ALDERSON COURT REPORTING

CHRISTINE ALLEN

HOUSE COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY,

SELECT SUBCOMMITTEE ON THE CORONAVIRUS PANDEMIC,

U.S. HOUSE OF REPRESENTATIVES,

WASHINGTON, D.C.

INTERVIEW OF: HOWARD A. ZUCKER, M.D.

Monday, December 18, 2023

Washington, D.C.

The interview in the above matter was held at the O'Neill House Office Building, 200 C Street, SW, Conference Room 5480, Washington, D.C., commencing at 10:38 a.m.

APPEARANCES:

ON BEHALF OF DR. HOWARD ZUCKER:

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ON BEHALF OF THE SELECT SUBCOMMITTEE ON THE CORONAVIRUS PANDEMIC:

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EXHIBITS

EXHIBITS (continued)

EXHIBITS (continued)

P R O C E E D I N G S

[10:38 a.m.]

Mr. Emmer. This is a transcribed interview of Dr. Howard Zucker, conducted by the House Select Subcommittee on the Coronavirus Pandemic, under the authority granted to it by House Resolution 5 and the rules of the Committee on Oversight and Accountability.

This interview was requested by Chairman Brad Wenstrup as part of the Select Subcommittee's oversight of the Federal Government's response to the coronavirus pandemic. Further, pursuant to House Resolution 5, the Select Subcommittee has wide-ranging jurisdiction but specifically to investigate the implementation or effectiveness of any Federal law or regulation applied, enacted, or under consideration to address the coronavirus pandemic and prepare for future pandemics.

Can the witness please state his name and spell out his last name for the record?

Dr. Zucker. Howard Alan Zucker, Z-u-c-k-e-r.

Mr. Emmer. Thank you, Dr. Zucker. My name is Jack Emmer, and I am counsel for the Majority Staff of the Select Subcommittee. I want to thank you for coming in today for this interview. The Select Subcommittee recognizes that you are here voluntarily, and we appreciate that.

Under the Select Subcommittee and Committee on

Oversight and Accountability's rules, you are allowed to have an attorney present to advise you during this interview. Do you have any attorney representing you in a personal capacity present with you today?

Dr. Zucker. I do.

Mr. Emmer. Will counsel please identify themselves for the record.

Mr. Boxer. Nelson Boxer, B-o-x-e-r, from Petrillo Klein and Boxer in Manhattan.

Mr. Emmer. And is there also an attorney present representing your employer with you today?

Dr. Zucker. No.

Mr. Emmer. For the record, starting with the majority staff, can the additional staff members please introduce themselves with their name, title, and affiliation.

Mr. Benzine. Mitchell Benzine, the Republican Staff Director of the Select Subcommittee on the Coronavirus Pandemic.

Mr. Osterhues. Eric Osterhues, the Republican Chief Counsel of the Select Subcommittee on the Coronavirus Pandemic.

Ms. Langley. Anna-Blake Langley Research Assistant for the Republican staff.

Mr. [redacted] Democratic counsel for the Select Subcommittee.

Mr. [redacted] Democratic Staff Director, Select Subcommittee.

Ms. [redacted] Democratic Senior Counsel, Select Subcommittee.

Mr. Emmer. Thank you all.

Dr. Zucker, before we begin, I would like to go over the ground rules for this interview. The way this interview will proceed is as follows: the majority and minority staffs will alternate asking you questions, 1 hour per side per round until each side is finished with their questioning. The majority staff will begin and proceed for an hour, and then the minority staff will have an hour to ask questions. We will then alternate back and forth in this manner until both sides have no more questions. If either side is in the middle of a specific line of questions, they may choose to end a few minutes past an hour to ensure completion of that specific line of questioning, including any pertinent follow-ups. In this interview, while one member of the staff for each side may lead the questioning, additional staff may ask questions.

There is a court reporter taking down everything I say and everything you say to make a written record of the interview. For the record to be clear, please wait until the staffer questioning you finishes each question before you begin your answer, and the staffer will wait until you finish

your response before proceeding to the next question. Further, to ensure the court reporter can properly record this interview, please speak clearly, concisely, and slowly. Also, the court reporter cannot record nonverbal answers, such as nodding or shaking your head, so it is important that you answer each question with an audible verbal answer.

Exhibits may be entered into the record. Major exhibits will be identified numerically. Minority exhibits will be identified alphabetically. Do you understand?

Dr. Zucker. I do.

Mr. Emmer. We want you to answer all of our questions in the most complete and truthful manner possible, so we will take our time. If you have any questions or do not fully understand the question please let us know. We will attempt to clarify, add context to, or rephrase our questions. Do you understand?

Dr. Zucker. I do.

Mr. Emmer. If we ask about specific conversations or events in the past and you are unable to recall the exact words or details you should testify to the substance of those conversations or events to the best of your recollection. If you recall only a part of a conversation or event you should give us your best recollection of those events or parts of the conversations that you do recall. Do you understand?

Dr. Zucker. I understand.

