having fewer and less people exposed to these products. One of the things I want to call out is Dr. Holtgrave and his team, the emerging drug threats infection. When we see emerging threats regarding overdose... We see them before other people see them partly because we have a team in the Office of Drug User Health who does drug checking. Last July, they identified N-propionitrile bupropion. N-propionitrile bupropion was new to me. It's a type of drug which again was new to me. What I heard from some of the treatment providers where they really were thankful we told them about this because it helps them, in their words, see around the corner of what's coming. I think that's really helpful for people who are on the front lines of this. You know, N-propionitrile bupropion is rare. It was identified in rural New York. Nearest we can tell it came and then it didn't surface again. It's felt that it's likely more potent than fentanyl, but it's something we keep track of. This is just a great example of what the emerging threat team does is look for what is new and what is around the corner, so people know what is coming. So very thankful for the work they're doing with that.

Dr. McDonald Since we last met the Medical Aid and Dying Law has been implemented. If you're curious what we did to get ready for that; we promulgated regulations, we did webinars for not just health care providers, hospitals, nursing homes and more so people knew what the Medical and Dying Law was, more importantly what it was not. We've got a website available for the public with a frequently asked questions page as well. Trying to make sure everyone knew how they got all the questions answered. I thought that was really important as well. We will report at the end of the year as required from Legislature and report on whatever metrics we learn from that.

Dr. McDonald the last thing I want to cover just... You know, Governor Hochul's been a big proponent of the New York Swims Program. There's been over \$260 million invested in the New York Swims Program since it started with over seventy-six programs. One of the more recent programs I thought was really interesting. I was down in New Rochelle last week for the, quite frankly, how we're partnering with all the YMCAs across New York State. They have \$5 million just to teach more and more kids swimming lessons. Their goal this year is to teach 23,000 kids how to swim. I think that's really important. You know, swimming is one of those things where it's not just a life skill. It's not just a way to save your life. It's not just that. It's all of that, but it's also great exercise. I really appreciate the Governor doing what she can to make swimming available to all New Yorkers.

Dr. McDonald with that, let me stop and see what questions you have today.

Mr. Kraut Thank you very much, Commissioner, and I just want to point out Mr. Robinson and I got our flu vaccines yesterday because we were concerned that when we saw you, you were going to ask us.

All (Laughing)

Dr. McDonald That's awesome. Way to go. I have got to give you a bonus point. Both of you for that. Congratulations.

Mr. Kraut He actually got the COVID too.

Dr. McDonald I like him better. There you go.

All (Laughing)

Mr. Kraut I see you sucked up to him.

Mr. Kraut Other questions for the Commissioner?

Mr. Kraut Yes. Dr. Rugge, please.

Dr. Rugge I suspect that everybody in this room, including the Commissioner are concerned about the federal Medicaid cuts. I'm just wondering whether Dr. McDonald might have anything he can share with us that we should know.

Dr. McDonald Well, I'm happy to share with you that Amir Bassiri, who leads our Office of Health and Insurance Programs has been all over this. Amir does a lot of wonderful work with his team on this. We are ready for all the changes that are coming when it comes to work requirements starting January 1st. The team has done a lot of very intentional work so that we can be as possible as much as we can, verifying and validating as many people as we could who have one the fourteen exemptions, including chronic disease or medical fragility. That's really important work. We also have something we're integrating to the electronic interface we use so people can submit verification documents, whether it's work or whether it is community service or proof of education. We're doing what we can to follow the rules that Health and Human Services put together. I just want to put a little tidbit on that a little bit, because one of the things I think you hear sometimes is they have to work eighty hours a month. It's interesting. It's actually not eighty hours a month in New York State. Now, we aren't getting a discount on that. It's just that eighty hours a month is actually a \$580.00 a month income requirement. Because keep in mind, in much of the United States, minimum wage is \$7.25 an hour. I think that should concern people more than it does on a national level, by the way, but that's just important to know. If you were to say work in Upstate New York where minimum wage \$16.00 an hour, or in New York City where minimum wage is \$17.00 an hour. It's only \$580.00 you have to show that you made in a month. Now, if you're curious, if you make \$17.00 an hour. I'm going to do the math in my head really quickly. It's about thirty-four hours a month. Someone can check my math on that. I think it's 34.2. It's important to know that we're very concerned about the impact of H.R. 1, not just on the Medicaid population, but on October 1st with our population of people covered on the Affordable Care Act. It's really important to know Danielle and her team have done everything we could to keep as many people covered as possible under the Affordable Care Act Insurance products that we offer as well. Obviously, we know at the New York State Department of Health, health insurance is a social determinant of health. We're trying to track this very carefully.

Mr. Kraut Dr. Berliner, then Dr. Watkins.

Dr. Berliner I just want to say really cool shirt.

All (Laughing)

Dr. McDonald Thank you. I really appreciate having this cool shirt. The team got me this cool shirt. I actually sat with McLean this morning and said I think I'm going to wear it to PHHPC this morning because they would appreciate it. Thank you for noticing.

Mr. Kraut Could we order PHHPC shirts?

All (Laughing)

Dr. McDonald I can't speak to whether we can get shirts for you, but I will take it back to my Public Affairs Team and see what's possible.

Mr. Kraut I'm not optimistic. It took us years to get water.

All (Laughing)

Mr. Kraut Let's not push our luck.

Mr. Kraut Yes, Dr. Watkins.

Dr. Watkins Good morning, Commissioner. I just wanted to say cool shirt.

All (Laughing)

Dr. Watkins in addition, I want to echo your comments about your communicable disease team. They have worked very well with the health departments, and especially with the recent measles outbreak. That brings me to my question about measles itself. Because measles has been extinct back in 2000 or so, we're really concerned that hospitals are not capable of... Not capable, but hospitals just do not have the supply for IV immunoglobulin for pregnant women.

Dr. McDonald That's true.

Dr. Watkins I was contacted by a nurse practitioner who attempted to refer a pregnant woman to a local hospital for intravenous immunoglobulin. She was told that the hospital just did not have that supply at the time. Given the short window to administer IV immunoglobulin to pregnant women, I was wondering if the department would consider establishing a statewide preparedness requirement or a centralized procurement distribution system so that hospitals including rural and smaller hospitals either maintain an appropriate supply of IV immunoglobulin or have a reliable mechanism to actually obtain what we would consider a rapidly way to get that immunoglobulin to hospitals that do not have the supply.

Dr. McDonald Thanks, Dr. Watkins. That's a great question. And just so I put this in the room, why is that an important issue is because if you've been exposed to measles and you haven't had the measles bumps around the vaccine, then post-exposure prophylaxis with immunoglobulin could actually help you not get that. I think it's important. I think it is an interesting suggestion on your part. It's funny you say this. When I was meeting with local health departments in Central New York, they brought up the same issue with me a couple of weeks ago. I'm going to take it back and look at that. I think that's an interesting question. Immunoglobulin is important. One of the things that I heard was that there was a concern. What I did ask my team to do a couple weeks ago was reach out to hospitals to

make sure it was available. You're right. There does become issues with national shortages sometime. This might be something we should look at. Thanks for the suggestion. I'll take it back. It's a good idea.

Mr. Kraut Any other questions for the Commissioner?

Dr. Soffel Good morning, Commissioner. It's always a pleasure to see you. This is a question I have not asked you in quite a while. I am interested in how the department is doing in terms of staffing levels. I know that you have said not that long ago that we were back to our almost back to pre-COVID levels of staffing. I am concerned because pre-COVID, the department was very understaffed because of years of budget freezes and hiring freezes. I am curious...where are we now in terms of staffing levels? Are there particular areas where you are concerned about staff being overextended within the department?

Dr. McDonald Thank you, Dr. Soffel.

Dr. McDonald I'm glad you asked. I don't ever forget you asking me this here too. It's interesting. You remind me of when I took over in January of 2023, I had this really resilient team of 4,000 staff. It was just an amazing group of people who chose to stay with the department through what was really a very difficult time, the pandemic. We're now around 5,450, which we are considered fully staffed. I also want to make sure you know that as much as the federal government has tried to cut our research grants, my health research incorporated team, and my research team is fully staffed as well. Partly because of that is as much as they've tried to cut our grants, they haven't been successful. I have really good people on our research grant team. We're pretty well staffed with that as well. Here's what I'm looking for the future though. What I'm really seeing is trying to respond to what do I see the future looking like. I think with the impact of the climate having changed, I'm really looking at my environmental health team for next year. How can I plus up my environmental team? I'm looking at that for next here. That's one of those areas where I feel like I just need to be very thoughtful and deliberate about what is it for my needs for the future. One of the things I do want to call out is we did see some real increases in teams here. I saw my friend Val Dietz over there. Val, when I took over in 2023 had a very small staff, but the Governor gave us really quite a bit of resources. We were really able to plus up Val's team in 2024 and 2025. They've done a really good job at just doing all the work they do in regulatory space and nursing homes in particular. I just want to acknowledge, you know, when I first met the Governor, it really was not a question of staffing. She really like, well, you just tell us what you need. She's really been very responsive to that. I don't think most state health departments get a Governor that's as responsive as I do. Public safety is really important to the Governor. She cares very deeply about it. She recognizes the important role we play. I think it's something we've illustrated today. When you think about it we don't just inspect nursing homes and fight immediate jeopardies and hospitals are fighting immediate jeopardies. Those are the most serious things we find. We've been really successful in doing work with overdose base and just Increasing work there. When I talk about Dr. Holtgrave, he was in addition I've had a lot of great additions to my team. We're not just adding people. We're adding high-quality people like Cheryl Donald from Health and Human Services. What I'm saying is it's interesting when I think about the department we've grown into. We brought on some national experts. I'm pretty excited about that. I'm optimistic about our future in spite of what you see in the federal public health world. You would think as a country coming out of a pandemic, we would have embraced public health that just isn't what we did. My Governor did embrace public health and I'm very thankful to her for that.

