

NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
COMMITTEE ON CODES, REGULATIONS AND LEGISLATION MEETING
June 18, 2025, 9:00 AM
90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

Mr. Holt Good morning. I'm Tom Holt, Chair of the Committee on Codes, Regulations and Legislation. I have the privilege to call to order the Codes Committee and welcome members, participants and observers. I'd like to remind council members, staff and the audience that this meeting is subject to the Open Meeting Law and is broadcast over the internet. The webcasts are accessed at the Department of Health's website. The On Demand webcast will be available no later than seven days after the meeting for a minimum of thirty days, and then a copy will be retained in the department for four months. There are some suggestions or ground rules to follow to make this meeting successful. Because there are synchronized captioning, it's important that people do not talk over each other. Captioning cannot be done correctly with two people speaking at the same time. The first time you speak, please state your name and briefly identify yourself as a council member or DOH staff. This will be of assistance to the broadcasting company to record this meeting. Please note that microphones are hot mics, meaning that they pick up every sound. I therefore ask that you avoid rustling of papers next to the microphone and also be sensitive about personal conversations or sidebars as the microphones can pick up that chatter. As a reminder for our audience, there's a form that needs to be filled out before you enter the meeting room, which records your attendance at these meetings. It's required by the Commission on Ethics and Lobbying in the Government and in accordance with Executive Law Section 166. The form is also posted on the Department of Health's website under Certificate of Need, so in the future you can fill out the form prior to council meetings. We thank you for your cooperation in fulfilling our duties as prescribed by the law.

Mr. Holt With that, I'll call the meeting to order. We for the members of the public that are here today, and I do know that we have a couple of folks who signed up to speak. We'd like to remind you to limit your comments to three minutes or less. Presenters are limited to one per organization. Be prepared to deliver your comments promptly when your name is called. Your name will be called in order. Move close to the front to deliver your remarks. We have three regulations on the agenda for today, one for information and two for adoption. The first for information 22-6 amendment of Section 23.5 of Title 10 NYCRR expedited partner therapy for sexually transmitted infections. This regulation is being presented to the committee for information only and will be presented to committee in the full Public Health and Health Planning Council at a later date for adoption. Ms. Bethsabet de León Stevens and Mr. Jonathan Karmel of the department are available and will provide us with information on this proposal. They are in Albany.

Mr. Karmel How about now?

Mr. Holt Yep, we got you.

Mr. Holt Thanks, Jonathan.

Ms. León Stevens My name is Bethsabet de León Stevens. I'm with the Office of Sexual Health and Physiology with the AIDS Institute and the Department of Health. For background, this is, as you indicated, a change in regulation to a line of statute. Expedited partner therapy, or EPT is a clinical practice of providing individuals with medication or a prescription to deliver to their sexual partners as treatment for STI without requiring a clinical assessment for those partners. On January 1, 2020, Chapter 298 of the laws of 2019 went into effect, expanding New York State Public Health Law 2312 to permit EPT for STIs in the United States Centers for Disease Control and Prevention recommends for expedited therapy. Prior to this change, EPT was allowable in New York for chlamydia. In addition to EPT for chlamydia, the CDC supports for this EPT as a strategy for managing partners of individuals with gonorrhea and jacuna myosis as well. Interim guidance was issued by us by our office in December of 2020. To ensure regulatory consistency, the proposed rules sent NYCRR 23.5 to align with Public Health Law 2312. This modification formally extends EPT eligibility beyond chlamydia to other STIs that's supported by the CDC. The current regulations define EPT solely in relation to chlamydia again, restricting its broader application. The proposed changes redefine EPT as a general strategy for treating STIs rather than limiting to chlamydia alone. There were also just some general other modifications to the regulation. As an example, shifting from binary language to gender neutral language promote inclusivity and removing stigmatizing language that previously stated individuals at high risk of comorbidity with HIV to seek medical evaluation. Since HIV testing is already recommended in a previous section in this regulation, this additional call out is redundant and could reinforce stigma.

