

**NEW YORK STATE DEPARTMENT OF HEALTH**  
**PUBLIC HEALTH AND HEALTH PLANNING COUNCIL**  
**HEALTH PLANNING COMMITTEE**  
**April 9, 2025, 1:00 PM – 4:00 PM**  
**ESP, CONCOURSE LEVEL, MEETING ROOM 2 ALBANY**  
**TRANSCRIPT**

**Dr. Rugge** I'd like to call this a refresh start. It's not a brand-new start, but we're trying to jump in and get refreshed, or be refreshing. For all the new starts, I couldn't help but go back to our origins, which is 2011 with the statutory creation of this council and definition of what we're supposed to do. I'm not going to read too long. We have powers and duties associated with establishment and construction of healthcare facilities across many different agencies and all the rest. Along the way, in carrying out its powers and duty, the council shall take into account the impact of its actions and recommendations on the quality, accessibility, efficiency, and cost-effectiveness of care throughout the state. All we have to do, each one of us should have a specialty so we can really do it. Here we are. I hope everybody remembers, at the committee at its last meeting approved a new charge. The initial charge way back in 2012 was a little lengthy and various and specific. Ours, I think, is much more elegant now. For all the new charge, certain features of our planning activities and this Planning Committee remain the same. Close collaboration with the Department of Health and its leaders, for sure, that this really is coming together with their providing most of the work and our providing perspectives across many fields and input that is being generously welcomed and generally accepted, which is our role. The need for this continuing activity planning, I think is due because the healthcare world of both delivery and reimbursement is changing in all kinds of ways. To keep up with that or to anticipate the changes, here we are. So simple. As we came to review all this, Ann and I have been treated with a lot of time from people to my right, Gene and Jackie, and the understanding is, and I think it's helpful, that our planning is really about what comes to the PHHPC, what comes to the council. Instead of looking at some of the big, broad issues that we're being considered and looked at, which are still important, we're not advisory. We're not just giving general look at the whole health care world. Instead, we are looking at specific issues where we can make a difference by making recommendations and having sometimes a Codes Committee, but the full council enact or modify but make progress. This is our job. We need to pay attention. Again, I think the difference is many policy councils are general. They can be easy to read, but there is not necessarily specific follow through. The difference here is we can make that kind of difference, even though it may be in a slice, not the entire area that we all are concerned about. They are, again, our discussions, I like to think are actionable. They're not just out there for consideration. They're recommendations for change. That most likely will be accepted because we'll be voting. As we do this, I think all of us will remember, recall, look to see how these have implications for those bigger policy issues and hopefully by taking this kind of step forward we can influence others who are thinking and going. We will be leaders in that respect. We thought the best next step for us to do, or maybe this is the first refresh step is taking a look at what the recent activities of the Planning Committee have been and how that's some precedence for us, some examples, or maybe some things to stay away from. This is all up to Dr. Heslin. Eugene, the floor is yours, so the microphone is.

**Dr. Heslin** Thanks, Dr. Rugge.

**Dr. Heslin** Gene Heslin, First Deputy Commissioner and Chief Medical Officer for the department, and Ms. Sheltry to my right and myself will be tag teaming on this part of the discussion.

**Dr. Heslin** Do we have the document that we can put up on the screen? Is it in front of people?

**Ms. Monroe** Could we before we start do introductions?

**Dr. Heslin** Ah, yes.

**Ms. Monroe** I don't know that everybody knows everybody because it's a pretty new committee. Why don't we start here?

**Ms. Monroe** Who are you? Do you remember?

**All** (Laughing)

**Dr. Berliner** Aaron Judge has been going so bad in Detroit, I came back here, shrank a little bit so you wouldn't have to do autographs. I'm Howard Berliner, member of the council.

**Ms. Monroe** Ann Monroe, member of the committee.

**Dr. Rugge** John Rugge, another member of the council and the committee.

**Dr. Heslin** Gene Heslin, DOH.

**Ms. Sheltry** Jackie Sheltry, Department of Health.

**Ms. Ngwashi** Marthe Ngwashi, Department of Health.

**Ms. Leonard** Colleen Leonard, Department of Health.

**Mr. Stelluti** Mike Stelluti, Department of Health.

**Mr. Bintz** Jacob Bintz, Department of Health.

**Dr. Watkins** Kevin Watkins, member of the council.

**Dr. Friedrich** Marcus Friedrich, member of the council.

**Dr. Torres** Anderson Torres, member of the council.

**Mr. Thomas** Hugh Thomas, member the council.

**Ms. Farrell** Lindsay Farrell, member of the council and the committee.

**Dr. Eisenstein** Larry Eisenstein, member of the council and the committee.

**Dr. Soffel** Denise Soffel, member of the council and the committee.

**Ms. Cozzens** Kimberly Cozzens, Cardiac Services Program.

**Dr. Schenone** Aldo Schenone, Department of Health and a speaker today.

**Ms. Monroe** We have Abbie Guisbond who will be trying to fill the shoes for Jackie when she leaves us for a while. We'll be seeing her.

**Ms. Monroe** Sorry to interrupt you, Gene. I just thought you should do that.

**Dr. Heslin** No, no, thank you so much for doing that, Ms. Monroe. I do appreciate that.

**Dr. Heslin** We're putting up some technical things on the screen, if we can get it up on the screen. The request from the committee previously was that the Health Planning Committee wanted to see the retrospective work that had worked on in the recent past to have some understanding of the types of things that had been covered by both the committee itself and also the Public Health Council and then the department. I'm going to talk about the first one for just a second. That's the one that actually is going to become the topic of today. PCI, which we'll define later for everybody, and we'll have a discussion about was initially started in New York State around 2000. There've been multiple iterations of changes to the rule sets over time, and that'll be talked about today as well in presentation. Back in 2018 was the most recent change to that set of regulations updated, and that was done through the department, through something called a regulatory modernization initiative and then through the Codes Committee. The regulatory modernization initiative was built out of planning at the time. That's why that one's on the list.

**Dr. Heslin** I'll turn it over to Ms. Sheltry to talk about the others.

**Ms. Sheltry** Thanks Dr. Heslin.

**Ms. Sheltry** I think unless there are specific questions from the members in relation to the prior work of the committee the main point of presenting this and putting in your meeting packets was in response to the questions and comments the members raised in December during our meeting about what the landscape was and if there were any unfilled policy topics the committee hadn't yet completed or taken on at all based on 2018 charges to the Health Planning Committee for different policy topics. I think overall what we really want to distress by presenting this in addition to the PCI history that Dr. Heslin just presented on is that there really has been substantial work that either this committee directly or through relationships with the Department of Health or via the PHHPC Codes Committee completed. Overall, other than I think one or two topics that are on this list which are ongoing in under active consideration by the Department of Health, there really aren't any big outstanding policy topics that the committee was charged with handling in 2018 that remain open. We were hoping to present this information for you to look at on your own or if any questions arise right now, but really to highlight the fact that we feel like the topic that Dr. Rugge and Ann will introduce in a few minutes here is really prime for the committee to consider because there isn't any large outstanding work. As Dr. Heslin mentioned, it really does, this new policy topic really does align with prior work that the full council and this committee helped on regarding cardiac catheterization procedures and modernization initiatives. With that set up, I think Dr. Heslin, and I will welcome any questions about any of the specific content that's in this packet, but really again, just trying to overview all of the work either this committee directly or indirectly has engaged in, and I think that the landscape is pretty open for the committee tackling new policy topics going forward.

**Dr. Eisenstein** Thank you.

**Dr. Eisenstein** I think that last comment was really important. If you look at all of these, many of us are newer members from the last couple of years. All of these date back to before the COVID-19 pandemic. Quite frankly, the world and especially the medical world has changed dramatically. I put forth, Mr. Chairman, perhaps we should evaluate what, especially if work hasn't been done or too much work hasn't invested in it. Perhaps some of these things, I have even looked at them are out of date or perhaps we as members have an opportunity to kind of relaunch what new priorities should be as six years in today's health care reformed world is dramatic. I just want to bring up that maybe the committee could have a time to evaluate what is worth moving forward on and perhaps the opportunity to bring up new concerns.

**Dr. Rugge** That kind of conversation will go along. In the meantime, what DOH and I gather even the Governor has brought to us is a priority issue that we need to address as soon as we can. Not to displace any other kinds of dialog or topics for opening possibilities. As you'll hear. PCI, which many of us never knew what that stood for until this committee is now on the to-do list. We like to believe that we have a lot to add, a lot of different opinions, perspectives, experience, and that will help to inform and secure the recommendations that come forward. As you can see from the previous retrospect review, we're not the first to deal of cardiac services or ambulatory surgery centers, but this is the continuing evolution. On the personal side, my best favorite example is when I started practicing at the hospital and the health center, the only way to get somebody's level of oxygen in the blood was to send them to the hospital lab, have them stick the femoral artery, draw some blood, send it to the laboratory, and the next day I'd get a report. These days patients do it whenever they want, all overnight, and sometimes through their wristwatch. That's the kind of change that we may be facing. Probably not doing it by wristwatch to do coronary procedures. We have to address all these. We have to make up for lost time, as you suggest, and try to keep going forward. This is probably not going to be our last discussion about cardiac services.

**Dr. Soffel** Hi. At our last Health Planning Committee meeting, we had a very lively conversation, I think people would agree on issues of the day, things we thought we should be thinking about, concerns, priorities. This was not on that list. I'm a little bit confused about why all the things that we had talked about have gotten pushed aside for the moment and this has come out of what feels like left field.

**Ms. Monroe** Can I comment on that, John?

**Dr. Rugge** What I like to believe is the committee discussions and the list making was, how to say this... A prod. It was showing that with our refreshed charge, we're ready to go to work. Because of that, the Health Department, the person of Dr. Heslin brought to us, Ann and me in the prep sessions, the importance of dealing with this particular change because it's due or maybe overdue. They feel if not necessary, it's certainly important for that discussion. Understanding that we depend upon the collegiality and the relationships that we have, professional. We thought, well, this is what we need to consider. If there's further discussion and there's time, we can certainly bring up other issues of concern. Only otherwise to say when we did the survey, there are a lot of issues out there. There was no single one that was really a dominant concern of everybody. Everybody has their experience and concerns, and so does Dr. Heslin and the Commissioner and the Governor. We need to work with them to get to a better place.

**Ms. Monroe** If I could add some context.

**Ms. Monroe** I, too, remember that meeting and what we talked about, the level of energy in the room. We're at a different place. It took a little while for me to get from there to here as well, and that might be helpful to share how that worked for me. We talked a lot about larger health policy issues that were important. As we, as John and I dug down into those, a lot of things have changed. The world has changed. We don't know how to approach some of those things. Also, the department has had some significant priorities set that we thought that we might be able to start with. It doesn't mean that we can't go into those, but it is important to do something where we can serve the purpose of the PHHPC Planning Committee to look at an issue, and it happens that this is the one that's come to us from all sides. What are the policy issues? What are the quality issues? What are fiduciary issues? What happens to hospitals who don't have these services anymore? What's the patient census for these? What's the reimbursement? Take a smaller issue that falls within the PHHPC parameters and say how can we make sure that that gets planned in a way that it's for the best interests of the people of New York? There's no other body within PHHPC to do that planning. It was a big shift, as I said, for me to go from A to B. I've had more time to do that. I respect the department and what priorities they want to set. I think together we can put as much into this issue in terms of what our responsibilities are under the charge that we might if we had taken them up really big issue in the light of everything that's happening externally. I'd like to share that with you as kind of my path to get from there to here. I understand it's kind of a... Wait a minute, how did we get here? Maybe that's helpful about how we got here, but we're here.