Dr. Boufford Jeff's giving me the mic ahead of his announcement. Thanks. Really nice to see you. I wanted to follow up on a question I had asked you last time, apropos of the workforce issue. The Council, the Public Health Committee has identified public health workforce as one of the priority areas we want to work on with your department as we have in the past on maternal mortality and some of the other issues. We know there was sort of termination, if you will, of federal support for a lot of the public health, you know, generalist public health work force issues and work both in the local health departments, the money you were able to pass through the local departments, as well as in the department itself. I think I asked last time and how that might be being considered relative to whatever resources are being invested and or getting ready for budget requests going forward into the Spring.

Dr. McDonald We are looking at next year's budget already. In case you're curious, I started looking at it in June. So, that's forward thinking in our part, because this is now my fifth budget I'm getting ready for. I kind of know how this works now. I want to give you a little thought process like this. As much as the CDC's been cut, we haven't been. One of the things about New York State Department is that we do everything CDC does. We just do it for New York State. In fact, there's a lot of things we do that CDC doesn't do, and we do it for other states as well. If we do something for other states, in case you're curious, yes, we get paid for that from the other state. Wadsworth is a great example of what we're doing in that space as well, but I'm really looking at the public health workforce. One of the things I'm also looking at too, in case you are curious is what's called the Public Health WINS Survey. It turns out across the United States of Public Health Workforce is aging. I'm part of the Aging Public Health Workforce, but not planning on retiring soon, in case you're curious. Across the country, you see the public health workforce aging and planning on retirement soon. We look at that as well to make sure we have succession planning built into the New York State Department of Health as well. Because one of the things we need to look for is who is the next generation of public health leaders, which is really something I focus on as well. You know, one of things I've really seen at us, though, is that we actually are attracting a lot of young talent as well. I look around at these young PhDs running around the department. It just thrills me. Not just doing public health, there's young principal investigators we're attracting from some other states as well. It turns out Wadsworth is a great place to work. It's a more sensible place to work right now too as well. We are recruiting people. I'm very concerned about the public health workforce in the future. It's interesting too. One of the things I'm seeing is there are people from other states coming to join us because they like what New York is doing.

Mr. Kraut Thank you, Commissioner.

Mr. Kraut We appreciate the remarks. Thank you so much for joining us today.

Dr. McDonald It was great to stop down. I hope you have a good rest of your day today.

Mr. Kraut Thank you.

Mr. Kraut I'm now going to turn to Ms. Donald, who's going to give us a report on the activities of the Office of Public Health.

Ms. Donald Thank you.

Ms. Donald Good morning, everyone. You all have our report. I think I'm going to take liberty and introduce myself to those of you who may not know me. I am Cheryl Donald. I recently retired from the Senior Executive Service at HHS. I spent twenty-five years there. However, the bulk of my career was actually with the health resources and services administration as the Regional Administrator for HRSA Region 2, which is located many of you know, in Lower Manhattan at 26 Federal Plaza. So, spent about twenty years there leading those HRSA programs and the implementation of our maternal and child health programs, our Ryan White HIV programs, organ donation, many of our 340B programs that our hospital partners are familiar with, as well as our public health workforce programs, just to name a few. It really is seamless transition. It has been a seamless transition from the federal sector to the Office of Public Health. It's been three months. It feels like three years. Sarcasm. I started July 2nd. I am actually originally from Mississippi. I know you all can tell by my accent. I am an Army brat, a military kid. I started on July 2nd, and I was immediately on conference calls on the 4th of July celebrating the 250th. This team immediately put me in the fire. I had the opportunity to really look at the dynamic staff that we have at the Office of Public Health. Our Center for Environmental Health and those responders to our chemical issues, our radiation issues, the way they're responding to the work in Western New York and throughout the state, as well as our Center for Community Health and looking at our family health programs, our vaccine programs, our measles responses. I could go on and on, but the Commissioner has covered much of that work that we've been doing in the Office of Public Health and looking at areas such as vital records and ways that we can modernize and be better stewards of customer service for you all who need to access those resources. My goal really is to unify the Office Public Health so that you all have a seamless experience with our various centers and divisions and that you feel that you are being supported in ways that you need to be supported in a time that we know is unprecedented for public health. New York is an outstanding state. I can say that as an almost thirty-year-old resident of the state we are unique. The things that we do in New York State are modeled throughout the country and actually throughout the world. When we think about what's going on right now with our Northeast Public Health Collaborative, that work has really been led out of our experts in the Office of Science here at the Department of Health. My goal is to continue to improve the work that we're doing. My goal is make sure that we are protected from some of the outside challenges that we are experiencing from our federal partners, my, well, I don't know if they're my former colleagues because many of my colleagues are gone, but those impacts on the cuts that we're experiencing and how we're being supported at the federal level. I hope to be able to use those resources to support you there. I'm happy to answer any questions that you all may have about me or my vision. Any challenges or recommendations that you may have for me as I continue to onboard into this role, especially in the space of public health, you can ask those of me now or you can feel free to reach out to me via email or you can check me out down at 90 Church Street in New York City.

Mr. Kraut Well, I want to thank you very much and welcome you. You know, the council historically was the Public Health Council and that was its complete focus. We're looking forward. I'm sure Dr. Boufford and her remarks will say the same thing of a close working relationship. We believe that there's a lot of opportunities for our participation and partnership. We look forward to giving meaning to those words that you just expressed.

Ms. Donald Absolutely. Likewise.

Mr. Kraut What I'm going to do right now is I'm, because we have a time issue with us, with some of the staff that are in the room, I have the indulgence of our other chairs of other committees and Ms. Sheltry. I'm going to turn now to ask Mr. Holt to give the report

on codes and I'll ask then Mr. Robinson to follow the EPRC report and then we'll come back to the agenda.

Mr. Holt Thank you.

Mr. Holt Good morning at the September 17th, 2026 meeting of the Committee on Codes, Regulations and Legislation. The committee reviewed and voted to recommend adoption of the following regulations for approval to the full council. They are available should the council have any additional questions. I move to accept the this regulation for adoption.

Mr. Kraut I have a motion.

Mr. Kraut May I have second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Are there any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Holt Thank you.

Mr. Holt The second regulation of review this morning was nurse aid training program. Ms. Cazer from the department presented the Nurse Aide Training Program proposed regulation to the Committee on Codes for adoption. They are available to the council should there be any additional questions from the members. I move to accept this regulation for adoption.

Mr. Kraut I have a motion.

Mr. Kraut May I have second?

Mr. Kraut Dr. Watkins.

Mr. Kraut Any questions?

Mr. Kraut Yes, Ms. Monroe.

Ms. Monroe Well, it shouldn't surprise you that I am opposed to this regulation and let me just explain why. I thought the Commissioner spoke about this. Our workforce is aging. We know that with nursing homes and secondary care, CNAs are relied on by more, are relied on more and more for providing the daily care for people. The fact that New York State has a higher requirement to become a CNA, to me is a point of pride, and not something that we should dilute to the federal level. The nursing shortage is such that aides and CNAs are doing more. I just don't understand why we would, at this time, reduce the

requirements to become what is a terribly important role to play in the care of the most vulnerable people. I have to be opposed to this.

Mr. Kraut Dr. Boufford.

Dr. Boufford I'm trying to sort of bridge a bit of what Dr. Soffel mentioned earlier and Ms. Monroe mentioned. Can I just get a clarification? You're talking about reducing from the New York minimum is 100 now and to the federal minimum, which is 75, but it doesn't preclude anyone from offering training programs that are larger, that are longer than that, and I think Denise, I think you alluded to the fact a number of training programs in New York are already in and around the 100. Perhaps we should ask you what your expectation is in regard. Because setting a minimum floor is different from sort of saying thou shalt do only 75 hours.

Ms. Pergolino This is Kristen Pergolino, Department of Health. Yes, thank you very much for that point. It is not requiring 75 hours. It is just reducing the minimum. Again, I want to reiterate two points. One is that we currently have thirty-one programs that are successfully meeting the curriculum criteria and testing and producing an educated CNA workforce in less than 100 hours. Twenty-six of them are doing it within the federal 75 hours. I cannot stress enough that it does not... Respectfully, it does not dilute the content. We're not changing any of the curriculum whatsoever.

Mr. Kraut Do you have any evidence the rest of the country that is doing it at 75 hours is producing any poor quality in CRNAs?

Ms. Pergolino We have no evidence to support or to the contrary.

Mr. Kraut Is there any other questions?

Dr. Gerdes Hi. This is Dr. Gerdes. I just want to say there was a letter that we received that had some supporting evidence from the literature that said that when the nursing aides needs had higher hours that there was reduced adverse events with the patients in the nursing home.

Mr. Kraut Thank you.

Ms. Pergolino Also, that twenty-nine other states have a higher level of hours than the federal level.

Mr. Kraut Any other comments?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut I have one, two, three, four, five, six, seven, eight, nine. Motion fails.

All (Clapping)

Mr. Kraut I've never a motion on codes, so we'll have to send this back to the department for consideration, correct?

Mr. Kraut Yes, Dr. Berliner.

Dr. Berliner Could I recommend that we do a reasonably quick study, a comparison of the two parents and the proposed?

Mr. Kraut Well, I would say the department needs to come back with some more evidence-based issues, just basically supporting some of the things you've just said, and we'll take that up at the next Codes meeting. Is that fine, Mr. Holt?

Mr. Kraut I'm going to now turn it over to Mr. Robinson for report of the Establishment and Project Review Committee.

Mr. Robinson Thank you.

Mr. Robinson Am I on?

Mr. Kraut Yeah, you are. .

Mr. Robinson Thank you very much, as Mr. Kraut mentioned at the start of the meeting, we are going to batch these applications.

Mr. Kraut Just pull the mic in front of you.