Mr. Holt Thank you very much.

Mr. Holt Do we have questions from the members of the committee or the council?

Mr. Holt Dr. Watkins.

Dr. Watkins First, I want to thank you for your presentation, and I want to thank the department for expanding the EPT for other STIs. But my question to you is what strategies have been put in place by the department to reduce the hesitation by providers in the community who's afraid to administer a prescription for EPT for those who they are not familiar with. The hesitation is often based on their inability to have examined the other partner. Those hesitations against potential allergies, hesitation on potential pregnancy for the other partner. Has there been any strategies by the department to help educate our providers in our community about writing prescriptions for EPT?

Ms. León Stevens Yes, our office, the Office of Sexual Health and Epidemiology within the AIDS Institute has embarked on a campaign to promote the EPT in New York State as a clinical practice that makes sense. We have updated all of our materials and

actually had a campaign with socials last year that was targeted to both providers and to patients that could benefit from EPT. Additionally, we updated all of our brochures, including our provider and pharmacist FAQ. We continue to educate EPTs. The clinical practice is recommended. It's not mandatory. The concerns that you state, we still hear from providers. The only thing that we can do is continue to train and to have situations where we've had clinicians that are prescribing EPT talk to their peers about how that goes for them, how they track it in their EMR. A big barrier to EPT is the whole prescription phase and the issues around liability, which you indicated. A lot of our clinicians have moved to EPT on hand, which is another strategy. They hand medication. This is all about education of the providers and the community to understand that EPT is an okay strategy to use to curtail the spread of STIs. That liability is really limited. It's addressed in the regulations, but in the law.

Dr. Watkins No, but maybe you could talk more about that strategy of the physician dispensing the medication. In that case, where does the physician get it?

Ms. León Stevens The way that because of e-prescribed, they can do a prescription that just indicates EPT, and they can send that to the pharmacy. We've also done a lot of outreach and education to pharmacists to understand that they can go ahead and dispense that medication that it is legal in New York State even though it doesn't have a patient's name on it. Again, I think a lot of this is reach out and community engagement and education of both providers and patients. One of the barriers to speak to your point, Jonathan is the EMRs and how they sort of collect this data in EMR. A lot the EMRS do allow for, and this is something that we educate providers on to add an anonymous patient. That prescription goes to that anonymous patient with the specific EPT on it. The practice understands that EPT was prescribed to the original patient as a way to prevent from getting STI reinfected, but the medication is going to be to the partner and then education accompanies the prescription so that partner is aware that if they do take this medication, if they have any allergies or think they're pregnant that they should really seek a healthcare provider's advice. I hope I answered your question.

Mr. Holt Thank you very much.

Mr. Holt Do we have other questions from the members of the committee or council?

Mr. Holt We did not have anyone signed up to speak. We'll just ask if there's anyone from the public who's here who wish to speak?

Mr. Holt Seeing none, then this regulation will now be presented to the full council for information and will come back to us at a later date.

Mr. Holt Now, onto adoption. We have four adoption amendment of Section 405.6 of Title 10NYCRR, general hospital medical staff recertification. Can I have a motion for a recommendation of adoption of this regulation to the full Public Health and Health Planning Council.

Mr. Holt Members of the committee only.

Mr. Holt Dr. Yang.

Mr. Holt Dr. Watkins.

Mr. Holt Thank you very much.

Mr. Holt Mr. Josh Breeden and Jonathan Carmel from the department are available and will provide us with information on this proposal.

Mr. Breeden Hey, good morning, I'm Josh Green. I'm a Policy Coordinator with the Center for Health Care Policy and Resource Development This proposed regulation is a minor technical change and align several sections within 405.6 to reflect required triennial review of general hospital medical staff recertification credentials, previously review was required on a bi-annual basis. The public comment period closed on May 12th, and there was one comment and support. You may recall this body adopted the initial general hospital medical staff recertification regulation changing review from biennially to triennially about a year ago.