**Ms. Monroe** John, did you have something?

**Mr. Kraut** I'm sorry I can't be up there with you.

**Mr. Kraut** I just want to kind of amplify a little of what Ann and John said. When we had the educational retreat, we had a lot of ideas. You kind of put those together also in your last conversation. The issue here is trying to say there are so many issues in health care that we can confront. There was a lot of people who wanted to confront the economic payment for primary care and things. We tried to say what is in our purview. What's in our work stream as Ann had said? What does the department need to have done that requires PHHPC involvement? I think where we're coming down and when you see the things that we worked on, those are things that are dealing with, I guess what Dr. Eisenstein kind of was dealing with. These are contemporary issues that are impacted by a somewhat anachronistic health code. The kind of the requirement now or the need right now that is aligned with our mission and the department's needs is for the Planning Committee to go through aspects of that code that need to be revisited, aired out, possibly eliminated. We just did some changes to CON reform. This was one of those items that more and more care is moving outside of the hospitals. There are new systems of care that we're looking at. This is one of the things we need to get ahead of. We're going to be getting applications that deal with these issues. We essentially don't want to be flat-footed having not discussed them and developed a policy before we're confronted with those applications. I hope that helps a little. Look, it's a big list. We really want to focus on, I think dealing with a more contemporary health code that recognizes and maybe addresses some these issues that others have brought up as well.

**Ms. Monroe** Was there someone else?

**Dr. Heslin** May I add something, Mr. Chairman?

**Dr. Heslin** From the department's point of view, we welcome all ideas. I'll just say that straight out. One of the things I said at the last meeting and still maintain is we have to figure out how we're going to function as a Planning Committee and then how we move forward. While this seems like a narrower topic, it's ideal because it gives us the ability to learn how to address a topic, which we've never done before, at least in the last six years in a cohesive fashion. This is taking one part of the department, what Jackie and I work on, working with a whole different part of department, which is where others work, working with a larger group, which would be maybe the Cardiac Advisory Committee and other public, and then working with the different points of view within the committee to get that 360 view to come up with a series of information and recommendations that will guide how regulations can be written in a thoughtful way. We've not done that in a long time. While all the issues are important, having a tactical way of starting to function that is manageable is really an important thing. To what Mr. Kraut said, the future is very liquid right now in terms of what's happening in the health ecosystem. Tackling bigger policy topics while gratifying may or may not be successful because we don't control all pieces of that world. This is a world that we actually control that is necessary, that is timely based upon what's happening in the world, both from reimbursement and desire from the medical community, desire from the Governor's Office to look at this. There's a lot of stars aligned in terms of learning how to function, and that's kind of one of the reasons why we thought this was an ideal topic to bring at this point in time for this particular meeting.

**Dr. Rugge** As another observation or two, not to be too defensive. I think when we come to some of the slides, it'll be clear how even though this may seem narrow compared to all the big topics it's still complex. We depend on very careful research and findings, some of which is published, some of it is experienced as data available to us through state requirements. Getting to the place where we make the right set of decisions in terms of criteria, guidelines, is for some people life or death. Therefore, this is not a small little thing why we're bothering with it. This is an example of the kind of thing we should be doing and doing and doing.

**Ms. Monroe** Other comments from the committee members?

**Dr. Rugge** Discussion is very welcome.

**Ms. Monroe** Howard, did you have a comment or anything?

**Dr. Friedrich** Marcus Friedrich, member of the committee.

**Ms. Monroe** I'm sorry.

**Dr. Friedrich** That's fine.

**Dr. Friedrich** I was privileged to lead the regulatory modernization initiative in 2018, especially the cardiac recommendations. I just want to add what Dr. Heslin was saying. Because what we did at that time, it was a collaboration between DOH and also outside people who came together to discuss this topic. Mrs. Cozzens was there and also Ed Hannon presented, but it was the purpose of the regulatory modernization initiative to bring in different viewpoints. I'm glad that we are picking this up again, because I feel strongly that this is the right path going forward, first to discuss that here, but also give the committee the marching orders for further down the road topics that are immediate or need immediate attention going forward. Thank you.

**Dr. Rugge** We really are creating a model for going forward while making a decision that is complex and has not been addressed before in this state.

**Dr. Rugge** Other comments?

**Ms. Monroe** Yes, John, I'll ask.

**Ms. Monroe** Are there other comments?

**Ms. Monroe** Denise, you look like you want to say something.

**Dr. Soffel** I do. I am not sure, but I do.

**Dr. Soffel** For new members of the committee, we spent, this committee spent about a year and a half looking at questions around Emergency Department overcrowding, especially in dental care and how that affected ambulance backups and a whole series of issues, which was not an issue that had sprung organically from the committee. It had come also from the department, who said at the time just what Dr. Heslin just said now. This is an important issue. It's complicated. It's complex. We need to figure it out. Some of us spent a lot of time thinking about that, working about that, reading about it, and listening to experts speak about it. It feels to me like that work all came to nothing. My concern is that this committee becomes a place where we committee members take it very seriously, invest a lot of our time and our expertise, and then find that for reasons that are never fully explicated that the priorities have shifted. I mean, that's really my issue, having now been on this committee and watched this process happen.

**Dr. Heslin** The world continues to shift. While work is done everything is not always in this arena. Out of that work that was done, a number of things happened, and that actually made a difference. We are internally looking at pieces of what was produced by the committee, and the convening function of that committee, which has brought in other external groups to be able to focus against that. We can talk a little bit more about that, probably not today. I've talked a little about this at previous council meetings where a series of legislative packages got built out of the work that was done by that committee and at that time it would require legislative change. Now, all that didn't come back in a formalized way, but it did get reported out to the full council that we have that happen. There was a dental package in there. There is a package about licensure in there. There is a package about improving essential function by moving some work from State Education Department over to Department of Health. There is a package about improving workflow in offices to be able to free up licensure. All that came out of that work. We have looked at complex medical discharge from hospitals because fixing the front end requires fixing the back end. All that was stuff that is happening, but that's happening in the landscape of everything that's happening on the federal transition, plus what's happening within the state. We just recently opened up another 125, maybe 150 OMH beds in the last couple of months. I think it was announced two or three days ago. A lot of those type of things have happened because we focused not just the group on a very narrower topic, but we focused on this Emergency Department backup, which required a multidisciplinary approach to fix. A lot of that's been reported out at the council meetings. Maybe a failure that we need to learn from is to have a better reporting out at this meeting as to what the accomplishment was so that we put a closure to that, and hopefully maybe some of what I just said will help that. I'll take that as my failure. I should have done more of that. We'll learn and we'll do better.

**Ms. Monroe** I would just add that I think that whether there's outcomes from what we do, whether there's accountability for what we do is going to have a lot to do with us. How much we put expectations on the department and hold to those expectations that we're going to get a report at this meeting. We want to get that report at that meeting and see where we are. I think as committees that meet very infrequently and sometimes have changing membership, we can often let ourselves slack on some of those things. I think John and I certainly want to be accountable for outcomes from this group and also for follow-up from this room. We need you to help us be accountable to that. I do think that we have to take that responsibility and not put it all on the department.

**Dr. Rugge** I can't resist one more observation, and that is instead of coming so directly from the department, the concern about waiting times came from SEMSCO, State Emergency Medical Services Council. It was just quickly passed through to us, and I think in a well-meaning way. The distinction is this is coming to us with the administration committed to this kind of change and feeling they need us to get the best outcome and the most secure pathway to better help. That's just an aspect, it's not the whole story, but here we are.

**Dr. Heslin** I'm going to just say one final thing.

**Dr. Heslin** If you went through that process, it was very loosely run. It took an extraordinary amount of time. We probably didn't spend it as wisely as we should. That's the committee, the department, and the way we did things. One of the reasons why we're very intentional and attention to detail in terms of this process. We don't want to end up in that type of quagmire. We want to end up with a successful way of being able to express ourselves. That's why I keep focusing on what's the process. Because last time, the process was sort of an organic growing octopus. This time looking to have a better way of having a way to do things. The next topic comes along, we have that way, and we improve. We keep iterating on better ways. Last time wasn't as good, this time will be better, ten times from now we'll have forgotten this time and have to reinvent the wheel again and then it'll be even better.

**Dr. Rugge** I can't help myself but one more comment.

**Dr. Rugge** Last time I think we were there as college people learning, undergraduates trying to feel our way not yet having developed a new charge but knowing we've got places to go. We're experiencing this issue as real graduates. We have a lot under our belt and ways to be more confident that will be important to the process and that we will be appreciated because of who we are.

**Dr. Heslin** Ms. Monroe.

**Ms. Monroe** I do want to go back to Dr. Eisenstein's point about this list of things that were completed six years ago or not completed. I think that one of our tasks for the next meeting is to really scrub this list about what are the gems in there that may be time for relook. This PCI happens to be one of them, but that's not how it got to us. It got to us separately from this list. What's in here that we think is critical to be moved forward for PHHPC to do its job in health policy? We will put this list, again, on the agenda next time, but for discussion and kind of probing rather than just sharing. Is that fair?

**Dr. Rugge** Give us a lot of reason to talk.



**Dr. Rugge** Any more thoughts, reflections would be very welcome.

**Dr. Heslin** I want to close one other issue down before it gets brought up, which is that we also said we were going to take a look at regulatory issues. We are working on that. We have worked with the different various associations, hospitals, nursing homes, FQHCs to ask them to give us a list of topics. We've also taken it internal to the department to give a look at the different regulations that might be either antiquated or not relevant to current practice and are trying to put that list together. As you know, Public Health Law, which was in a book that was about a half inch wide about thirty years ago is in about twenty books along the length of this table and is an incredibly intricate octopus of implications and so working our way through all of those pieces to come back to the council and planning to start to look at that. We haven't forgotten that. It's just not on the top end in terms of having something that we could work on today that was relevant and necessary.

**Dr. Eisenstein** Just to clarify, you know, Dr. Rugge, I don't think any of us thought of this topic as a small or unnecessary topic. It just came at us out of left field in the sense that at our last meeting, you and Ms. Monroe asked us to put our thoughts in writing. As to what Dr. Heslin just said, for those of us here, we come from incredibly varied backgrounds in healthcare and as a committee and even the state can't fix something if they don't know what's broken or what the problems are. I think that if we're asked to spend our time putting forth what we see as concerns from our unique expertise and viewpoints, I would hope that the conversations on this committee are not only a pre-chosen list, but that as committee members we have an opportunity to have our concerns heard and at least considered. I obviously understand that not everybody's every thought can be evaluated and that we don't have time or ability to do that. In the process I do think if you ask us what we see as concerns, somewhere there's got to be an opportunity for evaluation. It may be as simple as you speak with Dr. Heslin about what's practical or what the state sees as a priority or not. A lot of people put a lot of time into the work, and it shouldn't just be ignored and left out.