Mr. Robinson We are going to be batching these applications. I'm happy to pull anything out of the batch that you'd like us to consider independently. We'll begin with just one item in the first batch, but this is Application 261252C, an application for an ambulatory surgery center, 21 Reade PI ASCLLC doing business as Bridgeview Endoscopy in Dutchess County. This is to certify a new single-specialty ambulatory surgery center extension clinic for gastroenterology to be constructed on Snook Road in Fishkill. 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 so move.

Mr. Kraut I have a motion.

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 The motion carries.

Mr. Robinson Thank you.

Mr. Robinson These are applications for residential health care facilities, 251186E Highland Operations LLC doing business as Highland Park Rehabilitation and Nursing Center. This is in Allegheny County, and it's to establish Highland Operations LLC as the new operator of an eighty-bed residential health care facility currently operated by HRNC LLC at 160 Seneca Street in Wellsville. The department and the committee is recommending approval with conditions and contingencies. Application 252238E TPRC OPCOLC, doing business as Astoria at Rochester Nursing and Rehabilitation Center. This is in Monroe County. This is to establish that alphabet soup TPRC OPCOLC as the new operator of the Pearl Nursing Center of Rochester, which is a 120-bed residential health care facility and renamed the facility to Astoria at Rochester Nursing and Rehabilitation Center. Department and committee recommend approval with conditions and a contingency. I move that batch.

Mr. Kraut I have a motion.

Mr. Kraut I have second, Dr. Torres.

Mr. Kraut Any questions on 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 The motion carries.

Mr. Robinson Thank you.

Mr. Robinson These are for home health care agencies and changes of ownership. Application 241233E, Peak Outcomes LLC doing business as Do It Care at Home. This is to establish Peak Outcomes LLC DBA Do It Care at Home as the new operator of a licensed home care services agency currently operated by Besure, Home Health Services Agency. This is located at 115 West 30th Street. Department and committee recommend approval with conditions. Application 241270E, Easy Living Home Care of NY Inc. This is to transfer 91% ownership interest from three withdrawing shareholders to one existing shareholder and one new shareholder. Here again, department and committee recommend approval of conditions. Application 241273E, Simpson Solutions LLC doing business as All Care Living Assistance Services. Here we're transferring 90.1% ownership interest from one withdrawing shareholder to one remaining shareholder. Department and committee recommend approval with conditions. Application 251085E, Bridges LHCSA LLC doing business as Bridges Cornell Heights Home Health, which is to establish Bridges LHCSA LLC as the new operator of a licensed home care services agency previously operated by Bridges Senior Concepts, Inc. That was located at 403 Wyckoff Avenue in Ithaca. Department and committee recommend approval with conditions. I move that batch.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Any questions on these?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson Thank you.

Mr. Robinson Applications for ambulatory surgery 251159E, Wehrle Drive ASC LLC doing business as Atlas Surgery Center in Erie County. This is to transfer sixty percent ownership interest from one withdrawing member and six remaining members to one new member LLC. Department and committee recommend approval with conditions and a contingency with an expiration of the operating certificate three years from the date of its issuance. Application 261203E, Binghamton ASC LLC doing business as Greater Binghamton Eye Surgery Center. This is Broome County. Established 90.1% ownership interest from one withdrawing member of LLC to the sole remaining member LLC. The department and the committee are recommending approval with a condition with an expiration of the operating certificate three years from the date of issuance as the department and the committee make that motion. I move that batch.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Any questions on these applications?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson These are applications for diagnostic and treatment centers. Application 242223E, Carr Health LLC doing business as Park Avenue Health Center in Rockland County, transferring 100% ownership interest to two new members and a member LLC. Department and committee recommend approval with a condition and a contingency. Application 261177B, Richmond Comprehensive Health LLC doing business as Richmond Comprehensive Health in Richmond County. This was to establish and construct a new

diagnostic treatment center at 4885 Arthur Kill Road in Staten Island. I will note for this application that committee members questioned the staffing projections in this application and requested that the applicant submit a letter of certification to the department. We received a letter with corrected FTEs and salary details and that exhibit has amended to indicate the FTEs will increase by five by year three. The budget was correct as originally presented. With that remark, the department and the committee recommend approval with conditions in a contingency. I move that batch.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Any questions on these applications?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Kraut Before we call the next application, St. John's and the subsequent one, Maimonides, I just thought that I want to provide some background material and context regarding the process the committee followed. Some of the substantive background it received prior to considering the applications at its public meeting on August 27th. Now, we had to consider two applications that were somewhat unique. Montefiore's acquisition of St. John's Riverside in the New York City Health and Hospital Corporation's acquisition of Maimonides Medical Center. Both of these applications have been approved to receive funding under the New York State Safety Net Transformation Program. These applications are receiving a total of close to \$3 billion in funding. We thought that that was an event that required us to understand a little about the safety net transformation program and the financial consequences or circumstances of the applicants before we considered the application. That's why we determined it will be useful to understand both these things. To that end, we heard presentations from two department officials independent of the applications, which I just want to summarize so everybody who was not at the meeting understands some of the context. The first remarks were made by John, who is the Director of the Hospital Transformation and Planning Grant. He provided the committee with a very high-level overview of the Safety Net Transformation Program, explaining that its eligibility is defined in Section 2825-l of the Public Health Law. And to qualify, an applicant had to meet one of four statutory criteria to designate as a safety net hospital. First, the institution had to need a minimum threshold of inpatient discharges comprised of Medicaid, uninsured, and duly eligible patients, or they must serve a minimum threshold of county or multi-county residents who are Medicaid, uninsured or duly eligible, or at the Commissioner's discretion, they serve a significant population of such patients. Additionally, each safety net hospital has to identify and select its own partner organization to jointly apply and implement the transformation plan aimed at improving the resilience of that institution. Now, he described the application process of having two sequential steps reviewed on a rolling basis. First is a letter of interest that's followed by an invitation to submit a full application to be reviewed by trained department staff. These applications are evaluated against standardized statutory and programmatic criteria that span policy, clinical, and financial considerations. A final award determination is made by the

department executive staff and the executive chamber based on the reviewers' assessments, its statewide prioritization, and the availability of funding. There are five objectives that the state is trying to achieve in these programs. First, stabilizing the essential safety net providers. Second, advancing system transformation, improving the care quality in patient outcomes, promoting financial stabilization. Lastly, aligning investments with the health system, statewide health system priorities. Informed the committee that the department has completed two rounds of awards. They've made fourteen awards to date, totaling \$4.6 billion, and he noted that the program provides both capital and operating funds, and awardees are permitted to use the funds as well for debt reduction. The award period is five years, during which time the awardee continues to work with the department to ensure progress on the goals. Now, the next presentation we heard was from the New York State Medicaid Director, Mr. Amir Bassiri, and he talked about the financial context regarding the circumstances that are confronting both institutions that are subject to these applications. He addressed the broader Medicaid financing landscape for financially distressed hospitals and spoke to the specific conditions of each of those hospitals. He explained that the state maintains a cadre of programs providing supplemental payment assistance to distressed hospitals, including the vital access program, the hospital budget incentive payments under the 1115 waiver and capital grants. He noted that the aggregate funding for the state provided to this set of hospitals has literally increased by billions of dollars over the last five years. Now, despite this massive investment that the state has made, we've not seen corresponding improvements in quality, outcomes, or underlying financial condition at certain institutions. Now, you can measure it by operating margin, days cash, discharge value, many indicators. These factors have been eroding the value of the state's investment and resource constraints have made it clear that partnership opportunities and collaboration are necessary as the financial model for standalone independent hospitals as in many cases is no longer viable to be a standalone independent hospital in this day and age. He provided us with some historic background on the two safety net applications. He described the discussion around St. John's Riverside and Montefiore as a longstanding relationship, having developed over years of dialog. He noted that there were significant clinical, financial, and operational synergies that have been identified between those facilities. And under the 1115 waiver, incentive-based funding was developed to allow the hospitals to think strategically about their future, develop a path to financial sustainability. That process yielded a constructive collaboration which demonstrated benefits for pursuing a partnership. He went on to say that with St. John's Riverside, they continue to face financial erosion. There's significant appliance in inpatient volume, even with subsidy the states provided, and emphasized that from a patient perspective, the community continues to need the acute and complex care that's delivered by St. John, and this partnership offers that a viable and sustainable pathway to maintaining those services for the community. He's concerned that without that partnership, the financial support St. Johns would require going forward would increase to levels that couldn't be supported with the state's current financial resources, and noted that Montefiore has made significant investments and turned around its own financial situation compared to five years prior, and is now in a position to help St. John's Riverside to ensure the continuity of care and access to that care for the communities that the hospital serves. With respect to Maimonides Medical Center, Mr. Bassiri described the financial situation as very acute, which the state has spent an extensive amount of time evaluating, analyzing and considering options. The trajectory he outlined was both striking and I would say sobering. Prior to 2002, Maimonides received zero dollars in state financial or operating subsidy. Since 2002, it's received over \$1.5 billion in state operating subsidy and approximately \$1.7 billion in when capital grants and other rewards are added to that. The annual direct subsidy has grown from approximately \$400 million in 2002 and increased every year since then. Despite the

substantial and growing support, the state has seen continue financial erosion and increases in the operating expenses. Those increases exceeded double-digit percentages and outpaced both state subsidies and increased Medicaid reimbursement rates. The EPRC, before they considered these applications got this background. We did that to ensure that all the members, and particularly the public, understand the programmatic framework and financial realities that underlies safety net hospitals in general in these two applications and specifically both St. John's, Riverside and Maimonides are safety net institutions. They serve communities that have significant public needs, and both face financial circumstances that are clearly unsustainable on a standalone basis. With that context, I'm now going to turn it back to Mr. Robinson to introduce the two applications. And then on each of those... Well, I'll make some comments on one of the applications further just to be clear about what the process was.

Mr. Robinson Thank you, Mr. Kraut. Very helpful.