Mr. Holt Thank you.

Mr. Holt Do we have questions from the members of the committee or council?

Dr. Kalkut Just a comment.

Dr. Kalkut I think the reception to this change has been very positive, and you would get a standing ovation if it didn't break decorum at this meeting. Thank you, and thanks to the department.

Mr. Holt Anybody from the public wishing to comment on this?

Mr. Holt Hearing none, then I call the question.

Mr. Holt All in favor?

All Aye.

Mr. Holt Abstentions?

Mr. Holt That motion carries and will now go to the full council for adoption.

Mr. Holt Next, we have 710.1, the approval of medical facility construction and general provisions We just point out that this has been through public comment. We'll accept comments at this time. I know we have a couple of folks that have signed up to speak. I

also want to acknowledge two letters that we received from various associations that have been distributed to the committee and to the council members.

Mr. Holt Can I have a motion for recommendation of adoption of this regulation of full Public Health and Health Planning council?

Mr. Holt Dr. Watkins.

Mr. Holt Dr. Yang, second.

Mr. Holt Shelly Glock and Marthe Ngwashi of the department are available and will provide us with information on this proposal.

Ms. Glock Thank you.

Ms. Glock This is Shelly Glock from the department. I'm also joined by my colleague George Macko in Albany, who is the Director of Division of Planning and Licensure, who will also be joining me for this presentation. So, this regulation, this proposal is a repeal and a replacement for Section 710.1 of Title 10 of the New York Code's Rules and Regulations. This regulation defines what the Certificate of Need process is and the parameters for review of construction projects that require the approval of the Commissioner under Public Health Law 2802. This proposal was presented to the committee at the education session in late Spring of 2023, and those concepts we discussed there form the basis for this proposal, which was then presented to the committee again in early February, on February 6th of this year. The regulations were published in the state register on 2/26/2025, February 26th, with a sixty-day public comment period that ended on April 28th, 2025. Generally, the proposal streamlines and modernizes the CON process for construction of healthcare facilities. We're not talking about establishment applications. These are construction only. It reorders subdivisions and paragraphs logically. It combines language that pertains to all levels of review up front and eliminates some obsolete language. I will cover what the major changes in this proposal are, but I just want to start with just generally saying high level that review levels are determined broadly, right, the delineated appropriate review levels with total project cost thresholds. But from there, the level of review is not determined solely by the total project costs. In some cases, the regs go onto specify and delineate that certain projects, even if they meet certain lower total project costs are delineated or specified to go at specific levels. I just want to provide that general framework. This proposal increases the project cost thresholds that broadly delineate the appropriate review level. We believe that these new total project cost-thresholds reflect an appropriate balance between the increased costs of construction and the desire for the department to continue to maintain sufficient oversight while reducing some administrative barriers. You can see that we last increased these project thresholds in 2017. The proposal also revises certain level, certain review levels for specific types of projects to reflect the advances and the evolving changes in health care for services no longer considered cutting edge, they're more routine services. Specifically, I'm just going to highlight some of the changes. The proposal removed the specific, the

