

STATE OF NEW YORK
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

HEALTH PLANNING COMMITTEE

Minutes

April 9, 2025
1:00 p.m. – 4:00 p.m.

Empire State Plaza, Concourse Level, Meeting Room 2, Albany

COMMITTEE AND COUNCIL MEMBERS PRESENT

Dr. John Ruge, Chair - Albany Ms. Ann Monroe, Chair - Albany Howard Berliner - Albany Dr. Kevin Watkins – Albany Dr. Marcus Friedrich - Albany Dr. Anderson Torres – Albany Mr. Jeffrey Kraut (Zoom)	Mr. Hugh Thomas – Albany Ms. Lindsay Farrell – Albany Dr. Larry Eisenstein – Albany Dr. Denise Soffel – Albany Mario Ortiz – Albany
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DEPARTMENT OF HEALTH STAFF AND GUESTS PRESENT

Dr. Eugene Heslin, DOH – Albany
Ms. Jacqueline Sheltry, DOH – Albany
Ms. Marthe Ngwashi, DOH – Albany
Mr. Mike Stelluti, DOH– Albany
Mr. Jacob Bintz, DOH– Albany
Ms. Abigail Guisbond, DOH – Albany
Ms. Colleen Leonard – Albany
Dr. Alda Osinaga, DOH– Albany (Guest Speaker)
Ms. Kimberly Cozzens, Cardiac Services Program - Albany (Guest Speaker)
Ms. Susan Schmid, DOH – Zoom (Guest Speaker)
Mr. Alan Bass, DOH – Zoom (Guest Speaker)

I. Meeting Background and Overview

Dr. Ruge opened the meeting by explaining the committee’s new focus with a renewed charge toward actionable recommendations. He highlighted the committee’s unique position to directly influence regulations and improve specific areas of healthcare delivery. Ms. Monroe and Dr. Heslin added that while larger health issues remain important, the immediate priority is to focus on PCI (Percutaneous Coronary Intervention).

Members of the Committee, Council, and DOH staff in person and online introduced themselves.

II. Initial Policy Topic for the Committee's Consideration

a. Introduction to Topic and Purpose

Dr. Heslin and Ms. Sheltry gave a brief overview of the prior work done by the committee and explained today's topic (PCI). Ms. Sheltry mentioned the prior list of policy topics drafted by the committee that can be discussed going forward. She then briefed the committee on PCI and how it will now be a priority topic for the committee.

Following the overview, some committee members expressed confusion and concern regarding the selection of PCI as the current focus, noting it had not previously emerged as a top priority. Dr. Heslin and Ms. Monroe explained that PCI was chosen due to alignment with DOH and Governor priorities, and because it serves as a practical case for revamping committee function.

Dr. Heslin further clarified that The Department is looking at what was produced by the committee (e.g. the report on Emergency Department overcrowding), but the world continues to shift, and priorities change. He also added that what we can learn from this and do better at reporting out the accomplishments during this meeting.

b. Cardiac Services Program and Cardiac Advisory Committee

Dr. Alda Osinaga, DOH Office of Health Services Quality and Analytics and Kimberly Cozzens, Cardiac Services Program presented, covering the following key information and data. Additional information was provided as questions were asked by the Committee:

- PCI is a minimally invasive procedure for diagnosing or treating coronary artery disease, currently only performed in hospitals in NYS.
- Data is collected via three registries: Adult Cardiac Surgery, Pediatric Cardiac Surgery, and PCI Registry (interventions only, not diagnostic).
- In 2024, about 52,000 PCIs performed. In 2018: 102,000 diagnostic catheterizations performed. There were about 46,000 done at the same time as PCI, so around 150,000 total cauterizations a year.
- In 2024, there were 78 total PCI-capable hospitals. Over the years, there have been about 35 (plus or minus) cardiac surgery centers. Diagnostic catheterizations are not consistently tracked post-2018.
- Risk adjustment in PCI data reporting is critical for comparing differences in patients, including pre-existing conditions and procedure history.
- Quality checks are performed by data matching with SPARCS (readmissions data) and vital statistics (mortality data outside of the hospital). Emergency cases are excluded from physician-level reporting.
- There are no current approvals for PCI in freestanding Ambulatory Surgery Centers (ASCs) in NYS. About 40% or 20 states in the U.S. allow for this practice.

Following the presentation, committee members asked questions which generated

responses including some of the following data and information.