Mr. Robinson I do note that Mr. Bassiri is here today as well, so that if the members of the council have any questions that they'd like to direct to him, they should feel free to do so. I have one other sort of overview comment for these next two applications, and that is to acknowledge both the diligent work and discussion that the committee had as we entertain these two applications. I especially want to acknowledge public participation, both by people in favor of and people opposed to the application. The input was invaluable. I think we paid close attention to it. I have to say that everything was handled in a very respectful and I think thoughtful manner. Just wanted to acknowledge both the people on the committee and the public who participated.

Mr. Robinson With that, I am going to call the applications. I'm going to do them separately. 261152E, St. John Riverside Hospital in St. Johns Division, located in Westchester County. The application is to establish Montefiore Health System as the active parent and co-operator of St. John's Riverside Hospital and its three campuses, St. Johns Division, Park Care Pavilion, and Dobbs Ferry Pavilion with no changes to services. The department and the committee recommend approval with conditions. I so move.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Any comments on this application?

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

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson There were certificates in between these two applications, but I'm going directly to the Maimonides application now. Application 261237E, Maimonides Medical

Center in Kings County. Couple of recusals to note. Dr. Wilcox, who's not present. Dr. Torres, you have a recusal, and I'm going to wait until you leave the room. I will also note a conflict and recusal by Dr. Yang, who is also not present at the meeting, and an interest by Dr. Kalkut. The New York City Health and Hospitals Corporation is to become the operator of Maimonides Medical Center and Maimonides Midwood Community Hospital through two new subsidiaries. Please note that thirteen support letters and two opposition letters were received and distributed to members, and then a revised staff report was distributed to the council and posted on the public website for this project. The revision included the addition of a newly elected board member to the H&H board. The staff report includes the required character and competence review background of Grace C. Bonilla, and that was added. With those two notes, I will indicate that both the department and the committee recommend approval with conditions and contingencies. I so move.

Mr. Kraut Before I ask for a second, I want to clarify that statement. The thirteen support letters and two opposition letters were recently received after the conclusion of the EPRC meeting. We received a lot more letters and documents prior to the EPRC.

Mr. Robinson Thank you for that clarification. That's correct.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Before I ask for questions or any discussions, I want to summarize the process here. I'm doing this because I thought it's important, given the number of documents that we've received and the number public engagements that occurred, I want it to be clear, people spoke in opposition and in support of the application. You know, the previous application, there was no opposition voiced by the public. There was significant, as you heard Mr. Robinson say, significant comments both in support and against this application. I just think it's important to kind of summarize for the benefit of our council members who were not at the EPRC what occurred. When that application was called, the department presented its analysis and recommended approval you know subject to conditions and contingencies and then we heard and questioned the applicant, elected officials, individuals and organizations opposing the transaction, those supporting it and members also had before them as you all do a substantial written record, including the department's exhibits and the revised exhibits, the Health Equity Impact Assessment, letters from elected officials, community and religious representatives. We received affidavits. We received petitions with a significant number of signatures, over 30,000, 34,000. Analysis submitted by opponents and their advisors. Letters of support from organized labor, physicians, hospitals employees, healthcare organizations and community representatives. Our responsibility was to weigh that entire record on the three principle criteria that PHHPC applies in establishment matters, public need, financial feasibility, and character and competence. On public need, I think the record was ambiguous. Maimonides is an essential healthcare institution for Brooklyn. The issue before us was not whether it's needed, clearly is. The question was which course of action provides the strongest reasonable prospect of maintaining access to its services. We heard evidence showing that Maimonides financial distress is real and threatening. Its own financial statements demonstrate that condition. Without intervention this hospital faces the possibility of severe reductions in service, bankruptcy, potential closure. The committee therefore concluded that the need criterion was clearly satisfied, and that our overriding

concern must be preserving access to the services Maimonides provides to the communities dependent on it for care. With respect to financial feasibility, we considered both the strengths of the proposal and the concerns raised by the opponents. The Medicaid Director advised us that Maimonides had extraordinary state financial support since in 2022. Its financial condition has continued to deteriorate, and a partner is needed in order to continue its financial viability. This proposed transaction provides approximately \$2.2 billion in safety net transformation support together with access to supplemental Medicaid patients that are presently not available to Maimonides as an independent hospital. Health and Hospitals also identified operating opportunities through EPIC implementation, improved billing, collection, purchasing efficiencies, referral relationships, and other system capabilities that will be brought to bear. The question was not simply whether H&H can operate Maimonides with substantial state support. The more important question is whether this structure creates a credible trajectory towards reducing Maimonides operating deficit and its reliance on extraordinary state support over time. The committee concluded it provided a reasonable opportunity to do so. We recognize, like many other safety net institutions, some level of ongoing public support may be continued to be necessary. Since delay is not risk-free, our responsibility is to evaluate an actionable transaction against the alternatives that are actually available, not against a hypothetical transaction that presently has neither a committed partner nor a comparable plan of financing. Continued uncertainty can accelerate physician departures, employee anxiety, deterioration in credit and vendor relationships, and ultimately create the operational crisis we're all seeking to avoid. With respect to character and competence, the committee reviewed H&H's experience, governance, quality, record, and enforcement history. Now, H&H operates the largest municipal health system in the country, and the department reviewed its background of the individuals who have governance responsibility, and the committee also can look at the quality and enforcement concerns that were raised by the opponents. We didn't disregard them, and some of those incidents identified are certainly serious and demonstrate areas where there needs to be continued attention and improvement. Individual enforcement matters have to be evaluated in the context of a system of the size and complexity, and on the record as a whole, the committee did not find any evidence of a systematic deficiency to support or conclude that H&H did not have the character competence to honor operate Maimonides. Those were the three statutory criteria. There was another issue to which the committee gave particular attention. Maimonides historical relationship with the orthodox and broader Jewish community and its commitment to culturally appropriate care for all the diverse communities it serves. Now, the Health Equity Impact Assessment submitted for review assisted the committee's review of that transaction and in that document, the impact to many communities, including the Orthodox Jewish community was discussed. In addition to the impact statement, the Health Equity Impact Statement we heard concerns about preserving commitment to serving kosher food, Shabbat and holiday accommodations, visitation, clergy involvement, end-of-life procedures and policies, and we considered those concerns that were absolutely legitimate. We questioned the applicant directly on those issues. Dr. Katz committed on the record to preserving Maimonides historic relationship with the Orthodox Jewish community and these practices. H&H general council advised us that specific commitments to maintain these traditions are contained in the transaction agreement. That was an important consideration for us. These are not simply expressions of present intent. They are reflected in the transaction documents. Now, we also understand that fulfilling these commitments are going to require continued engagement with the community of Maimonides serves. One of our members made that point quite eloquently. The committee expects the Health and Hospitals to preserve meaningful community participation and to honor those cultural and religious commitments going forward. Opponents also raised the question of the hospital closing after five years of the safety net funding. However, there's

no plan for closure as part of this transaction. So, after reviewing the department's analysis, through extensive written record, hearing testimony both for and against the transaction, questioning the department staff and the applicant and deliberating, the Establishment and Project Review Committee voted unanimously to recommend approval subject to the department's conditions and conditions, and I particularly want the record to be clear, particularly clear on one point. We considered the contrary evidence and concerns. We did not ignore them. We considered them on record before it determined the evidence supporting approval was more persuasive under the applicable criteria I mentioned. Specifically, we concluded that Maimonides is an essential community resource. Its present financial condition is absolutely unsustainable. This transaction provides a credible financial pathway that's presently available. In fact, with the strongest one that we could see, Health and Hospital satisfies both its character and competence standard. The applicant has made specific commitments to preserve the historic religious and cultural practices. We're expecting that to be maintained with its relationship with the communities it serves. There certainly are many questions raised in improving this transaction, but there's also substantial risk to act while the institution continues to deteriorate. I should say there's substantial risk in failing to act, while the institutions continues to deteriorate. Ultimately, our responsibility is to identify a pathway to maintain access that's needed for this hospital to give them a reasonable opportunity to remain viable for the community we serve. On balance, the EPRC determined that the evidence and arguments supporting approval was stronger than those supporting rejection or delay. For those reasons, the Establishment and Project Review Committee unanimously recommended approval. That's my remarks just to make them available.

Mr. Kraut The second was Dr. Berliner.

Mr. Kraut For those, I'm going to ask now if any members who attended the EPRC wants to clarify or expand on my comments or summary or if there's any additional comments or questions that any member of the council would like to ask. It's critical because even though the committee voted to advance this application, I want to make sure that we have a full and fair discussion and a vote on this. I want to make sure everybody's questions are answered.

Mr. Kraut Dr. Kalkut.

Dr. Kalkut Jeff, I don't know if there's anything else to say. Your comments really systematically went through the process and what our outcomes need to be. This is an essential hospital in Brooklyn, in a community that has more than one hundred years of a relationship. Preserving access for an essential hospital is going to happen here, and to the credit of everyone in the room. Thank you.

Mr. Kraut Oh, I was particularly struck by your final comment about making sure people in the community get behind. I don't know if you feel, I'm sorry to spring it on you, but I... It was one thing that constantly resonated.

Ms. Monroe Well, my memory isn't what it used to be. My point, I think, and I just still feel it very strongly is that once the council makes a decision. First of all, it was a very painful process. People were passionate on both sides of the issue. It was not an easy decision. Once it's made, we have to make it the right decision so that we can all move forward and get the benefit out of this transaction, so I think that's what I said.

Mr. Kraut Yes, you basically hope the opposition would get behind and support the hospital.

Ms. Monroe Yes, that we all need to get behind this and make it work.

Mr. Kraut Thank you.

Mr. Kraut Any other questions or comments that anybody wants to make?

Mr. Kraut Dr. Fish, I am sorry, you did want to make a comment, I think.

Dr. Fish No worries. Thank you.