automatic specified full review for addition of beds totaling less than ten percent of the current beds or the conversion of less than ten percent of current beds to a bed type of a higher level. Again, I want to clarify that the total project cost threshold of proposal is \$60 million for a total project for a full review would still apply. Secondly, this proposal removes specified full review for therapeutic radiology, cardiac catheterization, bone marrow transplant, epilepsy services, burns care, AIDS Center. These are now what I was referring to earlier as more routine services than cutting edge. The department will still review these projects, but the review level will be generated by the total project cost and whatever the impact on the operating certificate. We added specified full review for lung transplant projects to group them with the transplant projects. We added language allowing projects funded primarily by state grants be approved administratively. We removed the specified review levels for projects that involve emergency room space. Previously, the reg stated that anything to do, even a minor renovation, if it involved an emergency space had to go as an admin. Those reviews will now be governed by the total project cost. Under limited reviews, we exempted exam rooms from clinical space. The department looked at this and felt that the exam rooms posed minimal risk. They're used for a limited scope of services with minimum physical environmental requirements. We added specified review levels for mobile van extension clinics. Those projects had been determined to be administrative reviews. We have moved those to the limited review category. Generally, mobile van extensions clinics have fewer generally accepted design and construction standards than brick and mortars. So, extension clinics, the brick-and-mortar buildings will continue to go as admins, but we are proposing to move the mobile van approvals to the limited reviews. We changed that for limited review applications that are self-certifications that don't change an operating certificate, so minor construction projects that don't change a facility's operating certificate could be submitted as notices to the department. We are proposing changing the total project cost threshold, which will allow architectural self-certifications to be raised from \$15 million to \$30 million. As Mr. Holt mentioned, the department did receive two letters outside of the public comment period, and those have been distributed to members. We did receive comments from five associations representing general hospitals and other healthcare providers regarding these proposed amendments. Those were received from the Greater New York Hospital Association, the Healthcare Association of New York State, Community Health Care Association of New York State, New York State Association of Ambulatory Surgery Centers, Suburban Hospital Alliance. The comments were similar in expressing support for the proposed updates, the Certificate of Need Threshold Regulations. Some other comments that I'll just hit on are that both HANYS and the Suburban Hospital Alliance both suggested the use of an automatic annual inflation adjustment to the project review cost thresholds. The department did consider such an approach, but we concluded that the annual incremental change was not significant enough or impactful enough to warrant the administrative changes necessary to implement that on an annual basis. Instead, the department had consulted construction cost indexes. We applied actual inflation since the last cost threshold increase in 2017. We estimated for future inflation, and we believe the project review cost thresholds proposed in this regulation should be appropriate for the next several years. HANYS had suggested the use of grant award announcements as proof of funding for projects receiving state consideration. We will

consider that comment, but any subsequent change to policy or processing would not require a change to this regulation. And then there were a number of comments made that were outside the scope of the regulation, including a suggestion that the department adjust the Health Equity Impact Assessment, and that the Department also align DOH, OMH, and OASAS approval processes. I just want to comment that the OMH and OASAS approval process are outside the of this regulation. So, happy to take any questions from the committee.

Mr. Holt Do we have questions?

Mr. Holt Mr. Kraut.

Mr. Kraut It's not a question, it's just, again, as we said previously when we review these regulations, we want to just thank the department. This has been a long time coming, as those of you who have been on the council. This came with the support of the Governor's Office and the Governor and the State of the State, acknowledging the need to refresh our regulatory approval process for CON. We had, as you recall, those who attended the educational session, extensive discussion on this. You heard what we said, and we were pleased to hear that it came back in the form of regulations we could vote on. We had a public hearing when it was originally presented at the Codes Committee previously. We had another extensive discussion on these regs and get them posted. Ms. Glock and you and your staff, I just want to thank you for really responding to what the council has been trying to do for these last three or four years. We hope this is the beginning of a refresh of the state code and not the end. It's not just CON. We have a couple of other things we have to look at in the state to fix. That's my comment.

Mr. Holt Thank you, Mr. Kraut.

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

Mr. Holt Seeing none, we do have a couple of folks who have signed to speak, and my understanding is they plan to join us jointly.

Mr. Holt Would Ms. Uttley and Mr. Hannay come forward, state your name, you guys know the process, get as close to the microphone as you can. As Mr. Kraut has reiterated, we've been through public comment on this, and we'll accept your comments. I will mark your time at three minutes and let you know when there's one minute remaining.

Ms. Uttley Thank you.