**Ms. Monroe** Your points well taken.

**Dr. Rugge** I think it's one more demonstration of the need for this new charge, so we know what we're doing.

**Ms. Monroe** Is there anything else about kind of this shift in focus or about our expectations of each other or of the department before we get into the next issue?

**Ms. Monroe** Well, it's important, even if we have nothing left to say that we can all dig in on this issue and bring our best to it, because if we stand back and just feel it's maybe not important enough or not one that we're interested in will not get the best out of each of us and therefore out of all of us. I'm looking forward to robust discussion and a lot of questions. I didn't even know what PCI was when it came up. I maybe if not the only person here. I think we should be able to share all of our comments and questions about this topic to get the best.

**Ms. Monroe** Are we all in this together?

**Ms. Monroe** I see a lot of nods.

**Dr. Rugge** Just going on to the next little item, or maybe it's not so little on the agenda. Thinking, again explicitly about our charge and how that emerged from all those other

activities that all didn't work out as planned. I'm not going to read the whole thing. It says the Health Planning Committee in consultation with the Commissioner of Health. This is a necessary partnership that we can add a lot, but we can't do it all by way of proposing new changes or doing all the evaluations or finding all the data. That's one issue. That the recommendations are regarding emerging health and healthcare issues and initiatives. Good example. This is something that couldn't have been considered ten years ago. Here we are catching up now, but not too late. We're able to fulfill our responsibilities through membership expertise, data and research, stakeholder engagement, and consultation with other relevant state agencies, advisory committees, and regulatory bodies. We have a broad reach, and having this topic will be a good model, I hope for how we proceed with other issues too. The discussion was supposed to be after all that, but I think we've had a pretty good discussion so far.

**Ms. Monroe** I'm fine, unless people have anything else, we'll move on.

**Ms. Monroe** We want to hear from others and that will be the next step in the process after today. As you listen to the folks from the department, who are the folks outside the department outside of state government that we think we need to hear from in order to have a fulsome picture of this issue? Keep that in mind as you listen to our guests.

**Ms. Monroe** Are you introducing them, or would you like me to?

**Dr. Rugge** We've got a little work to do before that. That is choosing our topic and the purpose. We may have covered that pretty well so far. Again, we talked about percutaneous cardiac interventions, coronary interventions as important and a good example of how the healthcare system is changing. No doubt we'll have other topics that we need to bring up. I certainly would hope this committee and the council will be influential in determining where to go next. Background discussions, I think will be important. Purpose. This may be pretty obvious, but we're looking for safe and cost-effective care with necessary and important backup service. It has to be done the best it can in the ambulatory setting, but if something goes wrong, again, we need to know they're swift. Transportation, swift readiness to take any further medical action that may be necessary for life saving. This is not a simple process or a simple procedure, medical procedure. As Ann has already suggested, along the way, I would imagine we'll come up with the side effects. What does this mean for the hospitals? What does it mean for patients? Where will our providers be located? Those are the implications of the decision making we're expected to assist with.

**Ms. Monroe** We have two guests from the department. Let me introduce them briefly. They'll talk a little bit about PCI, what it is, where it's being done, what does the state know about how effective it is. In that discussion, you want to be looking at what else do we need to know, and from whom else might we get that. We have with us from the Cardiac Services Program and the Cardiac Advisory Committee, we have Dr. Alda Osinaga and Kimberly Cozzens. Now if I put you with the wrong title or department, forgive me, you can correct that. We're going to listen to this and then Gene is going to talk about the relevance to patients and delivery system. That's where we want to be thinking about alternatives. Let me turn it over to them. After Gene talks about the topic relevance, we'll also hear from the Office of Health Insurance Program Susan Schmidt and Ron Bass about the reimbursement overview. How is this paid for? Is it paid for differently in hospitals, certain hospitals than others? We'll get a pretty full picture of how the department views this issue and its various complications.

**Ms. Monroe** Let me turn it over to you.

**Dr. Osinaga** Thank you.

**Dr. Osinaga** Good afternoon, everybody. We were asked to come to the committee to discuss our Cardiac Services Program and the Cardiac Advisory Committee. Kim and I, unfortunately we weren't here at your last committee meeting. We know here that you've been talking about PCI. You'll see our first slide is about PCI. You might all know about all this, but we'll go through what this is. We wanted to start off our discussion first about PCI, and then we'll move on to talk about what our Cardiac Services Program is and what our Cardiac Advisory Committee and who they are, and really to give you an overview of what we do in the department in this space.

**Dr. Osinaga** Oh, thank you. I didn't print out all the slides. I didn't realize they'd be behind me. Thank you.

**Dr. Osinaga** The slide I'm showing here says percutaneous coronary intervention. You've been all referring it to as PCI. It sounds like you have an idea of what this is, but I'll just go through this. It just might be an overview for you. I wanted to first point out here on the first bullet here, it talks about cardiac catheterization. It talks diagnostic or interventional. We'll make a distinction in our presentation about this. Specifically, when you look at our regulations on this topic it talks about cardiac categorization. Today here, we're talking about cardiac catheterization of the coronary arteries. We talk about it in two different spaces, on the diagnostic side and on the interventional side. When we say diagnostic catheterized in this context, we're talking about a catheterization procedure that has been done to diagnose whether there is a blockage or a narrowing in the coronary arteries. Intervention would be same thing, catheterization to look at the coronary arteries, but in this case to see if you need an intervention, if you needed treatment for it. You've gone in, you see that there's a narrowing, you see there's blockage, and you're going to do a treatment. That treatment could be your stent. You can go in and you can dilate. You can open it up, the stent would be left in permanently. It is just to regain and make sure the blood has flowed to the heart. When we talk about the coronary arteries, your blood pumps the blood out to your body, but the blood in itself is a muscle. It's an organ. It needs oxygen. The coronal arteries are the ones that feed and supply oxygen to the heart. Other words for PCIs are coronary angioplasty, coronary stenting. I think the other main point we wanted to make here is that this isn't surgery. This is a non-surgical minimally invasive procedure. You access these coronary arteries by going in through a distal blood vessel either usually on the wrist, the arm, or in the groin. It's done in a day. It's done currently in New York State only in hospitals. The most common reason you would get, one would get a PCI, or a diagnostic catheterization is if they have chest pain or you have an abnormal stress test, you want to see if you have coronary artery disease. This is when this is done. It's not on the slide. It's done when a person has a myocardial infarction and a heart attack to go in and do an intervention to provide some therapy. At least that's our starting point for what a PCI is.

**Dr. Osinaga** We can go to the next slide.

**Dr. Osinaga** This slide is about specifically our Cardiac Reporting System, but this is also... I'm going to take a moment here to talk about our Cardiac Services Program. Kim Cozzens sitting next to me is our Director of our Cardiac Services Program. I work in the department. I work in an office here. It's called Office of Health Services Quality and Analytics. We do a lot of quality and analytics, data analysis of a variety of different

conditions and actually an equality around either in hospitals and managed care plans. One of the things we do is that we work with the Cardiac Services Program, which is not part of the department. The Cardiac Service Program is located in the University of Albany and what was formerly known as the School of Public Health and the College of Integrated Health Sciences, now it's known as that. We've had a partnership with the Cardiac Services Program for years. Kim is the Director there. I work in here in the department. Part of what the Cardiac Services Program does, much like what my office does is think about data and analysis. One of the major functions of the Cardia Services Program is to collect data on the cardiac procedures that are performed in New York State. Not only does the Cardio Services Program collect that data, but they analyze that data, they validate that data. Kim will talk a little bit more about that later here in the presentation. The other thing that the Cardiac Services Program does is it staffs our Cardiac Advisory Committee, which also Kim will talk about. This slide is specifically talking about the data collection. This is what we wanted to make sure everybody here understands what's available to you, right? As you're thinking about this question of whether PCI should go into Ambulatory Surgery Centers, what is the data that we already collect on this? Here on the slide, you'll see, we have three different reporting systems where hospitals report to the department report to the Cardiac Services Program about the cardiac procedures, their specific cardiac procedures. The first one on the bullet up here is the Cardiac Surgery Reporting System. It's for adult. It's the first reporting system that was established here. It was established back in 1989. We have a wealth of data for this. This receipt was on cardiac surgeries, cardiac surgery such as a cabbage, cardiac surgery such a valve repair, valve replacement. The second registry you'll see here, which was established after the adult, it's the pediatric. The pediatric is also for cardiac surgeries. You would also get data from surgeries that were done for congenital heart defects. The third one you see here is the registry data on PCIs. We collect data on the PCIs that are performed in the hospitals in New York State. I say that it's just PCIs, because the thing I wanted to let everybody know is we do not have data and diagnostic catheterization. We talked about on the first slide, right? There's a whole bunch of catheterizations that are just done for diagnosis. Some of those diagnostic catheterization will convert into a PCI. During that time, you go in as a diagnosis and then you say, I can do a treatment. We would get it if it's a PCI, but not if it is just a diagnostic. We don't have data on that. We do for right now on the PCI. I think that's something just for you all to keep in mind. You can see here that all New York State hospitals that perform these procedures need to submit data for each and every case.

**Dr. Osinaga** I see we have a question, Dr. Berliner.

**Dr. Berliner** Do we know what the number of diagnostic PCIs compared to the interventional?

**Dr. Osinaga** This is actually good, Dr. Berliner, because I was going to pass it on to Kimberly, that you knew somehow at this point to talk to you about what kinds of data we collect. We actually looked into this question for you.

**Ms. Monroe** Any questions, any other questions?

**Ms. Farrell** Do other states gather this data similarly? Do we compare with other states?

**Ms. Cozzens** There are some other states that do public reporting, which I'm going to talk about. They don't have clinical registries in the same way that we do. They might use administrative data. They might use professional society registries, such as from the

Society for Thoracic Surgery, or from the ACC, which is American College of Cardiology. There are some, but they don't do it in exactly the same that we do.

**Dr. Friedrich** Dr. Osunaga and Mrs. Cozzens, can you talk a little bit about the cardiac reporting? I don't know if you will talk about that because as I understand it, it is unique, and the data is available for everybody to see. Maybe you can also talk a bit about how far down, what level the data is available these procedures.

**Ms. Cozzens** Perfect segue into the next slide.

**Ms. Monroe** Well, let's just see if there are any other.

**Ms. Monroe** I had a question about can any hospital do this? Do you need a special license or a special certification? Could any hospital today do PCI?

**Ms. Cozzens** There is a certificate of need required for PCI. You do need to be certified for both the diagnostic actually and the interventions is controlled through the Certificate of Need process.

**Dr. Berliner** Excuse me. Are there any hospitals that are not certified in the state?

**Ms. Cozzens** Yes.

**Ms. Monroe** We see those at PHHPC?

**Dr. Heslin** Yeah, cardiac cath lab. It will come through as a cardiac cath lab. You do see and have approved every single cardiac cath lab that has come through.