Dr. Fish I'm Doug Fish, Deputy Commissioner for the Office of Health Care Delivery with the department. The department just wanted to note that it has a finance team that works closely with all the financially distressed hospitals on a routine cadence to assess their cash flow and the latest financial data. On an annual basis, these hospitals submit projected financial information for a given year that's certified by the hospital's board of directors. Financially distressed hospitals routinely engage an outside consultant to assess their current fiscal state and to make recommendations to the hospitals for potential course corrections. The assessment that was referenced in the department's remarks at the Establishment Project Review Committee is an example of this type of engagement. It's one of the many inputs the state considered in its analysis and understanding of Maimonides Medical Center's fiscal state. The report was not the basis of the Maimonides Health and Hospital Certificate of Need application that's before the Public Health and Health Planning Council today.

Mr. Kraut Thank you very much.

Mr. Kraut Any other questions or comments?

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

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstain?

Mr. Kraut The motion carries.

All (Clapping)

Dr. Boufford I wanted to make a general comment for the council and really it's kind of a question not related to the specific transactions but being from New York City, being pretty familiar with Health and Hospitals as well as Maimonides and Montefiore, and I don't know the situation in other parts of the state but I assume this is the case. Those hospitals that have traditionally, I think treated the most vulnerable populations and also have really been trying to emerge systems dealing with ambulatory care, dealing with prevention. I don't know if the amount of money that's been discussed in relation to these two

transactions is just humongous. I want to put aside for the moment the Medicaid issue or the administrative efficiency issue. I think those are all important issues and I'm sure they were very important in taking this to account. I think we need to kind of think about, and maybe this is the place to do it with Dr. Becerra or others. The degree to which there is continuing investment in hospitals as a solution and inpatient capacity as a solution to the problem, rather than some more balanced investment in primary care and prevention as part of the solution. We keep, as Don Berwick used to say, you keep putting money into the same thing and you get the same result. I think we really need to think about that. I don't know what the mechanism would be perhaps, but I would ask if we might have a presentation to discuss what is going on in this. Maybe in the detail of some of these other investments, what components of it are dealing with health system development, primary care and prevention, many of which is the goal, stated goal of a lot of these hospital mergers in the system development. What are they doing in that area? How are we helping them or not helping them with the way the current payment system is structured? Thank you.

Mr. Kraut So, just for the department, there are other programs that support non-hospital provide. More generally, how it is. Maybe we can put that on as a presentation.

Dr. Boufford They tend to be limited grant programs. Very focused on the SCN network is terrific, but it's very specific populations. It's not solving the problem. It seems to me that we ought to think about that more holistically.

Mr. Kraut I think nobody will debate your thesis.

Mr. Kraut Let me return, Mr. Robinson, if you'll continue making the presentation of the EPRC.

Mr. Robinson Well, and even though I can do it at the end of the report, I do, particularly because of the Maimonides application, want to acknowledge the work of the department on this application and the staff that particularly were focused on it. I think they did a terrific job. They're in the face with both applicants and opponents during this whole process actually is a part of why this is coming out the way it did. I just want to express my gratitude and the gratitude of the committee on behalf of them.

Mr. Robinson We're going to certificates now, and again, batching them. There are two certificates for amendment of the certificate of incorporation, one for Long Island Select Healthcare, Inc., and one for River Spring DTC Corp. On both, the department and the committee recommend approval. I so move.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Robinson Application 252013E, the Endoscopy Center of Queens Inc, DBA, the Endoscopy Center of Queens in Queens County. I will note an interest by Dr. Lim on this application. This is to establish the Endoscopy Center of Queens LLC as the new operator of the Endoscopy Center of Queens. Do you think this is getting a little repetitive?

Mr. Kraut Yeah.

All (Laughing)

Mr. Robinson A single specialty freestanding ambulatory surgery center currently operated by the Endoscopy Center of Queens, Inc at 23-25 31st Street in Astoria. Both the department and the committee recommend approval with a condition and contingencies with an expiration of the operating certificate three years from the date of issuance. I so move.

Mr. Kraut I have a motion.

Mr. Kraut May I have second?

Mr. Kraut Dr. Torres.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries

Dr. Boufford I wanted to use this opportunity to raise, in the context of EPRC, which is where I think it belongs, there are a couple things that have been pending. One of them is what we had talked about with the prevention agenda being quite different from the way it had been done that we needed to revisit the language in the acute care CONs around the prevention agendas probably needs to be revised. We had also at one point talked about looking at sort of prevention agenda community engagement a little more explicitly in relation to going beyond the acute care hospital and moving into ambulatory surgery and other areas. I want to put that back on the agenda for the committee to consider. The other thing I wanted to raise again, which is also something we talked about in the PHHPC before, is this notion of some kind of strategic plan for long-term care services in the state. This has come up, this was first, I think the PHHPC first asked for this six or seven years ago. A lot of things have intervened, it's complex, but the idea was regardless of the, Ms. Monroe has raised this in terms of the Pace program and others looking at the multiple vehicles, not just residential, but are we, we just every time we have multiple approvals and I think do we really know what we're doing here, we're in what geographic areas. I

want to raise that again for consideration and perhaps those are two strategic areas we might develop as we've done for, I don't know what the long-term care group is doing, we'll hear about that later. I think it's not irrelevant to the workforce issues in long-term care that were raised earlier in the earlier discussion.

Mr. Robinson Thank you for making that comment. As you know, I've had a concern about what's now the evolution of Article 28 diagnostic and treatment centers and where they're headed. I'm really concerned that we're on a bit of a slippery slope there as well. That, to me, those centers are really the underpinning of primary care, community-based preventive care. I'm right with you on it. Whether this is an activity that the committee, the Establishment Committee takes on, or this is an activity of the Planning Committee, I'm not sure, but I do think we need to take a strategic look at this and in that context then be handling more strategically these individual applications that come forward.

Mr. Kraut Let's have a follow-up conversation, not today, but maybe we'll get a phone call. We just need to focus not so much the problem, but the objective of what we would get by coming here and how we would want a process in order to result in something that's useful that would be guidance for policy or for funding.

Mr. Robinson This concludes the report of the Establishment and Project Review Committee.

Mr. Robinson I turn it back to you, Mr. Kraut.

Mr. Kraut Thank you again, and thanks again to the department.

Mr. Kraut Yes, Ms. Glock.

Ms. Glock Did we do the two certificates?

Mr. Kraut Yes.

Ms. Glock Oh, sorry.

Mr. Kraut I had it checked off here.

Ms. Glock Sorry.

Mr. Kraut It's okay.

Mr. Kraut Just again to thank the department staff. This was a previous CPRC was a lot of work on a lot of people and really show it was very, very, very well done as people have said. I'm going to return to the normally planned programming.

Mr. Kraut I will now turn to Ms. Sheltry who is going to give us a report on kind of a new program, material transactions. This is something. This is something she'll talk about from the state, but it's something we're using this venue to inform the public, it may not be directly involved with what we do, but it is a very important thing, and I thought this was a great venue to make sure it's communicated.

Ms. Sheltry Hi. Thank you, everyone. I'm just waiting to join the remote meeting to pull up the slides, but you should have it in your packet. I'll be going through those slides currently.

Ms. Sheltry Oh, there we go. Just bear with me one minute.

Ms. Sheltry No, pull them down.

Mr. Kraut They're up there.

Ms. Sheltry Yes.

Ms. Sheltry I'm okay to go ahead?

Mr. Kraut Yes, please. I'm sorry.

Ms. Sheltry No, no, that's okay. I wasn't sure if there was a change in the agenda again.

Ms. Sheltry I am Jackie Sheltry. I am the Director of the Center for Strategic Health Initiatives in the Office of Primary Care and Health Systems Management. I'm joined physically here by two colleagues, Isabella, a data analyst in our unit, as well as Abigail, who will be helping me present on our program today. Virtually we have another staff member, Greg, who's joining us via Zoom. As Mr. Kraut set up at the beginning of this conversation, I want to emphasize that we're really sharing this information for two critical reasons. One, because I thought based on comments I've heard over the past year, year and a half from some members here, this might be of interest given some developments in private practice, non-regulated healthcare space. Perhaps more importantly, we really wanted to use the PHHPC forum as a forum to educate the public about this law, which has existed since mid-2023 and has really ramped up over the past few years, as you'll see in some of the data I'll present today. As I'll get into the weeds as we go through this presentation, there is a really unique opportunity for the public to comment on the transactions that are reported to us. Unfortunately, I think there's a lot of laws in New York State and that's gotten buried. We really wanted to use this public opportunity to educate the public and interested stakeholders about the opportunity to comment on business transactions in the healthcare space that are reported to us that they might want to opine on because there are patients impacted or represent patients who are impacted by the transactions.