Mr. Emmer. Although you are here voluntarily and we will not swear you in, you are required, pursuant to Title 18, Section 1001 of the United States Code to answer questions from Congress truthfully. This also applies to questions posed by congressional staff in this interview. Do you understand?

Dr. Zucker. I understand.

Mr. Emmer. If at any time you knowingly make false statements you could be subject to criminal prosecution. Do you understand?

Dr. Zucker. I understand.

Mr. Emmer. Is there any reason you are unable to provide truthful testimony in today's interview?

Dr. Zucker. No.

Mr. Emmer. The Select Subcommittee follows the rules of the Committee on Oversight and Accountability. Please note that if you wish to assert a privilege over any statement today that assertion must comply with the rules of the Committee on Oversight and Accountability. Pursuant to that Committee's Rule 16(c)(1), states "For the Chair to consider assertions of privilege or testimony or statements, witnesses or entities must clearly state the specific privilege being asserted and the reason for the assertion on or before the scheduled date of testimony or appearance." Do

you understand?

Dr. Zucker. I do.

Mr. Emmer. Ordinarily we take a 5-minute break at the end of each hour of questioning, but if you need a longer break or a break before that please let us know and we will be happy to accommodate. However, to the extent that there is a pending question we ask that you finish answering the question before we take the break. Do you understand?

Dr. Zucker. Okay.

Mr. Emmer. Do you have any other questions before we begin?

Dr. Zucker. No.

Mr. Boxer. Do we have a chance to review the transcript for errata after the testimony?

Mr. Emmer. Yes, you will.

Mr. Boxer. Is that before you publish it?

Mr. Emmer. Yes, we will do that.

Mr. Boxer. I am sure there won't be any errors, but just good practice, I think.

Mr. Emmer. So I want to thank you again for taking part in this interview voluntarily. We are going to just get started by discussing your educational experience.

EXAMINATION

BY MR. EMMER:

Q So where did you attend undergraduate school?

A McGill University.

Q And what degree did you graduate with?

A Bachelor of Science.

Q Where did you get your doctorate?

A My medical degree I got from George Washington University Medical School.

Q Okay. And your law degree?

A My JD degree from Fordham University Law School, and my LLM from Columbia Law School.

Q And who is your current employer?

A Centers for Disease Control and Prevention.

Q And your job title?

A Deputy Director for Global Health.

Q And when did you start at the CDC?

A January 2023.

Q Can you briefly describe the hiring process for that job?

A The issues regarding CDC I don't feel I should be discussing, and I did receive a letter from the Assistant Secretary for Legislation from HHS saying that issues related to CDC should not be addressed at this hearing. So I am not going to go into that.

Q Got it, Dr. Zucker. This is just a preliminary question about experience, but if you do not feel comfortable answering that we can move on.

A Great.

Q So can you briefly go through your professional career up until now?

A Sure. After I graduated from medical school I did a pediatric internship and residency at Johns Hopkins Hospital. I followed that with an anesthesiology residency at the Hospital of the University of Pennsylvania. I followed that with a pediatric anesthesiology and pediatric critical care medicine fellowship at the Children's Hospital of Philadelphia. After that I worked as an assistant professor at Yale University School of Medicine in anesthesiology and pediatrics. I worked in the Pediatric Intensive Care Unit and the operating rooms. I went back into training and did a pediatric cardiology fellowship at Boston Children's Hospital, came to New York after that to run the Pediatric Intensive Care Unit, had a pediatric cardiology practice, and did pediatric anesthesiology there. For close to --

Q [Inaudible.]

A Oh, sorry. New York Presbyterian Hospital at Columbia University, Bachelor's College of Physicians and Surgeons. So I worked in the academic system there, from assistant professor to associate professor. I went to law school at night at that time and to graduate school. After that I went to Washington, came down here as a White House

fellow in 2001 to 2002. I started September 4th or so of 2001. I worked for Tommy Thompson at that point and then stayed on as the Deputy Assistant Secretary of Health for Secretary Thompson for 3 years or so, and then Secretary Leavitt for a short period of time after that.

After that I left and went to Geneva, Switzerland, and was the Assistant Director General for the World Health Organization. I was the top American at the WHO at that time. I spent 2 years there in charge of health technologies and pharmaceuticals. I came back and was at the Harvard Kennedy School as an Institute of Politics fellow. I then went back into clinical medicine at Montefiore Medical Center in the Bronx as a pediatric cardiac anesthesiologist, which was my training. And I was there for a little over 2 years. I was a professor rank at Albert Einstein College of Medicine. And also during that time taught at Georgetown Law School as an adjunct in biosecurity law.

And also, actually, I finished my Global Health Policy postgraduate diploma from the London School of Hygiene and Tropical Medicine.

After that I went to work as the first deputy commissioner for New York State Department of Health, and then when my predecessor left I was the acting commissioner, and then, after the confirmation process, was the commissioner about a year -- literally, to the day, a year

later, and served as Commissioner of Health for New York State for about 7 1/2 years. And then after that I left, worked part-time for Color Health, which is a company, just as a part-time chief medical officer. I was also at NYU as an adjunct professor there. And then I went to the CDC.

I think I covered pretty much most of it.