**Ms. Monroe** Thank you.

**Dr. Berliner** We haven't seen one in years.

**Dr. Heslin** Well, that's... Well... That's right.

**Ms. Monroe** Anything else?

**Ms. Monroe** Please go on.

**Ms. Cozzens** Thank you.

**Ms. Cozzens** One of the things that we do with the data, it's a great opportunity to speak with you and tell you about the data. Our data collection includes demographic information, risk factors and comorbidities for every single one of these procedures that are performed. We also get procedural information. We learn about major events or complications that happen inside the hospital. Because of the granularity of the data that we collect, we're able to match that data to SPARCS, the administrative data to get additional information such as readmissions or follow-up non-cardiac procedures that may take place. We're also able to match to vital statistics so that we're to get mortality that happens outside the hospital. Within thirty days, for example is the main outcome that we look at in our report. We do have public reports for the PCI the adults and the pediatrics. In those reports, we show risk adjusted outcomes for hospitals that perform the procedures. These are available to patients, their families, referring physicians. They're also really used by the

hospitals themselves to assess their own performance. The other really I think important way that we use the data beyond the public report is that we engage with hospitals directly in their QI activities. These are through some regular feedback reports. We take the data, package it, and feed it back to them so that they can look at their progress or their status over time. We also have processes where we look at data to see if we might be noticing elevated mortality rates. That would be a time when we would interact more directly with the hospital to engage with them around their QI processes and opportunities for improvement.

**Ms. Farrell** Do you have the physician-specific data?

**Ms. Cozzens** We do have physician-specific data, yes. We publish for cardiac surgery and for it will be non-emergency PCI at the physician level.

**Dr. Eisenstein** You're talking about the data that you get. My question is how is compliance? What happens if people don't report this? Is there an opportunity? I would think maybe the people who do a wonderful job are happy to report. Where there's been problems may be less so. What is your responsibility in enforcing this? Basically, I'm asking how accurate is the data you're going to show us?

**Ms. Cozzens** The data, the reporting systems are in regulation. The hospitals are required to report the data. In part, because these services are related through CON and then kind of approved by the department, there's some leverage there that they really need to do complete and accurate reporting. We have a very robust system of data auditing and data review to look for accuracy, including at the chart level, medical record documentation review. We use the SPARCS data as sort of a double check, so an external validation that what has been reported to us is complete. We have different kinds of information, but we can check that they're in agreement based on what's reported to us and what's recorded to SPARCS.

**Dr. Eisenstein** Are there consequences if you feel there's a gap? I know it's in regulation, but what happens if somebody doesn't report? I'm trying to make sure that what you're going to present to us is accurate.

**Ms. Cozzens** Really, it's a cooperative system. It's been a long time since we've had to use the sort of leverage of the department in terms of interacting with that hospital to find them in lack of compliance. Certainly, those avenues are open to us if there are reporting problems.

**Ms. Monroe** Dr. Watkins.

**Dr. Watkins** You speak of the SPARCS data, but the SPARCS data that we get is somewhat outdated. It's pretty old. The report that you're going to give us today, how old is that data that you'll present to us today?

**Ms. Cozzens** Sure.

**Ms. Cozzens** What I'm mostly going to talk to you about really is just an introduction to our system. I would say ongoing challenges that we have is how quickly we're able to send out those reports and make those publicly available. Right now, the report online is for 2019 outcomes, the 2021 report is in the production process, and we anticipate it will be out

soon, followed shortly by 2022. We had a gap because of COVID, there was suspension of data reporting around COVID, so we're still in a bit of a catch-up period from that.

**Dr. Osinaga** Can you want to talk about the reports that we do to the hospitals directly? Because that's more timely.

**Ms. Cozzens** Sure.

**Ms. Cozzens** On those QI opportunities I mentioned where we interact with hospitals, we do that on a semi-annual basis. They report their data within three months at the end of a quarter, and then we review that twice a year to look for elevated mortality. Our QI work when we're engaging with hospitals around their outcomes, we use the raw data, so it hasn't been completely validated yet. We haven't matched it to external sources, but it's turned out to be a good opportunity really do a nearly real-time check of how things are going at the hospital level.

**Ms. Monroe** Dr. Berliner.

**Dr. Berliner** This may be a little off topic, but it seems to me that there was a time when the report of the Cardiac Surgery Committee was almost front-page news across the state. St. Francis was always number one. There was a hospital, I think one of the big AMCs in New York that was at the bottom, which created quite the stir. They had a hire a new Chair. I mean, you remind me about COVID, which I had forgotten about. Is that the reason we haven't seen any reporting about this? Because I think it goes before COVID as well.

**Ms. Cozzens** I think there has been somewhat of a change in the way it's been received and published in the media. Of course, in the early days, New York State was the first and only sort of public reporting around cardiac or lots of other things. We were really, New York State was a leader in this area by many years. I would say it's much more newsworthy at that time when you couldn't just Google and come up with sixteen different rating systems. I think that's a little bit of why it's less frequently in the press.

**Dr. Berliner** Just to go to something that Dr. Eisenstein mentioned, when we first started, when New York State first started doing this. There was a lot of reporting, a lot of academic research that said that serious cases were being shipped out of state because no one wanted to take a really serious case and get bad numbers. I don't know if that's still reflected in the data. I don't know if because everyone else is now doing it, that's kind of like a reciprocal tariff, if you will, pardon the expression. It's all evened out.

**Ms. Cozzens** That is one of the known kind of concerns or critiques of public reporting is that it could encourage risk averse behavior. That's something that the Cardiac Advisory Committee which I'll talk about in just a minute is very sensitive to. We've taken some steps to kind of mitigate those risks, particularly in the area of PCI where these procedures for some patients are done on an emergency basis. A patient that's having a heart attack, they say time is muscle. There's maybe less time to be evaluating. You especially in those moments don't want your provider to be thinking about if it could have a negative effect on their public reporting. We also know that in those cases outcomes might be less individually provider dependent and it reflects also the whole entire care team. We've done a few things around those emergency PCI patients in public reporting. We've introduced exclusions from the public reporting, so refractory cardiogenic shock patients, patients that have anoxic brain injury criteria, so they've had a cardiac arrest and are in a coma-like

condition before the PCI. Those patients are excluded from our public reporting. Additionally, we are now transitioning so that at the physician level, emergency cases will not be reported for their results. We're just going to have non-emergency cases at the physician level. That is something that is a concern. We've been really aware of and thoughtful around.

**Dr. Berliner** Thank you.

**Dr. Friedrich** I just want to mention something, Dr. Berliner, what you mentioned. I haven't followed the cardiac, the work of the Cardiac Advisory Committee. This is, like, really a great success story because the variation that was there in the early days of reporting between hospitals where there was a five-fold, six-fold mortality rate. The latest, the differentiation between all the hospitals that are doing that in New York is miniscule. It really talks to the value of public reporting in this space and also the work that the department is doing by collecting the data going forward. You mentioned something, and I hope you will get into that. Why is risk adjusting so important? I feel this is like a really important topic where there is also a lot of pushback in the media from that and discussion point overall. Why is that so important to risk adjust data when you talk about reporting?

**Ms. Cozzens** That's a great question. We know that patients come in for their procedure with a whole host of variation of their level of pre-existing conditions, for example. They might have differences in the acuity, how immediately sick they are, but they might come in with a lot of differences in terms of things like diabetes or peripheral vascular disease or how kinds of other procedures that they've had. Patients are very different. We know that they're not randomly distributed around hospitals. Some hospitals may have a sicker patient population in general. To do really fair outcomes assessment, we need to adjust for those differences in patients so that we're comparing apples to apples instead of apples to oranges in a nutshell is how we do that.

**Ms. Monroe** Dr. Rugge.

**Dr. Rugge** Would you be able to share with us the number of cardiac casts in the state on an annual basis, number of PCIs? Is there a trend? Are there more over time or not so much?

**Ms. Cozzens** That's a great question. For PCI, in 2024, there were about 52,000 PCIs. We do not have, unfortunately, good numbers about the number of diagnostic cath. As was mentioned, we don't collect data for diagnostic cath up until 2018/2019, we did an overall hospital summary report. It was not the same robust quality data that we're talking about for PCIs, but it was a number that they reported to us. If we go back and look at 2018, which is the last time we had that data, because of COVID, we discontinued the data collection. At that time, there were 102,000 diagnostic caths performed, just diagnostic. There were another 46,000 or so that were done at the same time as PCI. The patient goes into the cath lab, they do a diagnostic procedure, and then in the same lab visit before leaving, they do an intervention. We're talking around 150,000 total caths a year.

**Ms. Monroe** Quickly, before, I know Gene has something he wants to ask. Are we talking about both diagnostic and interventional, and should we be looking at them separately when we're evaluating whether it makes sense to move them into the community? Is that something you would recommend is that we look at them separately?



**Ms. Cozzens** I think that's one of the questions that would definitely need to be thought about, how that would be approached from a policy and eventually regulatory perspective.

**Dr. Berliner** Can you tell us what the difference is between the two?

**Ms. Cozzens** Between a diagnostic and a PCI? Sure. A diagnostic is...they're just trying to. Do you want to take this? I'm not a doctor. I could do it in non-doctor terms, but if you want to.

**Dr. Osinaga** I'll try it and then if it doesn't work, Kim will give it a go. Well, when we talk about a diagnostic cath in the sense of looking at your coronary arteries it is to go in to look if there are any blockages in any of your coronal arteries. You don't go in with an intent to potentially do an intervention. You're going into a look. You can look at other things outside of your coronary arteries. You can at how well the blood is pumping. You can see if you've got high blood pressure, pressures in some of your other blood vessels. You can see what your valves are. There are different reasons for doing a diagnostic catheterization. You're going in there just to see what you have, to see if have a diagnosis, to see if you have an explanation for the reason a patient presents with something. Can we explain it by whatever the results are from the diagnostic cath? When it's an interventional catheterization, it is going in there either you've gone in with a diagnostic and then you see something that can be intervened on, and you make a treatment. You go in specifically knowing, I know I'm going to see something. I know I'm going to have to make an intervention. I make an intervention. What I mean by an intervention is I'm go in there. I'm going to open up some narrowing of an artery. I'm going to go in and I'm going to put in a stent. If something is done, then it's your PCI. Both of those things are currently not allowed to be performed outside of a hospital. They go hand in hand, right? Because Kim just explained a lot of times you go in with a diagnostic, and then it converts into a PCI. To be able to look at them both, I think you have to look at them in this question.

**Dr. Berliner** When the council first allowed some hospitals to do just diagnostic PCIs, which were mostly what John would call, outside the beltway hospitals, one of the members of the council would use to make a very strong point that the hospital had to make sure to tell the patients if they were getting a diagnostic PCI, that in fact, if something turned up, they would then have to be transferred to another hospital and go through the process all over again. Not that there was anything wrong with, but just that they should be aware that if they're going to a place that can only do diagnostic, they may have to have more done.

**Dr. Osinaga** That's true and that's a great point.

**Ms. Monroe** Is that still the case today?

**Dr. Osinaga** If there are places that only do diagnostic tests, that would be the same case today.

**Dr. Watkins** I would think a less invasive diagnostic test would probably be like a CT angiogram, one that would be a lot less risk involved. Is there a level of diagnostic evaluations that you can do with a CT angiogram versus going in through an artery, for instance?

**Dr. Osinaga** You can do different tests to look at your coronary arteries without having to go in with a catheterization and with that meaning puncture through the skin with a tube

into your blood vessels and going through. You're right. You can do other non-catheterization tests to see if there is coronary artery disease.