Ms. Sheltry We'll start a little bit with background on the law and the program, and I'll turn it over to Abby to my left here to talk about the development of how we collect data in the program over the past few years. As I mentioned, this law took effect in August of 2023. The Public Material Transactions Law, what we call it is enumerated at Public Health Law Article 45A. Overall, the law requires healthcare entities to provide notice to the department of a quote material transaction as defined in the law, at least thirty days prior to the transactions closing. This is important to help the Department of Health understand impacts of transactions that we would not already have reported to us such as through the Certificate of Need process and how those impacts affect access, quality healthcare costs, health equity and competition in the marketplace. The data that we receive through the program, particularly after we started electronically receiving notices, also helps the Department of Health understand trends in the marketplace, such as what service lines are being most impacted over the past few years in higher costs, \$25 million or more transactions. As I mentioned at the top of the presentation, it also uniquely allows the

public to comment on the impacts they see associated with the transaction. So, wanted to walk through three key considerations that the public or stakeholders must consider to determine whether or not a transaction is reportable and that our team looks at to determine whether or not the transaction was correctly reported to us. The first key consideration are the parties involved, and that really is whether or not a healthcare entity is involved in the transaction. The statute specifically enumerates certain entities that must report and are defined as a healthcare entity, including a physician, practice, or group, a management services organization, or a similar services organization such as an ASO, a provider-sponsored organization, PSO, or a health insurance plan. The law also includes kind of umbrella terminology, which is, quote, any other healthcare facility, organization, or plan providing healthcare services in the state could constitute a healthcare entity. Historically, the Department of Health has very broadly interpreted that umbrella term, which we'll see in a future slide. The statute also does exclude certain entities from the definition of a healthcare entities. So, if they are the principal organization or entity involved in a transaction would not be reportable to us. That includes insurers authorized to do business in New York State, or pharmacy benefit managers registered or licensed in New York State. The second key consideration is the type of transaction. There are a wide range of transactions explicitly enumerated in statute, but it is a non-exhaustive list that I'll turn to in a moment, including mergers, acquisitions, affiliation agreements. We'll look at that in more detail momentarily. The one thing I wanted to highlight here, and we can talk about it a little bit more is that certain transactions that are already reviewed by the Department of Health under the Public Health Law, there's a number of articles mentioned in statute, including Certificate of Need, establishment and construction applications are not subject to review under the material transactions law, which is why the PHHPC forum would not be seeing material transactions on their face in this setting. The third and critical or factor that we look at to determine whether or not a transaction is reportable is whether or not the monetary threshold is met. That means that the transaction must meet the de minimis threshold, in which case the healthcare entity has to increase its gross in-state revenues by \$25 million or more, either as a single transaction, which is a majority of those that are reported to us or as a series of related transactions. There is an analysis the parties must do, and the Department of Health must do to determine whether or not transactions are related in order to determine whether or those kinds of segmented different transactions all amount to meeting the \$25 million threshold. As I mentioned, with respect to the first prong of that analysis, whether or not the parties involved constitute a reportable transaction is to determine whether or not it is a healthcare entity. Of course, the statute enumerates a few different entity types that I listed out, but really a lot of our work at the Department of Health is not looking at the enumerated entities by statute, but whether or not that umbrella term is met in terms of whether or not it's some other organization providing healthcare services in the state. As I said, we at the Department of Health have interpreted that umbrella term pretty broadly and there's a list on the slide, either in front of you or on the screen that you can see. Some entities just by way of a non-exhaustive example that we have included meet the definition of a healthcare entity, included pharmacies, including wholesale pharmacies and secondary wholesalers, pharmacy manufacturers, wholesale medical device distributors and clinical laboratories. Just by way of illustrative example, I think the one entity that was brought to us as a question whether or not the constituted healthcare entity for the purposes of reporting was a veterinary or animal pharmaceutical company. We had to assess whether or not there could be downstream impacts on patients, human patients, pharmaceutical costs that might actually warrant constituting a veterinarian practice as a healthcare entity. Ultimately, we decided it wasn't but just wanted to give you the scope of what I mean when I say we do broadly interpret this terminology. As mentioned previously, the third, excuse

me, the second key prong that we look at in determining whether or not a transaction is reportable is whether or it is a type of transaction that the law covers.

Ms. Sheltry Here is a non-exhaustive list as detailed in the statute including mergers, acquisitions, affiliation agreements, and formation of certain partnerships. The one thing I do want to mention is that, as I said, this is a non-exhaustive list. The law also does explicitly exempt certain types of transactions to us, including clinical affiliations. That's detailed in the law what types of clinical affiliation are exempt, as well as transactions that are already reportable to the Department of Health, as I mentioned before, such as but not limited to Certificate of Need, establishment, or construction applications. That said, one thing that has come up, I think just in two applications or two transactions is it is possible to have a hybrid transaction, part of which will be reported to the Department of Health through existing Certificate of Need processes and reviewed there and then another aspect of the application that would be reported to the material transactions program. We do look at those kind of siloed. Although, we do ask parties in our electronic reporting form to identify if there are Certificate of Need aspects that we should be aware of and then alert our colleagues at the Department of Health.

Ms. Sheltry I'll turn now to Abby to walk us through what the reporting process looks like, including other entities that are kind of involved in the notification and review process and the electronic data reporting forum that we use.

Ms. Sindzinski So, during the reporting process, we collect information on the names of all the parties to the transaction, pre- and post-closing documents, all locations where services are provided in New York State, and then transaction impacts on services, and a description of the material transaction itself.

Ms. Sindzinski Initially, the parties were required to notify the department via email. In May of 2025, we launched a detailed electronic reporting form using the platform. The reporting form has allowed us to standardize and streamline reporting. The team receives a notification when the notice is submitted and so do parties. Importantly, parties can upload documents in the form itself, and these documents can include a spreadsheet that collects information about the practitioners by location and one that collects revenue information by location, giving us insight into what the parties are doing and how much revenue they're generating. In terms of the reporting process, the department reviews notices for completeness. When applicable, DOH requests additional information from the parties. The thirty-day notice clock starts when DOH determines the notice is complete. Importantly, upon receipt, the department submits a copy of the notice to the Office of the Attorney General.

Ms. Sindzinski Can we move on to the transaction?

Ms. Sindzinski In terms of the transaction impacts, we look at impacts in terms of quality of care, access to care, impacts on health equity, and impacts on competition. The form asks detailed quantitative and qualitative questions about impacts to these areas, particularly those four that I mentioned before. As an example, question, you can see that we are asking for information about whether any public stakeholders have expressed concerns about the transaction and the impact of the transaction on quality. In other parts of the form, we ask for information about press releases or other public information that the parties have received in response to the transaction, the proposed transaction.

Ms. Sindzinski Through our impact reporting, we have identified impacts in a couple areas. We want to stress that, by and large, parties report no change in terms of a pre- and post-closing impact. For this reason, we'd like to encourage public comment. We've gotten some information about anticipated layoffs and a war notice in four transactions. But by and large, parties have expressed that the transaction won't impact the larger market or patients.

Ms. Sindzinski Research that we've seen on this field suggests that private equity acquisition is associated with hospitals in particular, but broadly is associated with changes in cost, quality, and quality measures. For instance, increases in net income, hospital charges, and charged to cost ratios compared to non-PE-acquired hospitals. The reporting form goes beyond required reporting of financial details, and the department wants to follow transactions to determine how New Yorkers are impacted, looking at, for instance, how sales these could impact costs.

Ms. Sheltry So, wanted to walk through, before we turn it over to questions, some of the data that we've collected through the program. As mentioned, when the law first took effect in August 2023, we initially were just getting email transactions. Once our electronic reporting forum launched, which includes really detailed information as well as the ability to upload documents, we have enhanced the quantitative information we've been able to receive. So much of what I'll show on the next few slides is post-electronic reporting form, so post-May 2025. Since the program was initiated in 2023, there have been thirty-seven transactions reported to date as of yesterday. You can see on the bar graph that definitely an upward trend in the number of transactions that are reported. I think both because of movement in the industry as well as awareness that the law exists. For 2025 and 2026 to date, there have been fourteen transactions in each year. Of course, we anticipate additional transactions reported before the close of this year. So, continued upward trend in the number of transactions that are reported to us.

Ms. Sheltry This is a snapshot of the types of providers that are identified as the primary parties in the transactions reported to us. As you can see in the numbers outlined here, primarily physician practices, private practice groups, as well as pharmacies and diagnostic laboratories tend to be the core entities that are involved in the transaction. The other primary group we see, which isn't really reflected well here in terms of the actual numeric count, or management services organizations.

Ms. Sheltry As you can see on this slide, we have four reported, but that's because that was four MSOs that were a direct party or a principal party to the transaction. If you kind of peel back one layer and you look at a multiple party, so two plus transactions, or if we're looking at either a parent or grandparent level that's involved in the transaction. There are actually a lot more services organizations, including management services organizations administrative services organizations and in some cases dental service organizations that actually are involved in the organization, or excuse me, that are involved in the transaction. To date, we've counted twelve MSOs or some other type of service organization that are involved in transaction, which I think roughly accounted for a little over 30% of all transactions that are reported to us. So, definitely a growing kind of body that's involved in these private practice space transactions.

Ms. Sheltry As you can see on this graph, and I was actually surprised by it myself when we started to do our data enhancements on our web page, every county in New York State has been affected in some way by a material transaction. New York City, not surprisingly, being the most heavily affected, including over 200 locations within the five boroughs. I

can't do it on the slide here, but we do have an integrated webpage which allows people to hover over each county to see the exact number of transactions and what transaction number it was so they could actually look at what transaction or transactions were happening in their county and get a little bit more detail. Principally, the reason why I think it's a statewide impact there has been a few laboratories or excuse me pharmaceutical transactions that had really statewide impact which is why this map looks the way it does. Our website, as I said, is really interactive and will allow stakeholders, patients, to see what's happening in their areas.

Ms. Sheltry The other interesting data point that is available on our web page as well are the purchase prices of these transactions. We were kind of surprised to see that nearly two-thirds of the transactions are over \$101 million, and approximately 32% are actually over the \$501 million mark. These are costly considerations, or I shouldn't say costly, high consideration transactions. One other thing to note before we talk about some policy developments or policy attempts in this space is that there are a lot of other states that have very similar material transactions laws. Three are reflected here. It is definitely not an exhaustive list, but these three states we thought reflected most either mirroring laws and programs to New York State or states that have instituted material transaction laws for a longer period of time than New York, and we really see as models whether that's looking at their program and legal development or consulting with their program staff in order to make program improvements ourselves in New York. These are really the three core states that we collaborate and learn from most, Massachusetts, Oregon, and California. Just some interesting things to add to what you see on the slides there. Of these three states, Oregon is the only state that has approve or deny authority for material transactions meaning the state can actually decline to allow a transaction to go through. Neither Massachusetts nor California has that authority nor does New York State. Oregon has a requirement to have ongoing reporting of transaction impacts, which we'll touch on a little bit as something New York State tried to do. Both Massachusetts and California have what is known as a cost and market impact analysis allowance. It's not done for all of their transactions but for a select few, which is something we looked into doing in New York State and I'll talk about that in a slide or two.

Ms. Sheltry The next slide.