Ms. Uttley Lois Uttley with Community Voices for Health System Accountability. I appreciate that it may seem that we're coming late in this process. I must tell you that ordinary health consumers have a heck of a time trying to keep up with publications in the state register and codes and so on. We appreciate your attention. I want to begin by

thanking Shelly Glock for that confirmation that the revised regulation would not exempt from full review any hospital project that costs more than \$60 million, but which adds or makes changes to fewer than 10% of the existing beds. That was reassuring to hear that, and I thank you. Given that clarification, we have one further comment. It really makes no sense to us that the addition of 10% or more beds would receive full review by your council, while under separate parts of the regulation, the decertification of beds or services would still receive only limited review by the department. Add beds, you get full review. Remove beds, we only get limited review. This would allow the closing of an entire maternity service or an emergency department to be approved by department staff without ever coming to your council for full review, discussion, and a vote on a recommendation from your members. We appreciate that many of you are experts in public health and health administration, so you're well aware that the closure of maternity units is contributing to what the March of Dimes, one of our partner organizations has labeled a maternal mortality crisis, and particularly affected our rural counties and Black women in urban areas who are dying from pregnancy-related conditions at rates far higher than white women. I'll stop my part of remarks and turn it over to Mark.

Mr. Hannay Yeah, Mark Hannay. I'm also with Community Voices for Health System Accountability. We're also concerned about the fact that the closures of entire hospitals also don't merit a Certificate of Need application at all. These are carried out through a notice to the department and submission of a closure plan. We appreciate the department's recent action to at least require hospitals to hold a public meeting and answer questions from the local community about why they are closing and what steps would be taken to protect their access to care, but that's clearly, in our eyes, not enough. We met with the department recently to discuss some recommendations around that. When hospitals want to shut down units of services or close entirely, affected people and their families deserve an opportunity to appear before your council and comment on that. Maintaining the status quo of non-public state review a proposed decertification of services and closures contradicts the Hochul Administration's pledge to bring greater transparency to the government and also flies in the face of two successive overwhelming votes by the state legislature in support of the local input for Community Health Care Act. We would urge that closures of the hospital units as well as foreclosures would be a full review matter and come before the council.

Mr. Holt Thank you very much, both, for your comments.

Mr. Holt Anything else from the members of the committee?

Mr. Holt Seeing none, then I'll call the question.

Mr. Holt All in favor?

All Aye.

Mr. Holt Any opposed?

Mr. Holt Abstentions?

Mr. Holt That motion carries, and it'll go to the full council for adoption later today.

Mr. Holt That concludes the Codes and Regulations.

Mr. Holt Yes, Ms. Monroe.

Ms. Monroe I just have a clarification. Currently, institutions and departments for closure do not come to us. Is that accurate? This does not change that.

Mr. Holt Shelly, do you want to?

Ms. Glock This regulation does not change the situation regarding closures or decertification of beds. They remain as in the current regulation.

Ms. Monroe You were thinking about that differently than opening things, cause those come to us?

Ms. Glock When you say opening things, you're talking about adding additional services?

Ms. Monroe Well, services, beds, even a new institution.

Ms. Glock So, the regulation, again, things are governed by the total project costs. Under limited review, there is a couple of categories. Those projects tend to be very limited in scope, equipment, minor construction, and then to add or decertify certain services unless they are delineated as having to at a higher level of review in a different section of the regulation.

Ms. Monroe I was just wondering why we would treat closures so differently than what I called opening things. You've clarified what you meant by that. What's the policy thinking behind the difference between opening and closing and the need for a review by something like the council?

Ms. Glock Often with adding, a facility has to be certified for a new service, right? It's something they're not currently providing. It's a new bed type, it's a service type, and so that takes a deeper look. Often, it's an architectural look at the space, when you're decertifying, they've already been providing that service. They're not adding something new and there's no construction typically.

Ms. Monroe Well, I'm not on the committee, so I just still am a little puzzled about the difference in thinking, but that we can talk about that offline. Thank you.

Mr. Holt Thank you.

Mr. Holt That concludes codes.