**Ms. Monroe** Hugh Thomas.

**Mr. Thomas** There's a lot of history around this table today. I just wanted to just do a check on some history. Cath labs, historically, at least in my career, were licensed in hospitals that did open heart surgery. That was rare that hospitals without an open-heart program were permitted to run a cath lab. There's been a modernization of cath lab licensure, as I recall. You all can test me on this, which has made it much more efficient, easier for hospitals that don't have open heart surgery programs to operate cath labs. As the science and the technology has improved, the regulations have modernized along the way. I guess the questions I'm listening to today is, is there a facility need? Is there a lack of capacity that would cause the department and ultimately the PHHPC and this committee to modernize again and authorize or license either diagnostic or interventional cath in surgery centers? Longitudinally, I've been around big heart programs, and I've run surgery centers. I just want to understand the philosophy a little bit.

**Dr. Heslin** I'll handle this. I had them put up the next slide because you were so apropos in going through the history. I just had to have the history slide go up. Thank you for explaining about the data. Just to say a word about the data for a second. It's the most robust data set in the entire country. It's so robust, it is literally referenced in every single article that is written on this subject in the entire country, every single one. It is unique in what we have and yet as Dr. Osinaga pointed out, it has its limitations because we don't have the diagnostics in there. I'll just reflect back as a primary care doc, the patients of mine that used to have diagnostics were really high risk that we knew were going end up probably having vessel surgery, like open heart vessel surgery. They wanted to know what was going on. Were really low risk that they still needed to do the cath, but they didn't think we're going to go on for an intervention, needed to have some piece of information. That's how, at least back in the day, we used to risk stratify doing a diagnostic where a PCI splitting those two apart, diagnostic being one procedure and PCI being a separate procedure, one being diagnosis, one being intervention. Maybe we need to think about it using the word intervention and diagnosis, so we don't conflate the two together. To your point, we've been approached by cardiac groups, multiple throughout the state, talking about this in terms of an access issue. We've also been approached hospitals saying that they need to be using their cath labs for other things. Those cath labs can't handle all the capacity coming at them with diagnostic and interventions and need to use for more complicated types of interventions in there. We've been approached by both ends of the industry asking the question. What about the next step in moving these types of procedures from one place to the next? We've actually tested in the areas where the clinical groups have approached us and talked to those hospitals in those areas and asked them, what do you think? They're like that will be okay. We actually wouldn't mind having that happen. Now that might not be everywhere in the state. That will have to be something to be thought about, but it is actually an issue where both sides might actually agree.

**Ms. Farrell** Who looks at the economics of this? Again, concerned if you build it, they will come. It's a lucrative profit center. It's my understanding it's a lucrative profit center for most hospitals. They're all vying to sort of get the cath lab. In our market, one's always trying to knock out the other, right? They want their share of the business locally. I know it's highly competitive. Who's looking at it from the economic standpoint?

**Ms. Monroe** Well, I would just say that we should be looking at it from an economic standpoint here, looking at the tradeoffs. That's part of the data that we need to be getting and people we need to hear from.

**Ms. Farrell** There wasn't an indication for a stent, but there were lots of stents anyway, right? Who's looking at that? I'm assuming that's data that you all would have.

**Dr. Heslin** One of the great things about the data is years ago there were lots of people doing caths for all sorts of weird reasons, tons of them. Because the data set was so robust, that's how we were able to work and build a set of rules that I think was ultimately established as national standards in terms of how and what should be an indication to have a catheterization and that work was done by Ms. Cozzens and the School of Public Health, that cardiac group. That happened all because of the data that was collected in New York.

**Ms. Farrell** Again, just to follow on, again, I'm very familiar with the Dartmouth Atlas that looks at disparities in activity across the country, for example. Are we doing that similarly in New York State with respect to our various markets and regions?

**Ms. Cozzens** I think when new programs are approved that is definitely one of the things that is considered as part of that Certificate of Need evaluation is what is the volume per hospital, what are other... What's the need in that area? The overuse question is I think a really important one. As Dr. Heslin mentioned, it is one that we a few years back spent a lot of time and effort looking at around PCI. There's what's called appropriate use criteria for PCI interventions in particular. We were able to use our data to identify a fair proportion of PCIs that were done that appeared not to be meeting that criteria. Again, that was an area where we published the data. We fed that data back to hospitals. It kind of created a little splash. It made some attention. We did see shortly after that, and I don't think we can take entire responsibility for it. It was sort of a real professional society evaluation. We did see some changes in at least what's reported in terms of the indication for patients that are getting these procedures. This slide does speak to some of the history of where PCI has been performed in New York State. It goes all the way back to in 1999. Really before 2000 PCI was performed at centers only with cardiac surgery. We had one little outlier that had a shared program, but really PCI only at centers with cardiac surgery. In 2000, the department started allowing these time-limited waivers. It was started with just a very few hospitals where they were able to perform what's called primary PCI, which is PCI for a very specific kind of heart attack. Again, one where the evidence shows that really a quick intervention is lifesaving. In those circumstances, a few hospitals were allowed to begin performing PCI just for those emergency cases. This was part of a really robust quality monitoring and oversight program. Every six months, their data was reviewed closely and in combination with insight from the Cardiac Advisory Committee. We looked at things like mortalities, major events that happened in the hospital as well as transfers. Hospitals at that time were also required to be enrolled in a multi-state trial that was going on that was really setting the groundwork for establishing the safety of performing PCIs without onsite cardiac surgery backup. We went along like that for a few years. The number of hospitals performing PCI increased. Around 2007 it was expanded yet again so that instead of just those very emergency cases, hospitals could do full-service PCI. They had to do the emergencies. They could also take on elective cases too. Again, that was followed with a period of very close monitoring and oversight during that time-limited waiver. In 2009, you can see sort of in the middle section of this graph, there were regulatory revisions that allowed hospitals without PCI on-site to perform PCI subject to a CON approval. By that time around 2009, it was up to fifty-seven hospitals performing PCI. Our number of cardiac

surgery centers has been pretty stable, thirty-five plus or minus over the years. 2019 was the Regulatory Modernization Initiative, which was further changes in the Certificate of Need process that really allowed more hospitals to be approved for PCI without cardiac surgery on site. You can see there at the end, there's been further growth in the number of hospitals that are performing PCI. In 2024, there were seventy-eight hospitals altogether. There are still a few hospitals that are approved to perform diagnostic cath only, although most of the hospitals that at one time perform diagnostic cath have either closed their cath labs or become PCI centers.

**Ms. Cozzens** Next slide, please.

**Ms. Monroe** Dr. Eisenstein.

**Dr. Eisenstein** I'll wait. She'll probably address it.

**Ms. Cozzens** We mentioned the Cardiac Advisory Committee. We in the Cardio Services Program work as staff to the Cardiac Advisory Committee, which is an advisory body to the Commissioner of Health. We've included the regulation here that establishes who they are and what they do, but we have physicians and professionals with expertise in cardiac that are appointed by the Commissioner. They can advise the Commissioner and the department more generally on any matter related to cardiac services included but not limited to review of existing and prospective services. She'll advise all matters and advise the Commissioner thereon. This was formally established as a Commissioner's advisory body in 1974. They were really instrumental in the initiation of the cardiac surgery and PCI reporting systems that we talked about in 1989. They continue to this day to give us clinical guidance around our data collection and reporting, as well advising on issues of policy for the department. We did have Cardiac Advisory Committee members that were active in the Regulatory Modernization Initiative in 2019. We have members from inside New York State, as well outside New York State, which is a really nice balance to the committee, because it means that we have people that are very familiar with the landscape of providing care in New York State. It's mostly cardiac surgeons and cardiologists, but we have at times had members from other related disciplines. We have those people that are working with and affected by our reporting system and our regulations, and they know the landscape very well. Then those out-of-state members provide us some balance and knowledge of what's going on in other areas of the country as well. It is important to just emphasize that the CAC is an advisory body. They're not making policy. They are giving advice and recommendations to the department.

**Ms. Cozzens** Next slide, please.

**Ms. Cozzens** So just to finish up, you know, if this is something that as this committee moves forward, we're thinking of some ways that the Cardiac Advisory Committee may be useful to you in this process or may be able to share some expertise. This would be in areas like sharing insight from those other states where PCI is performed already in Ambulatory Surgery Centers. We know that the literature on this is very, very limited, extremely limited, but it is done in other states and so with those out of state members and their roles in larger professional societies we can get some insights from them. Also, they can be helpful with those clinical issues around how might you set selection criteria for cases to be performed in this new setting. They could help with identification of safety and quality metrics for outcome evaluation and perhaps even in that evaluation itself.

**Ms. Monroe** Larry.

**Dr. Eisenstein** Yes, thank you.

**Dr. Eisenstein** You brought up a point that I was going to raise before. We've heard a lot of different factors that we should be considering. We heard about access. We all agree that's important. We heard it about finances. That's really important. When I was preparing for this meeting and saw this topic on the agenda, first day of medical school popped into my head, first do no harm. The first obvious question was, is this safe? This kind of goes back even to Dr. Friedrich's of is it safe for everybody? I did a literature search myself. What I found was exactly what you described. There's really very little literature on it, although there is guidance and recommendations on it. I just hope that the committee would think of this in a sense, and I haven't taken a position here. I'm just trying to get the facts out. I certainly wouldn't want to sign on to something that turns out to not be safe as we create policy. That's a really important bullet, that the published literature is very limited. The standard of care in medicine is evidence-based research. I'm hopeful that we will see data that gives us a little bit more comfort in that. That's an important acknowledgement. Thank you.

**Ms. Monroe** Dr. Friedrich.

**Dr. Friedrich** I also have a couple of data questions that I assume that you maybe take notes and would provide us that data at some point. What is the length of stay for typical cardiac patient undergoing PCI in the hospitals currently? What are the most common adverse effects that is going back to what Dr. Eisenstein was mentioning about safety. What are the adverse events that are happening? I don't know if the department is collecting that on a basis, but that would be important to understand as well.

**Ms. Cozzens** I don't have exact data on that, but I can give you a little bit of a sense about that, particularly as it relates to PCI. As you continue to think about this topic, one of the things from those guidelines that do exist, not studies of evaluation, but there are guidelines. They describe sort of a low-risk patient where this might be considered. When we try to look at what those low-risk patients might look like compared to the data that we have for those that are performed in hospitals, we see about 40% of those patients spend the night in the hospital. The other 60% of what we can approximate as being very low risk go in, have their PCI, and go home on the same day.

**Dr. Heslin** What's being asked here is really good questions because that's going to be part of what next steps are going to have to be. The full expectation was not to actually go through a ton of data today, but to get the questions asked to come back to how we start to think about next steps. The first step was to get everybody sort of on a level playing field to even know what PCI is versus a diagnostic, versus inpatient, versus outpatient, versus ambulatory, versus ambulatory surgery center, and get terminology and phraseology to be consistent. The second step is to then start doing exactly what everybody's doing, which is to ask questions. The third step is to start to gather those pieces. I want Ms. Cozzens and Dr. Osinaga, they prepared for one thing. They didn't prepare for the rest of this. Thankfully, they overprepared so they knew what was coming. That's going to be a future state discussion as well.

**Ms. Monroe** I have a question.

**Ms. Monroe** Is the question of whether or not this should be done in Ambulatory Surgery Centers on your agendas? Have you been looking at that within your areas?