Ms. Sheltry Both last budget cycle state fiscal year 2027 as well as the state fiscal prior, we have tried to expand our existing material transactions law based on those lessons learned and the program implementation in the states I just talked about, particularly Massachusetts and California. Some of the things we tried to do at a high level were adding additional post transaction reporting. That is really to allow us to get more details on the actual impacts on cost, quality, access, health, equity, and competition in these transactions. As Abby articulated, we have the opportunity to provide really detailed quantitative data on impacts, but overall, by and large, what parties are reporting to us is that there's going to be no impact, although we have seen a little bit in layoffs. Those policy proposals did not pass, however. Programmatically, we have been working on some updates, including an interactive dashboard on our website that I mentioned that allows stakeholders, patients, to hover over transactions, to see what's happening in their communities and learn more about the transactions, as well as a new public comment form that allows patients, again, stakeholders, to submit a detailed forum about what the transaction, what they think about the transaction if there's any impact on cost quality access that they believe will be happening. That the Department of Health might not already be aware of based on the party's own submission. So, that launched about a month or so ago. We're really excited about it, which again brings us to this forum to really

encourage and educate the public to let us know what you're seeing if you're aware that your provider, your pharmacy is engaged in one of these transactions, what you think the impact will be on you or other patients. That is, it, but I am happy to entertain questions from this group on the program.

Mr. Kraut We'll take some questions because I, we, Mr. La Rue has to leave at a certain time. I got to make sure we get to the Ad Hoc. Let's ask some questions. Just remember, this is really for the public to hear as much as we are. These are not going to come into this room, these transactions for our review because they're outside the scope of CON.

Dr. Soffel Jackie, thank you, that was really interesting. I pay a fair amount of attention to the landscape of the New York State healthcare delivery system, and I have never heard of this. My question for you is as somebody who is educated and thinks a lot about these issues has no clue... How is the public being informed that this is an option that they can weigh in on? Are there any public notice requirements? How would anybody know?

Mr. Kraut And that's why we're here today.

Ms. Sheltry Exactly.

Mr. Kraut That's why I thought it would be important to start the process. Maybe it'll get reported on from the meeting. Look, it's important, I think more and more. There are only fourteen transactions, right, last year. Some people will call this the Full Employment Act for Consultants and Lawyers. As more and people become aware of this, these are issues that I think there's fundamental policies. I suspect as the data gets more organized as you've just done, there's going to be more attention paid to these transactions. There are always unintended consequences. In those states, even though we didn't go into it, there are some very, there are real problematic issues about other things that resulted in significant job losses. We'll go through that. I think the whole point, Denise, is to start here, and hopefully it's going to get reported.

Mr. Thomas Thank you, Mr. Kraut.

Mr. Thomas Hugh Thomas, member of the council. Thank you for that presentation. There's a whole lot of questions. I think Denise just got started with it. Very precisely, you coordinate with the Attorney General on part of this. I mean, the one thing that jumped out at me as being possible was antitrust, but is that primarily the area, that Department of the Attorney General's Office that you focus with?

Ms. Sheltry Yeah, so the law actually requires, and we do transmit notices as soon as they're received to the Antitrust Bureau, the Charities Bureau because of the nonprofit aspect, as well as the Healthcare Bureau. Pretty much as soon as the transactions are received, we transmit them to them. As we get more information through a request for additional information from the parties, we'll have kind of an ongoing transmission notice to the Office of the Attorney General.

Mr. Kraut Dr. Berliner, and then I'd like to go to Mr. La Rue, if that's okay.

Dr. Berliner Can you say something about the physician practices that were under this? I thought I didn't think that Department of Health had any control at all over independent physician practices.

Mr. Kraut It doesn't.

Ms. Sheltry These are all non-regulated entities. Well, for the most part, it's non-regulated entities that are reporting to us. If an entity is regulated, like we have had home care, for instance, report transactions to us, but the law definitely does cover private physician practices. That said, as I mentioned, the law doesn't give us approval or deny authority over these. It's really at this point in time kind of an information data gathering allowance and of course allows us to transmit information to the Attorney General if there are antitrust concerns, which do have investigatory authority

Mr. Robinson Thank you for this report, and I do agree that making the public more aware of what you are identifying and what you're reporting, and that's what you were saying, Denise, I think is very, very important. I think it also raises and it ties back to the issue around diagnostic and treatment centers that I was talking about before, and those going into more of the for-profit business world. I think there is a whole issue that the state, from a public policy standpoint, needs to look at. This is not going to be something that's going to be handled from a regulatory standpoint. It does require legislation, I think. The limited boundaries for the corporate practice of medicine just around hospitals in New York and the growing interest and role of private equity in investments in healthcare are a slippery slope in that, if a private equity investment is being made, there is obviously going to be a return on that investment. That's why those investments are made. Those are dollars that are going to be taken out of the healthcare system. Similarly, that kind of approach will ultimately have an impact on access to care or certain populations. I think all of these things really raise broader policy questions. That I do think, you know, obviously the department needs to think about and the executive, but I think this is an important consideration.

Mr. Kraut Dr. Rugge and then I'd like to go to Mr. La Rue to give the report because we're going to run out of time. They're going to issue one. He's asking if there are penalties for failing to report.

Dr. Rugge Is there a penalty for reporting errors or misleading report?

Ms. Sheltry There are no unique penalties under the material transactions law, Article 45A, but under Section 12 of the Public Health Law, there is the ability to impose civil penalties for any violation of the law per day of the violation. So, if a party or parties close a transaction and never notified us or notified us late, there would be a calculation as to how many days they were out of compliance with the law. To date, we haven't imposed any penalties, but there is an option there under Public Health Law.

Mr. Kraut So maybe in a year or so, you'll come back when you have some more data and experience. I suspect there'll be, as you say, the trajectory is there's going to be more transactions reported. Thank you so much. Appreciate it.

Ms. Sheltry Thank you for the opportunity.

Mr. Kraut Thank you.

Mr. Kraut Mr. La Rue, I'd like to go to you and Mr. Holt, on giving the report of the Ad Hoc committee on long-term care.

Mr. La Rue Thank you.

Mr. La Rue Thank you to everyone who participated in the meetings of the Nursing Home Ad Hoc Committee. I'm going to summarize the recommendations of the committee, but the official recommendation should be understood to be based on the way they are written in the letter that Vice Chair Tom Holt and I submitted that is attached to today's meeting materials. The committee met four times to discuss known challenges and feasible solutions in the review of the Certificate of Need process for nursing homes, and particularly in the character and competence portion of those reviews. We separated our review with the relevant issues into three pillars and made our recommendations accordingly. Pillar one, the operator's qualifications and experience. The committee recommends that we formally adopt a five-year minimum leadership experience threshold with limited flexibility. If adopted, this council will require that applications for a nursing home Certificate of Need include at least one member of the ownership group with at least five years of experience in the operational and high-level governance of a facility. For example, as an administrator of records. However, we recommend that the requirement be adopted with some flexibility, allowing applicants to otherwise demonstrate the requisite qualifications and experience to operate a facility. The committee additionally recommends that the department continue to use existing authority under Public Health Law 2803-W for purposes of monitoring the current operator's compliance with a written and mandatory corrective plan and reporting to the department on the implementation of such corrective action when the department is determined in its discretion that significant operational deficiencies exist. Our second pillar was financial sustainability and resource adequacy. The committee recommends that the council requires an independent certification by a third-party auditing firm of financial projections for all three-year models and budgets. The committee recommends that applicants for establishments submit independent professional appraisals to verify fair market rent and property values. This requirement is intended to be more rigorous than the current requirement of two letters by local real estate agents attesting to fair market value. The committee further recommends limiting related party rent to a maximum of 1.1 times the required debt payments unless the Bonafide lender requires otherwise. Our third and last pillar was related party and administrative oversight. The committee recommends that any entity or individual exercising management control or operational influence via a consulting agreement must undergo the same character and competence review as a Certificate of Need applicant. The committee recommends that every natural person, beneficial owner of an applicant entity must sign and notarize a certification under penalty of perjury, affirming that they will maintain independent judgment and maintain ultimate authority over all fiscal and operational decisions. Finally, the committee recommends much greater consultation between the department and the in the Office of the Attorney General's Medicaid Fraud Control Unit on all pending applications in which individuals and applicant ownership groups have been the subject of prior allegations, enforcement actions, or settlements. The letter we submitted contains additional explanations and justifications for these recommendations, and I urge everyone to review it. Tom and I are grateful for the contributions of the Medicaid Fraud Control Unit, the Bureau of Financial Analysis, the Office of Aging and Long-Term Care, as well as to all the members of the committee for their time and to the members of the public who provided comments on these proceedings. That concludes my report and recommendations.

Mr. Kraut Before I open it up for questions and comments, I just want to thank Mr. La Rue, Mr. Holt, and the members of the committee who participated in doing this. This took us a bit of time and the staff in supporting it. These are great recommendations and these have been vexing problems we've been struggling with for years. The work and the attention to the details were extraordinary. It's an example of other types of projects that I think can be

very productive for this council to engage in. As I understand it, what we're being asked to do is not necessarily to vote but to endorse the recommendations. Those recommendations will be forwarded to the department for consideration to incorporate into the process by which we solicit CON applications and review them. There are very clear criteria of what we're expecting. This won't happen overnight. They have a process they have to go through. I would argue, not argue, I would suggest that the public in hearing these things, the applicants who are going to come before us should begin to incorporate some of these suggestions voluntarily to the degree they're capable of doing so and not wait for the regulations to be finalized or the guidance, if you will, to be finalized. The motion I have from Mr. La Rue is a recommendation to the PHHPC to endorse the report and forward it on to the Department of Health, and that's the motion.

Mr. Kraut May I have a second?

Mr. Kraut Mr. Thomas.

Mr. Kraut I'll open it up for any questions.

Mr. Kraut You answered all the questions. You did scratch all the itches that we've had. Again, I can't thank you for your guys, the expertise and the involvement of the industry and frankly the staff and the support you've given this. It was excellent. Thank you so much.

Mr. Kraut Dr. Boufford.