- Ms. Farrell asked about interstate comparisons and physician-specific data in NYS. → Other states collect less robust data; some use administrative sources. In NYS we have physician-specific data, and it is published for cardiac surgery.
- Dr. Watkins inquired about updated data, since the data they receive from SPARCS is somewhat outdated. → The published report includes 2019 outcomes, the 2021 report is in the production process, anticipated to be out soon, followed shortly by 2022. Data collection gap due to suspension of data reporting during COVID. They are still catching up.
- Ms. Monroe asked about certification. → It was confirmed that hospitals need Certificate of Need (CON) approval for diagnostic and interventional PCI.
- Dr. Eisenstein questioned data reliability. → Reporting is required by regulation; accuracy ensured through audits and cross-referencing with SPARCS.
- Mr. Thomas and others raised questions on regulatory history and facility need. → Expansion pressure from both hospitals and physician groups; growing procedural volume.
- Dr. Eisenstein acknowledged that through literature search there was very little information out there regarding safety aside from what has been mentioned. Dr. Friedrich asked about safety of the procedure, adverse events, and same-day discharge rates. → 60% of low-risk PCI patients discharged same day; 40% stay overnight.
- Multiple committee members brought up the CON process. Dr. Torres mentioned it's important for us to look at character and competence as we've raised at many meetings. Dr. Ortiz mentioned the importance of looking at the geographic boundaries and quality indicators of care when reading CON applications. He also raised concern about the nursing workforce crisis against the growing aging population.

c. Topic Relevance to NYS Patients and Health Care Delivery System (Dr. Heslin)

Dr. Heslin urged the committee to move onto the next presentation since this was covered in prior discussions.

d. Reimbursement Overview (DOH – Office of Health Insurance Programs)

Susan Schmid and Ronald Bass from the Department's Office of Health Insurance Programs (OHIP) provided a regulatory overview of Medicaid and Medicare for PCI in addition to differences in payment structures. Committee members asked questions which also generated the following information.

- Regulatory Overview:
 - Medicaid covers PCI but limits it to hospital-based ambulatory surgery settings, in accordance with Department of Health (DOH) regulations.
 - Medicare allows PCI in both hospital-based and freestanding centers but

pays more for hospital-based settings.

- Payment Structures:
 - Medicaid uses different methodologies: APG (ambulatory payment groups) for clinics and DRG (diagnosis-related groups) for inpatient.
 - Medicare payment rates vary significantly across regions and states.
 - Medicaid has an Upstate vs. Downstate base rate differential for hospital outpatient services.

e. Committee Discussion

Committee members discussed financial implications of PCI and how it ties to exploring the motive of provider groups and others who have approached this topic. Dr. Rugge concluded the discussion, and transitioned the committee to next steps, by mentioning that we will need to move forward by identifying the right people, including officials and experts, who can include the clinical and financial implications of PCI.

III. Next Steps

a. Identification of additional information to develop a workplan

Dr. Heslin and Ms. Sheltry provided a brief overview and presentation on next steps. Dr. Heslin facilitated a brief discussion with the committee about how we will get this work done.

- Overview of the Work Plan:
 - Phase I: Learning sessions and information gathering.
 - Phase II: Input from stakeholders while continuing education.
 - Phase III: Decision-making, developing regulations, implementation plans.
- Depth of committee inquiry will influence the timeline—could take two years or more.
- Topics needing deep discussion include quality, multi-specialty dynamics, Certificate of Need (CON) implications, financial incentives, regional issues, etc.
- Meeting Structure and Approach
 - Potential for more frequent meetings.
 - Possibility of longer retreats or working days to accelerate the process.
However, a multi-day retreat to get all this work done is less likely due to staff and resource limitations at DOH.
 - Suggest hybrid approach blending stakeholder input with iterative educational discussions.
 - Suggest looking at other states CON processes, their best practices and how it feeds into this work.
 - Need for continuous monitoring and reassessment even after regulations are drafted and implemented since the regulation may not happen right away (after all this work is done).

Committee reflections on the above included the following discussion points:

- This is an iterative process that will involve multiple people from difference places, so a hybrid approach will be key.
- Ms. Monroe stressed to the Committee that if anyone feels strongly about this topic and wants to be more involved in helping to frame this work, the chairs and the DOH would welcome them.

In closing, Dr. Rugge stressed that today demonstrated the range of experience and a number of questions that can be brought up. He stressed that there is a lot of interest in the topic, and that we depend on everyone's considerations. Dr. Heslin publicly thanked the presenters and support team for their work preparing the session, particularly acknowledging Ms. Sheltry, who organized much of the meeting's materials, and wished her well on her leave.