**Dr. Osinaga** This question also came up to us. I will say from our perspective, you've heard a lot that we deal with data and we're quality. Kim and I have been looking at this with the Cardiac Services Program and the rest of my team in my office of how we would evaluate this if this was to, if we were to open up PCIs to be allowed in the Ambulatory Surgery Centers, like how would we evaluate that? What kinds of types of data would we need? How much data would we need? How long would we have to collect it to have enough numbers to figure out if we could see differences? What kind of complications would we want to look at? That's a perspective that we have been looking at to see how we would evaluate to get to this question of is it safe? To add to what's already been said, there are guidelines that came out that CMS started to reimburse for this. Guidelines came out to be able to say something about how this should how providers should handle PCIs and AACs. They make an acknowledgement there that there is an assumption that has to be made that an Ambulatory Surgery Center would have about the same outcomes as a hospital without cardiac surgery, because that's where the majority of the data is. I wanted to bring that up here, because there is such limited actual research in the PCI is happening in Ambulatory Surgery Centers and where there's more data is in hospitals without cardiac surgery. Are those equivalent, right? Can you say that the outcomes you have in one would be the same as in outcomes in the other? Can you that the outcome you would have for a PCI in a hospital without cardiac would be the same outcomes for PCI in an Ambulatory Surgery Center?

**Ms. Monroe** How many states currently allow PCIs in Ambulatory Surgery Centers?

**Dr. Heslin** It's about 40% of the country right now. 40% to the country has them. That's about twenty states. This was the next subject, Number C on the agenda, which is the relevance to New York State and the health care delivery system. We've covered bunches of this throughout the discussion. This might be a little shorter.

**Dr. Friedrich** The other question that I think is important is the nature of the Ambulatory Surgical Centers. As I understand here in New York, every Ambulatory Surgery Center is somewhat affiliated with the hospital. Is there like an assumption as well that the hospital would provide backup services if something would happen in terms of adverse events or not? Can the transfer agreement be to a hospital without cardiac surgery or not? Should there be a limit on how far the Ambulatory Surgical Center should be away from the hospital with cardiac services and so forth? I think those are questions that might be important when we talk about safety for the population.

**Ms. Monroe** Denise and then Howard.

**Dr. Soffel** I'm thinking back to the early days of coronary artery bypass surgery and the relationship between volume and outcome for cabbage. Does that same relationship between the volume and the outcome exist on the PCI situation? Is it a place that does 5,000 going to have better outcomes than a place that does 25?

**Ms. Cozzens** We've actually used New York data. This goes back to around the time of that Regulatory Modernization Initiative and looked at that. We found that the volume outcome relationship is not as strong in PCI as either it used to be or as it was in those early coronary artery bypass graft surgery studies. Actually, where the sort of inflection point of that quality difference is at a very high volume. When we were asked to give some input for volume thresholds for new programs, it really was at a point where we saw a quality and outcome relationship was at point much higher than would be a reasonable

threshold for to start out a new program. I don't have the number off the top of my head, but in the thousands of cases. It was quite high.

**Dr. Berliner** We currently license ASCs to be either single specialty or multi-specialty. If it's a multi-specialty ASC, which means, as I understand it, that it can pretty much do anything. Would it have to go through a CON review if this were to become a real thing, or certainly every single specialty? ASC would have to do it because none of them can do this now. That would be a ton of work. I mean, because there's a lot of them. I'm wondering about the multi-specialty ones in particular and what kinds of regulations might apply to them.

**Dr. Heslin** These are great questions, because you're jumping to what would be considered a phase three in this process, right? I'm going to talk a little bit about the relevance of the topic. We did talk about that a minute ago with Mr. Thomas. But just to reiterate for a second, we're being approached by industry about this. This was started in 2021 as a payment discussion with CMS. CMS put a payment code in place for this. About 40% of the states in the country are currently doing some form of this. As you can imagine, if that was started in 2021 or 2022, it is limited but growing and that's why there isn't a lot of data on this. All the points that have been asked about whether or not you should start with a diagnostic or an intervention, whether it should be single or multi-specialty, what's the CON, what are the quality indicators that we should be looking at, what can we look at now because we already collected, what do we have to develop to collect other quality indicators are all... The nature and affiliation thing that Dr. Friedrich brought up are all guardrails. That's part of what the Planning Committee has to look at. We have to either be able to get data on those subjects, say we don't have that data and need to develop it, and then decide what are the guardrails that the Planning Committee is going to suggest to the department through the eyes of consumers, people that run and administrate centers, hospitals, outpatient world and payers, frankly. That's all of what's around this table. Once we get those recommendations, that's how you craft a regulation. It would be easy to craft a regulation. I guarantee you; we might get it wrong. It's a longer process to be able to do it through this committee but gives us the 360 view of opinion of people that are subject matter experts. That's exactly why we're coming to Planning to have us get a guardrail set of advisements to be able to then craft the appropriate regulation. There's no preconceived decision about is it going to be just diagnostic first? We started with hospitals that didn't have thoracic programs before they went to doing interventions, right? There's no pre-conceived notion about it being only in thoracic surgery hospitals. None of that stuff is there. We haven't even said. Well, we know it's going to be a CON process because the hospitals are required to do a CON process now. Article 28's are required to do the CON processes. We're pretty sure it's going to be CON, but you guys may say, listen, we think it should just be a free-for-all. I doubt that.

**All** (Laughing)

**Dr. Heslin** The industry's going to push. It's not so much that we're going to probably not say, we're going to have a full no. There has to be appropriate guard rails and thoughtful discussion of how to move forward. The one thing that came up earlier that Ms. Farrell brought up was about impact and finances. Mr. Kraut covered this, I think, at one of the last meetings, which was there was great fear and trepidation when we moved from hospitals that had thoracic surgeons to be able to do diagnostics that didn't have those people to do diagnostics. The hospitals were going to crash and burn because it wasn't going to be possible to survive without having it in this narrow group. That just wasn't true. The next thing happened; we went to PCI in those places. Again, it was that the whole

world was going to crush and burn because we were going decimate the industry. That wasn't truth. What we did was we have some of the best access in the country at this point in time because the way we have thoughtfully rolled the program out. I'll bet a nickel because I never bet more than that. The Ms. Cozzens data will show that we have some of best quality in the county as well. We do follow it. We do work with our hospitals. We do pay attention to it. We have done this very thoughtful way of doing things. What we're dependent upon from the health care delivery system side, from the New York State patient side, and also from the department side is to have this group do that 360 view to make thoughtful suggestions about what could be a good guardrail, or what frankly might be a bad guardrail. The goal is to build a good program that has good access, that doesn't have so much regulatory burden that we cripple the industry in being able to move forward. Our aging population is really... You know, we're getting older. I have a birthday coming up this month. I'm getting older.

**All** (Laughing)

**Dr. Heslin** We know that there are cardiac things that happen to older people, more so than younger people like atrial fibrillation. Atrial fibrillation, one of the treatments is doing catheterization procedures. 15% of the population over the age of 75 has fib, atrial fib relation. Sorry, jargon. I should stay away from it. As more people are having that and more places have to deal with that complicated issue, we have to find a place for these other issues that have been, as technology has improved safe with appropriate guardrails to be able to grow the industry as we have for the last twenty-five years. I was supposed to cover relevance and delivery system. I'll entertain questions

**Ms. Monroe** I think we have a couple of questions here.

**Ms. Monroe** Dr. Torres.

**Dr. Torres** Dr. Heslin, in my household we would say that you're in your future birthday coming up yet you're better seasoned.

**All** (Laughing)

**Dr. Heslin** Just as long as I'm not over-seasoned.

**All** (Laughing)

**Dr. Torres** You know, I've had a flood of thoughts here. I think that it's very important for us to also look at character and competence as we've raised at many meetings. I think it's important for to us to really get to know who the players are, how committed they are, how their mission aligns to the skill set and delivery. You're going to get a lot of other folks that may be very much interested in the bottom line, right? The dollar, which is nothing wrong with that. How do you deliver care with compassion and with a certain skill set? When you look at certain communities throughout our wonderful state, you're going to have a prevalence of certain illnesses and diagnoses that will be disproportionate to some of the communities and how is that going to be addressed. I think it's important to really get to know the player.

**Dr. Ortiz** Two things to think about. One is, you know, I agree with Dr. Torres. We have to think about what it looks like when we read the Certificate of Need applications in terms of geographical boundaries, in terms quality indicators of care, right? I'm looking at both



depth and spread. My concern, as the nurse on this committee is that New York State is down 40,000 nurses, right? Each year, until 2032, the U.S. is going to be down to 193,000 nurses a year. Not total, but a year. Right now, if SUNY doubled every school of nursing enrollment, we would still not meet those numbers. As you can see, I start doing the math in my head. There are about 600,000 medical surgical nurses in the country out of 3.1 million nurses, 600,00 then practice in surgical type settings. You figure we start looking at operating room nurses, purely surgical nurses, I start worrying about who is going to care for these people. I am all for people practicing to the full extent of their license. At some point, nurses need to be in an acute care setting to take care of patients in a very adequate way. If the ambulatory care setting is going to... If we're going to move this to the ambulator care setting, then what I would like to see is a guardrail of the what if. Are they equipped to handle whatever complications may emerge or the transportation time to the nearest acute care setting? I worry about like the workload burden. Yes, we have the nurse-to-patient ratio law in the state, but I would venture to say we have lots of variances and violations of it that happen weekly because there just aren't enough nurses.

**Ms. Monroe** All of these things are really going to be food for our thinking. I appreciate that there are hospitals who would like to free up the cath lab to do other mystery activities. I also know a hospital isn't a hospital. We have safety net hospitals. We have rural access hospitals. When we start to look at the impact of all this stuff on hospitals, I want to that we can break down the types of hospitals so that we'd better understand the impact on perhaps a safety net hospital where this is a big piece of their income. It would move into the private sector. We've known with Ambulatory Surgery Centers that their desire to serve Medicaid is far below where we would like to see it. Well, what will this do to that? I think while guardrails are really important, there are some fundamental questions about whether this is the right thing to do at all. I want to make sure we leave that open. Not as, boy, we're naysayers, and we're not wanting to do what the department does. I don't think we're doing our job if we say, oh, well, we want to do it. How do we make it look good or do it right? It may be that in certain areas of the state this is not a good idea. It may be for certain populations this not a good idea. I just want to keep us open to the full range of possible recommendations, because we're going to be the only ones looking at this in any depth or dimension. I just wanted to add that.

**Mr. Thomas** Thank you.

**Mr. Thomas** You make a great point. All the options...I'm not on the committee, but if I were I'd want to hear about all the options. I'm sorry to talk so much, folks. It is a topic I would say we had a lot of interest in you can tell. Back to your comments Gene, the economics, and Lindsay's, which are great. This is a terrific slide. The evolution of the volumes and the way they've gone on. I can almost track the profitability of that line of business in my own mind, because I have that knowledge. It's definitely flattened out. The outcomes have remained really strong. What comes to my mind is entrepreneurial or proprietary surgery centers or hospital and system control surgery centers, et cetera. It's all fine. They do a good job. They're efficient. There's a profit potential in a proprietary surgery center that's different than a not-for-profit control. I am not casting aspersions. It's just the reality. The good news is, though, at least from my chair, listening to our colleagues today is we have a lot of data in this state about cath lab utilization and procedural, over procedurally, and we've learned. I lived that with a couple doctors. The good thing is we had the data set gene that's fantastic to allow us to monitor. post-decision, whatever the decision is. If it is to open this up, we have the data that would help us provide those guardrails. That's very, really well-regarded data. It'd be very difficult to refute. Just a couple of thoughts. Thank you.