Ms. Soffel I'm sorry, I just want to add, it was an absolutely eye-opening set of conversations that the committee had and, you know, we all kind of had our qualms about these transactions and what we learned in this process was very startling.

Dr. Boufford I just wonder if this might be a first step in looking at a long-term care strategic plan.

Mr. Kraut I'm going to now call a vote on these recommendations.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut None opposing.

Mr. Kraut Any abstentions?

Mr. Kraut The motion carries.

Mr. Kraut Dr. Boufford, would you like to give a report on the prevention agenda.

Dr. Boufford Thank you.

Dr. Boufford Thanks, everybody.

Dr. Boufford I wanted to thank the members, especially members of the Public Health Committee and others of the council that attended yesterday. We had a three-hour meeting of the Ad Hoc Committee. It was the second one for this year. I especially want to thank Dr. Whalen, who's here, and Mark, who has really taken over the staff for the local public health practice office. It's done a great job for us in organizing staff for this effort. We had about twenty-six members of the committee, about forty-five I think total, and then about fourteen state agencies that are involved in the Ad Hoc committee. And just for the new members of PHHPC and others to remind ourselves, the PHHPC does have statutory responsibility for oversight and monitoring of the prevention agenda, which is the state's health improvement plan. We take that very seriously. What the steps are that where we are in the calendar, I think which is important, because we may have more to tell you next time is the local health departments have to submit a community health plan after doing a community health needs assessment. Hospitals, by federal law, a federal statute, the sort of Obamacare Law have to submit a community service plan based on a community need assessment every couple of years I think. The hospital's due date was the end of December of last year. The local health departments, about 45% of, we asked that these local sort of, if we hope there sort of begin to be collaborations, consortia groups that are working at county level, at least sometimes at multi-county level are led by partnerships between local health, health departments and hospital, and their hospital colleagues. Now, the hospital due date is, as I said, the end of December. About 45% of the counties reported that local health departments and hospitals did collaborate on their planning, which is what we've been kind of moving towards in a voluntary basis for quite a while now. The other local health department that had not gotten their submissions and aligned with their hospitals were given an extra six months. They were due July 1st. We're in a position period now between now and the end of the calendar year. A lot of good analysis will go on, and we'll be hearing more about what the priority choices were of each of the partners, local partnerships and what they're going to be working on, especially at county level. Just to remind everyone, the new prevention agenda was quite different in structure from the previous one. We are operating with sort of twenty-three different objectives available. Each of them is slotted into one of five domains which were identified by the Centers for Disease Control in the Healthy People 2030 process to have a sufficient amount of evidence that they are determinants of health and need to be really tackled at a population and at a community level. Those are economic stability, social and community, context, neighborhood and built environment, healthcare access and quality, and education access and equality. This is the first time their prevention agenda has sort of a mandate to look at healthcare access and quality. We've been sort of stopping at the door of the clinical enterprise up to now. We're really trying to look at this very holistically. The panels yesterday we had from the, as I said, we had a meeting in May and had really good turnout from multiple state agencies which really have to cooperate with us. The health department only has leverage over healthcare access and quality. The other agencies manage issues like economic development and planning and transportation and others. We're beginning to bring in these other agencies to present what they're doing. The first panel was on education access and equality to hear what the Department of Education is doing in the area of health and wellness promoting schools. I wanted to mention there was a, we had a region and one of the senior people in leadership of the Department of Education present, which was great, along with Kathryn Hall of the New York Academy of Medicine and I mentioned this because we're trying to model the idea that each of these is a process of partnership between state government, between nonprofits, academic enterprises, advocacy groups. The Ad Hoc committee consists of nonprofits, professional associations, and advocacy groups that are statewide. Many of them are regional and most of them are statewide and they are kind of the public advisory process for the prevention agenda. The second panel was on economic stability, and we had

representation from Paul Beyer, who's from the Department of State, and Therese Daly from the United Way, which are the two major entities that deal with economic development, community economic development. They presented their programs and discussed those. The final panel was on the topic of neighborhood and built environment. We talked about opportunities in communities for active transport and physical activity to increase those and had presentations from the New York State Senior Action Council and Interagency Council of Developmental Disabilities, as well as Dan French from the Health Department, which is a group within the Chronic Disease Branch that looks at this issue of preventive interventions in communities focusing on physical activity and others. We got into a lot of interesting issues. I think one of the things that emerges certainly is the importance of alignment between state policy, regional policies if they exist, and local government. This is something that's becoming, it's an incredibly and really important issue relative to the fact that many agencies don't have the ability to make things happen at the local level. That alignment needs to be there. Obviously, local communities have responsibility over land use issues, decision about transportation policy and other things. That's the kind of area we're learning a lot about, which I think is really, really helpful.

Dr. Boufford The last panel was a presentation by NYSACHO, which has been contracted by the Department of Health to really, to do two things, really get a sort of sense through a survey process they've developed and they gave us some interim presentation to identify what people know about the prevention agenda, what they're doing in their own communities or through their own organizations to work with it, how we could make it more accessible and more make them as effective as possible in joining the prevention of agenda. There will be five regional meetings as part of this grant program. They will be managing these regional meetings over it's very collapsed timeframe over the during the months of October and November around the state to really try to focus again on this alignment, the regional, what are the priorities that are coming out of local health department, hospital, and other members' partnerships at the regional level, multi-county level, and how can they be reinforced and supported going forward. Our plan is we have another meeting scheduled in New York City for December 16th, and at that point, we'll be able to hear the results of these regional meetings, which are trying to develop regional priorities and recommendations from regions for the most effective implementation of the prevention agenda. One of the other areas we've done is we've been--

Dr. Boufford The other area we've been very interested in, one of the themes of the prevention agenda is to really have a population-focused health across all ages, but especially for older residents, older folks in New York that are over 65. That is a thematic area we're interested in. We've invited members of a coalition that was developed around the Master Plan for Aging to join the Ad Hoc committee. We're happy to have Ms. Haslinger joining the Public Health committee. We know they'll be well represented. A number of them there have been involved. AARP's been involved from the beginning, but I think we're very interested in how each of these areas affects older people. We'll be doing a crosswalk between the Master Plan on Aging recommendations, which are out, and the prevention agenda recommendations. We have an initial document, and we're going to be flushing it out a little bit and doing that at the next meeting. We'll be trying to focus on specific next steps for making this, the prevention agenda implementation steps most effective. I say the couple of areas that were identified as gaps, engaging the business community has always been a challenge and we have invited the New York State Business Council before, and we have invited them again. We'll keep working with them. We did have an interesting conversation with HANYS, because in past years, the trustees of many of the community hospitals that are now part of larger systems are certainly local businesspeople and people with significant influence at the local level. They had been

quite interested given the fact that as these systems are created, many of them no longer have the kind of governance or fiscal responsibility that they had because they're now part of a larger system, but they still have important voices and ability to recommend how they, these local hospitals and health centers can be more engaged and perhaps mobilized funding for local initiatives as part of the prevention agenda. We're going to be focusing on that. I think the other, another issue that came up, which I think is the interagency process, and we are working with Dr. Whalen about this is really how do we work with the agencies that are part of Ad Hoc committee kind of outside of the normal meetings to make sure they're beginning to present to us, we're learning what they're doing, but how to have them mobilized and allied with our agenda. A couple of issues were raised about their accountability. We had colleagues talking about the issue of county executives' role in this process and or hopefully at some point the, certainly the Governor's Office has supported it but in the department leadership as well which is working with us on trying to get, how do we get leverage in the partnership of the Department of Health with these other agencies that are interested in helping us promote health across the state. I'll stop there. Thank you.

Mr. Kraut Dr. Whalen, if you want to make any comment or any members of the council have any questions. If think about what we just heard, the work of the committee is extensive and it's hurting really to get everybody kind of aligned to do this. It's quite challenging.

Dr. Whalen I just want to thank Dr. Boufford for her remarks. It is a tremendous time and labor and people-intensive planning process. What we have found is that the partners that we brought into the fold for the Ad Hoc group are very willing to partner. And for example, I was speaking with some folks from the Department of Education yesterday, and they are saying, we should have been working together on so many things for so long. I think that there's tremendous possibility in this, and I think there is enthusiasm for this. I'm looking forward to what comes out of it.

Mr. Kraut The fact you got DOE to show up, it's just amazing.

All (Laughing)

Mr. Kraut Look, but it just tells you the leadership there has a different perspective than we've been experiencing historically, and I'll say that for the industry as well, beyond the Department of Health. Well, I thank you, Dr. Boufford, and thank the members of the committee.

Mr. Kraut I'm going to make a motion to go into an Executive Session and adjourning the public portion. But before I do so, I just want to make everybody aware the next regularly scheduled committee day is on November 19th. The Public Health Committee will meet on the 4th of November. The Prevention Agenda Ad Hoc Committee and the Public Health Planning Committee will be on the 16th of December. Lastly, the full council meeting will reconvene on December 17th. I am pleased to announce that, well, at least I'm pleased to announce it. All the meetings will be in New York City. We'll return to the city. For some of you... That's not a big thing to celebrate.

All (Laughing)

Mr. Kraut May I have a motion?

Mr. Kraut Right after we get our jackets and you get a second bottle of water.

All (Laughing)

Mr. Kraut Yes, I know the challenge, Ann. So, that's why I'm saying I'm pleased to announce.

Mr. Kraut May I have a motion to adjourn the Public Health and Health Planning Council meeting and go into an Executive Session to consider the report of the Committee on Health Personnel and Interprofessional Relations?

Mr. Kraut I have Dr. Boufford.

Mr. Kraut I have second, Mr. Thomas.

Mr. Kraut We are now adjoining the public session.

Mr. Kraut We are now going to an Executive Session. The public needs to leave the room. We will turn off the webcasting, please, and conclude that any of the staff who are going to participate on this review, please remain in the staff.

Mr. Kraut I'll turn it over to Mr. Thomas.