**Dr. Heslin** Just a comment.

**Dr. Heslin** We haven't even gotten as far, and all these are perfect comments. We haven't even gotten as far as is this going to start as a demonstration? I mean, there's a lot of different ways to exert guardrails as we think these things through. I put a lot of stuff on the table. There is no wrong discussion today, because this is putting stuff on a table. You know, I look at it, Dr. Ortiz, from the point of view of that right now only 49% of licensed nurses in New York State work in clinical settings. This might be an opportunity to bring people in because they have a different type of functionality that have a skill set. We have to think about it in that very broad view. It's not the right answer. is just another way to think through those components. We have many things we have to tackle. Workforce is clearly one of them. I so appreciate you bringing up that structural piece because that's a real issue.

**Dr. Ortiz** My concern is that I don't want nurses to be looked at as a nurse is a nurse is a nurse, right? 49% are in clinical settings. That means 50 some percent are not. Their skill set would have to be modified. You can't go from family medicine to a different specialty without some type of new residency and training. What would that look like? What I don't want to happen is that the agency tells us what that is. I want us to follow the AORN or the Medical Service to get nurses guidelines, and we build those in and see how the agency can meet them. I would feel fine about it. I would need something in there to say how not only is it going to protect patients, but it also has to protect the nurse, right?

**Ms. Farrell** I just want to encourage the use of the CMS data. I happen to look at it in preparation for this meeting. Obviously, there's a lot of it. I think it's fairly available. Again, as care moves out of the hospital it costs a lot less. Because I'm trying to provide health insurance coverage for all of my employees and that's a pretty bitter pill to swallow these days. I mean, the escalation rates are just unbelievable that again, making care more affordable makes it much more accessible ideally, right? The constraints in the network are placed by the managed care plan. I think we should use our partners in managed care who are excellent aggregators of our system, as well as CMS.

**Ms. Monroe** Gene, you want to go on then?

**Dr. Heslin** Well, I was done with my part, and I just think that I'm excited. I just have to say that this is a very cool room today. I'm pretty excited. I'm going to turn it over, I believe online we have from the Department of Health, Office of Health Insurance Programs, which is the Medicaid program. Some people to be able to speak a little bit about reimbursement as an overview for this.

**Dr. Heslin** Do we have our screen on?

**Ms. Monroe** How are we doing that?

**Dr. Heslin** That screen.

**Dr. Heslin** This is Susan Schmid. She works in Office of Health Insurance Programs.

**Dr. Heslin** You want to introduce yourself, Susan.

**Ms. Schmid** Hi. I'm Susan Schmid. I am a registered nurse. I'm the Healthcare Surveyor. I worked for Ron Bass in the Office of Health Insurance Programs in the Bureau of Medical and Dental Policy. I am the clinical lead for the reference file unit. We are the unit which basically adds all of the codes and all of payment structure for how fee for service physicians get paid within New York State Medicaid and from which most of the Medicaid managed care plans draw from.

**Mr. Bass** Good afternoon. This is Alan Bass. I'm the Bureau Director for Medical and Dental Policy. I have to apologize because I just tried to link or connect to my video, and it doesn't seem to be working.

**Mr. Bass** Do you want to take it away and provide a little bit of background on PCI and, I guess, Medicare and Medicaid?

**Ms. Schmid** DOH regulations limit PCI to the hospital-based ambulatory surgery setting. It is not permitted in Article 28, freestanding ambulatory surgery settings. Medicaid covers PCI. We are silent on setting. However, the expectation is that providers provide services in accordance with DOH regulation. Medicare has no published limits in place. They will reimburse PCI in either the hospital-based ambulatory surgery or freestanding ambulatory surgery settings. However, each individual state regulates where the services may be provided. Medicare has a payment differential in place, Medicare will reimburse a higher amount for PCI performed in a hospital-based ambulatory surgery setting versus a freestanding ambulatory surgery setting. As noted previously in accordance with DOH regulation, in New York State, PCI can only be provided in a hospital-based ambulatory surgery setting at this time.

**Mr. Bass** And of course, we also cover it on the inpatient side. I think that's a given.

**Ms. Monroe** Would you like us to ask questions if we have them?

**Ms. Schmid** Yes, that is the next bullet on my slide in front of me is questions.

**Dr. Rugge** Just curious about the difference in reimbursement rate from the ambulatory settings in a hospital and the inpatient settings. Is that significant?

**Mr. Bass** Yeah, two different payment methodologies. The inpatient, I think, would be significantly higher than the ambulatory surgery setting. We can get numbers on that in general terms, but it would be higher on the inpatient side.

**Mr. Bass** You know, inpatient is APR, DRG's. On the clinic side, ambulatory surgery is paid through of APG's, ambulatory payment risk.

**Dr. Rugge** It would seem this is one of the consequences of going ambulatory. It would be nice to have kind of the statewide data in terms of what the implications are for clinical care, but also for cost effectiveness.

**Ms. Monroe** Other questions?

**Dr. Soffel** Can you speak to on the Medicare side, the difference between the freestanding versus hospital-based surgery centers? I think I heard you say that there is a differential.

**Mr. Bass** Yes, there is a payment differential, but that's interesting. Medicare does recognize and does reimburse for PCI in both settings. In New York State, because it's limited to the hospital answered setting. There's only one payment here on the Medicare side.

**Dr. Soffel** I figured that there was sort of national information, but I understand we don't do it in New York, so you don't know. I get it.

**Dr. Heslin** That's a good question to take back, and we should be able to pull that out. As you know, Medicare pays differently all over the country. There's not a rate for Medicare. In fact, Medicare pay differently all over New York State based upon different factors. The number we can get would be kind of a general number with a delta, right.

**Dr. Heslin** It may be a factor of one and a half in certain parts of the state versus .5 in other parts of state. There's a huge variation in Medicare reimbursement depending upon where you are in the state and the country.

**Ms. Monroe** Is that true for the Medicaid payment as well? Is there such a wide variation across the state for PCI?

**Ms. Schmid** If you're talking about professional payment versus APG payment, APG is weighted and it's weighted based on Downstate and Upstate.

**Ms. Schmid** Professional payment, so professional claims to doctors are paid based off of one of the region's Medicare fee schedules, one of New York State region's Medicare fee schedules and a percentage of that.

**Mr. Bass** For a physician, it's a statewide payment rate. There's no differential, regardless of where the physician is located.

**Dr. Heslin** The procedure group is a... APG stands for procedure group. That is paid differently in different parts of New York State related to the Medicare groups. I think there are four maybe five different Medicare groupings that are in New York State going from New York City to the North Country.

**Ms. Monroe** Well, the reason I ask that, and maybe it is another thing to put on our list is in a particular region a hospital is at a certain rate and the APG is at certain rate. If you go to another region they're different, but are they advantaged in one region as opposed to another? I see two heads shaking. I think we'll explore that at some point.

**Dr. Heslin** That's the way the entire system works. In fact, recently, last year, Senator Schumer got a statute passed that actually increased the rates for much of Upstate New York, which was a huge benefit, because the rate that was being paid to Upstate was substantially different. That change resulted in benefit to a lot of struggling institutions. This is true throughout the entire country. We can do a little education on Medicare. Essentially, in a nutshell, Medicare pays one dollar across the board to everywhere in the country. Some people get a dollar and a half, and other people get half a dollar, and that's the way Medicare works.

**Ms. Monroe** I was thinking more of Medicaid and even commercial. Going back to the question of is it an advantage to move to Ambulance Surgery Center? I realize it may just be too complicated and too individualistic to draw any conclusions.

**Ms. Monroe** Anyone else have questions?

**Mr. Bass** You know, on the Medicaid side, there is an Upstate base rate, and then there's a New York City base rate. That's for APG's ambulatory surgery. There is a hospital OPD and Surg base rate. Again, Upstate versus Downstate and the Downstate rate is higher than the Upstate rate. You got two separate rates, one for Downstate one for Upstate and that would apply to both for clinic services as well as hemorrhagic surgery. As it turns out for PCI, there would be none reimbursed or covered for the freestanding clinic. Again, the pre-sanding clinic reimbursed a lower base rate than hospital feedings which have a higher base rate.

**Dr. Heslin** And at the end of the day, if we do proceed forward, then obviously, since Medicare reimburses for this, Medicaid would follow suit. We will be changing the regulations. That's what the whole discussion is today.

**Ms. Monroe** Are there other questions or comments for these folks, because my guess is we'll see you again as our discussions go on.

**Ms. Monroe** Did you have something, Howard?

**Dr. Berliner** No.

**Dr. Eisenstein** Well, we're talking about the financial implications of this. In the very beginning, Dr. Heslin talked about that the state has been approached by provider groups and others asking for this. I don't think that approach would happen unless there was financial or ease of work or some reasons, but I do think we need to explore the motive of those groups and see how that ties into this.

**Dr. Heslin** Actually, believe it or not, it was hospital group that approached us first about this because they had capacity issues. It was then physician groups and different parts of the state have approached at different portions of time. It's been a mixed bag as to where the approach came from.

**Dr. Berliner** It would be interesting to know. I mean, if hospitals are saying that they have a capacity issue when PCI is taking up too much of the capacity. Does that mean it's not paying enough relative to other procedures that they'd like to see more of? That's why they wanted to camp them from the hospital setting? I think it would be useful to hear from different types of hospitals in different areas to see what they're doing about it, how they feel about it.

**Dr. Heslin** I think that's probably a good point. It's mixed bag. I would think about it the opposite way, though, just as a thought, which is that they can't do some of these higher-end procedures and are looking at how they triage to be able to care for their population. You can't take a higher-end procedure and move it somewhere else. You have to figure out how to triage, to be able care for a change in population. That's the way I think about it anyway.

**Dr. Ruge** I think that's it.

**Ms. Monroe** We'll be back to you at another meeting.

**Dr. Rugge** Hopefully, everybody has had an opportunity to look at this presentation. I think it's very helpful and quite elegant in terms of our knowing what we're doing when and when we can declare that we've reached a settlement to go on to the next phase will be very important. That will be by consensus as I see it. Gene has already covered the first. We need some learning sessions. I think that's just about started. There will be more. We need to identify those people, those officials, those experts, those additions, who can really fill us in on all the implications, certainly including clinical, but also financial. This is going to take more than one meeting. How often will we have our meetings? What's the expectation by when phase one will be completed? Has Dr. Heslin worked all that out?

**Dr. Heslin** I was going to say next meeting we should be all done and ready to write regs, but there were a lot of questions that were asked today, and a lot very good points brought up. We're going to have to go back and look. To do this comprehensively, we're going to aggregate the questions, comments, thoughts, and discussions, then we have to talk to the groups, talk to other groups, and then bring them back in a thoughtful way. I mean, we just scratched the surface today in a discussion. We spent two hours doing that scratch of the surface. Part of it will depend upon how deep the committee wants to go. If we go deep, this will take two years or more.

**Dr. Heslin** Think about the subjects when you talk about quality, talk about single multi-specialty, you talk CON, you talked about nature and affiliation, you talk about financial incentive, disincentive, you talk about regions of the state, you talk about demonstration, non-demonstration. All of those could be fifteen minutes to multi-hour discussions. The committee has to give us a little understanding how deep they want to go. Depth will determine time, right? Because that requires us to go back to the groups that are going to be the subject matter experts to provide information. We haven't even gotten to the Cardiac Advisory Committee giving us their thoughts and their technical expertise. That's a whole half a meeting all by itself.

**Dr. Heslin** Well, that's a question for you guys.

**Dr. Heslin** That's the question for this group because I can answer how people get to their comfort levels.

**Dr. Ortiz** If they're working groups, do they have to still be held here? I'm just thinking of like if we're going to break up in the groups, can we Zoom those or are these all have to be official meetings? Like everything, like even if like three or four of us meet to discuss.

**Dr. Rugge** Aren't we glad that we have a small little topic, easy to assess. Aren't we glad we have such a quiet group of people around the table who just accept what we're told and not worry too much.

**All** (Laughing)

**Dr. Heslin** In terms of education, I think that a couple of things are going to have to happen. It's going to probably be iterative because it's going to be education and input from key stakeholders. It's got to be together. Phase I and Phase II are really a together step. As we get information and input from key stake holders, we're going to be educating at the same time. That's going to be an integrated step. I would suggest that what we're to end up having to do is we have capacity to handle issues, we may need to have sooner than the annual every two-month meeting, if you will. We're amenable to having more frequent meetings as we have the capacity to be able to bring groups and subject matter

experts in. We don't have any of that prepared right now. We prepared for today's meeting over the last couple months to be to get to this point. Are we going forward? It seems like we're going to go forward and have the discussion. Unless there's a strong no in the room, I think that's probably where we're going. We can start to sequence some of this to get to a place where the committee is looking at where do we do it? How do we do it? Who does it? What are the implications? What are guardrails? What's the data we want to have to be able to do a feedback loop to make sure we're getting to the spot we get to? We have to get to those points. If we start at this, these are the points we need to get to and reverse engineer the project backwards that will give us a better understanding of the timeline. I think that's probably the best way to do this in building a critical path.

**Dr. Friedrich** We have our retreat also planned for the end of May, if I'm not mistaken. It was on the calendar. It was a one-time thing. I am not sure.

**All** (Laughing)

**Dr. Friedrich** I thought that that is an ongoing thing. Otherwise, we could have used some of the time there to do that. Maybe this is like a way of spending a day together and trying to get the evidence and the data all together at a central point and trying figure this out.

**Ms. Farrell** Colleen is rolling her eyes in pain.

**All** (Laughing)

**Dr. Rugge** What I recall is in 2012, as we were getting started doing pretty comprehensive CON reform, the most meetings we had were seven in two months. There's a lot of flexibility here, but we have to decide as a group what's going to work the best. I think, as we've already been doing looking at the agenda ahead and making sure that we've got our questions all lined up will be another way to be speedy but also be thorough.

**Dr. Eisenstein** You know, even if it does take two years, as long as we're making progress. We're talking about if we get this wrong, people can die. I don't care how long it takes. I want to be satisfied that all the concerns and questions we have an answer to so we can make an educated, safe decision.

**Dr. Berliner** Would be required for this would have to go through the legislature, right?

**Dr. Heslin** This is a regulatory issue.

**Dr. Berliner** I want to agree with Frederick. We should either do this as a long day or two days and condense two years maybe into a couple of months because if hospitals need this and if ambulatory surgery centers need or want this, waiting two years just seems like a bit much and who knows what's going to change in the interim.

**Dr. Rugge** We have, I think, two responsibilities. One is we have to be very thorough, very careful. The other is we need to be timely as the systems keep changing so we're not looking at one issue when everything else is exploding.

**Ms. Monroe** Dr. Ortiz.

**Dr. Ortiz** In order to not to reinvent the wheel, it would be wonderful if at one of those educational sessions, your team could show us. It's a state or two that you think they're

doing it pretty good, right? No one's going to be excellent in the first couple of years. A structure from which we can see of how it could maybe possibly fit into ours. If there are aspects of it that we can tease out and move the processes and regulations along, then I don't see why we wouldn't do that. I would really want to see what other good states are doing for their outcomes.

**Dr. Heslin** To Dr. Berliner's point, it would be wonderful to do one or two days. However, there is a certain amount of workforce issues in our ability to produce the information. I'm going to suggest that we probably are going to have a hybrid sequential where we have gathering and moving forward. As we get towards the more robust discussion, having a longer time frame to maybe do that sort of thing. That's easier to plan because it's hard to get that short. To Dr. Ortiz's point, I think that's a great idea to look at other states. I mean, there is a national guideline that's out at this point in time, but many other states do not have CON processes. There's only a de minimis number of states that actually use the CON process at this time. Some of them have regulations. Some of them just reference the federal government. It's a mixed bag out there, which is why that data sometimes is a little difficult to assess. We can try to see if we can come up with some best practices out there. That'll take a little time to be able to do that forensic look.

**Dr. Rugge** As we merge Phase I and Phase II and are taking a look at our agendas in advance, I think informing DOH leadership and copying the rest of us in terms of ideas, key stakeholders, experts. There may be people at this table who have really good information and contacts we should use. All the work is not done just in the meeting. It's done by preparing and sharing our best experience. No pressure.

**Ms. Monroe** I think that the, what's on this slide is Phase I learning sessions, of which today was one, right? Identifying key stakeholders could really be combined. It's the key stakeholders who have a lot of that information, even if it comes just from their perspective. I would think we might be able to after today. I've made a lot of notes about topics related to this we want to hear from people about. Hospitals are a good example. What subgroups of hospitals? We can figure out how to make the learning sessions combined with the stakeholder sessions, so that tees us up for what do we want to do then with all of that data and information. That's, you're right, Gene, where the intense work with comments in.

**Dr. Heslin** I think that's part of it is, is that this is an iterative process. You have to take people from a place. Why I suggested the hybrid way of doing this is that if you do it all in one session, you're going to get burnt up and burnt out. If you have time to percolate on it and go back to your environment and work through it for a period of time, you are going to have a better process. That's the final push though. I love the pictures because Phase I and Phase II boxes are the same size. The Phase III box is bigger because that box depicts where the real work is going to be done. It was completely intentionally, unintentionally done that way. I just love it.

**Dr. Rugge** One of the decisions we can all look forward to is deciding when we have had enough input and experience to go to Phase III.

**Dr. Eisenstein** Dr. Rugge and Ms. Monroe, is it your intention for just, this is an internal committee question, that this is the sole work of this committee until this is resolved? Do you intend to take on any of the other issues that have come up while we're in process of this?



**Dr. Rugge** Well, this is certainly the major. Does major represent 75%, 98%, 99.99%? I think we'll be living that out.

**Ms. Monroe** I might just put a little different perspective on that. I think as we move one issue along from one phase to the next. I mean, these phases are probably what we'll want to do with whatever the next topic is. As you move to Phase III with this topic, we can start a Phase I with the next one.

**Dr. Heslin** That's what we had outlined at the last meeting was we would bring and bring things along. The critical factor will be is that we are a support team of one and a half. So why has been brought on is to assist while Ms. Sheltry is on maternity leave. We're right now at one and a bit more or two, we are going to go back to one and so that's our resource.

**Ms. Monroe** I will say, and perhaps we don't need to decide it now, but back when we met last time, we had some kind of considerations about whether we should pick a topic, if you recall that. Was there anyone on the committee that would want to be part of the leadership on this issue, other than John and I, or in addition to John and I... Or maybe other than John and I. I don't know. The point is if any of you feel strongly enough about this that you'd like to be more involved in helping to frame these things, the department would welcome it and certainly John and would as well. We don't expect you to jump up today but think about it if you would. We can always use more developmental work.

**Dr. Rugge** Along the way, we're fortunate that Dr. Heslin has no other work to do.

**Dr. Rugge** Moving along on the pages, so is that it?

**Ms. Monroe** Well.

**Dr. Rugge** We're getting close. Here are the committee roles that we need to do by way of identifying information.

**Ms. Monroe** I think we...

**Dr. Rugge** We've covered all that.

**Ms. Monroe** We've gone through this pretty much.

**Dr. Rugge** It is something of the timetable. Once we have our recommendations, there is yet more time to take, which is necessary. We have recommendations to present to the Codes Committee likely to the full council eventually. Publication is a proposed regulation so that the public and the experts can see it with a sixty-day comment period. A review of all those comments and then either presentation for adoption by the council or another forty-five days for more input. There are decisions to make all along. I think that's something we can do together as we experience the process.

**Ms. Monroe** I think that's important to remember, because even after we've done all our hard work, it's not going to happen right away, even if we see exactly how it should work. That's where we might want to look at, do we want to recommend it in a pilot phase, in a demonstration project, do want to go forward with a complete change of regulation? What's the implementation process for whatever we come up with?

**Dr. Rugge** Or develop specialized criteria for the initial set. That's more work for us to do, knowing we're doing it in conjunction and in collaboration with our colleagues in DOH who have serious responsibility for sure. The ongoing assessment continues. We will have a responsibility to look at how this is working out, how we've done by doing these assessments. On a continuing basis, just as the healthcare system is changing, we need to continuously monitor what is going on and look for further changes that may be necessary, either because the delivery and the finance is changing or because we didn't grade it quite right. We need to be open in any case. I would say, a couple of years before all this is done. We'll work as fast as we can. Maybe not. Maybe we can go faster.

**Ms. Monroe** Before we end today, I think you were at that point, John.

**Ms. Monroe** Are there any comments? I know we started the meeting with people going, what happened to where we were and where we are, and we still feel commitment to those ideas that came out? Do you feel there's a path now that we can follow with this that will have both substance and meaning for the people of New York?

**Dr. Rugge** And setting precedent so that we know what to do next when the next topic is developed.

**Ms. Monroe** Well, I know a few of you are here who are not on the committee, but you're more than welcome to join the committee.

**Dr. Rugge** No, we expect you to be here at every meeting.

**Dr. Heslin** I'd nominate him for the committee and be part of the leadership group.

**Dr. Rugge** Yes, absolutely.

**Dr. Rugge** Again, what was demonstrated I think today was the range of experience and the number of questions that no one person or two or three could bring up. We need that. Again, I'm sensing lots of receptivity, lots of interest in what everybody is considering and that is something we also depend upon.

**Dr. Heslin** I just want to do two things at the end, and I'm going to take the last one minute to do it. I want to publicly thank Dr. Osinaga and Ms. Cozzens, who presented today the lion's share of what we had brought to you as well as Mr. Bass as well. That work is in addition to what they normally do. We're grateful to have them here. We'll enthusiastically invite them back, because they'll be core. I also want to thank Dr. Musa, who's not able to be here today, but was part of the support team of this. All of this is due to Ms. Sheltry. She's the one who is the backbone who put all this together. We wish her well in her upcoming time and look forward to seeing her when she gets back.

**All** (Clapping)