Q That was an impressive narrative. So for the record, when did you start as commissioner at the New York State Department of Health?

A I started as an acting commissioner on May 5th of 2014, and then confirmed May 5, 2015. So it was essentially 2014, in the acting role until November 30, 2021.

Q So we are going to actually talk generally just about your role as commissioner.

A Sure.

Q Who did you report to?

A So I reported directly to the governor.

Q And prior to the pandemic, what were your duties and responsibilities?

A The time as the commissioner was pretty -- was fraught with many different issues. Everyone things about the pandemic, but in reality prior to that I dealt with Ebola -- there was the Ebola crisis when I was there -- there was a Legionella issue in New York City, and there was Zika virus, there was a bad flu season, there was a measles outbreak in

Rockland County, there was an e-cigarette crisis, there was an opioid crisis. I mean, the list goes on. There were issues with Candida auris in many facilities, which is a fungal infection. We were looking to try to restructure a health care system in Brooklyn, to try to improve some of the delivery systems there. Those are just a few. I mean, there were many things. Every day there was another crisis that we were dealing with, but those are some of the big ones.

Q Yeah. I mean, you briefly --

A Oh, sorry. And the AIDS epidemic. We took on a whole issue to try to move the curve down, and we approached that as well.

Q You briefly touched on it at the beginning, but can you explain a little more what had changed once the pandemic started, as far as your duties and responsibilities?

A So I think that right prior to the pandemic we were working on the issue of e-cigarettes, and they sort of overlapped. And right as that sort of ended in 2019, the end of 2019, going into 2020, the focus became, pretty quickly, on the issues of the pandemic, and it consumed my every day, along with everyone else. So we still needed to continue to run the operations of the Department, so it was juggling the both of those. But it soon became clear that everything was pretty much focused on how to address this coronavirus pandemic, and that is where we focused it.

Q Mm-hmm. And we are going to bounce back and forth here, but so prior to the pandemic how much interaction would you have in your day-to-day with the executive branch or its employees?

A So it really depended. So if the -- let me give you an example. So when the issue of Zika virus surfaced and we realized that this was a big concern there were daily discussions about that. Similarly, when the Legionella outbreak happened it was a regular discussion of how many are sick, what are we doing, how are we testing. Other times, when the issue in the Executive Chamber was on something separate from health that may have gone on for days or weeks, the conversations were infrequent.

Q So to be more specific, were those meetings with the governor or was it just his staff?

A So you're talking about prior to the pandemic?

Q Yeah, prior to the pandemic.

A So it depended on what the issue was, and the meetings sometimes were with the governor and his staff, which was more common than just a meeting with the governor alone. So it was more that let's figure out what we're going to do with -- you pick the issue -- Ebola. And so we'd sit down, and there were times that some of these crises required not just a few members of the staff but a lot of the staff.

Q Do you recall specific members of the staff that

you would have been meeting with more frequently?

A Well, some of the staff changed over. So early on, you know, Larry Schwartz was the secretary to the governor, so I worked with him. And after that it was Bill Mulrow, and I worked with him, and then after that it was Melissa DeRosa. So the secretary to the governor was obviously critical on that.

General counsel was another person that I worked with. So at one point -- I forgot who the first one was, but then it was quickly Alphonso David, and then after that it was Beth Garvey. There may have been some acting general counsels in there as well.

And then there were others who I worked with, but the general counsel and secretary to the governor, and his chief operating officers at times. Jill DesRosiers was chief operating officer, and there were others as well.

Q Got it. So moving to the second part, we started with the day-to-day. Before the pandemic, can you describe what would have changed in your day-to-day after the pandemic?

A So it depends on at what point. Early on, when the pandemic -- well, early on, when COVID-19 was a concern, before it was defined as a pandemic, we, in New York State, started to address what do we need to do. So at that point there were conversations within, from me and to the

governor's team, saying this is some of the things we need to prepare, and kind of that nature. When the first case was in New York, a documented case, let's just say, obviously things ratcheted up, and there were many more conversations on sort of what needs to be done. But we were already, prior to that, addressing this issue of how to respond when a documented case ends up in New York.

Q So in any way would you say that as a result of the pandemic did the fundamental structure of the New York State Health Department or any of its components, would you say that they were ever altered in any way?

A Well, I think that the State Health Department, early on, tackled this as we usually tackled health emergencies in the structured way we had, in a response team that was pulled into play. But as this became a much more expansive problem it really, obviously, required more than just a Department of Health response. It really required a statewide response. And at that point, you know, I was spending a lot of time trying to juggle the Department and also juggle some of the questions that were coming from the Chamber.

Q How much direction -- I mean, in your day-to-day, the New York State Health Department is supposed to operate, how much direction were you receiving in your day-to-day from the Executive Chamber?

A Can you define that a little bit more? What do you mean by direction?

Q So we are going to get into guidance that you issued, not just the March 25th one but other types of guidance issued under the New York State Health Department. And this actually is a question that I will be asking then too. So when you issue that, how much instruction or direction were you receiving from the Governor's Office to issue a guidance?

A Well, it depended on guidances, but there was a process when it came to guidances, which were that the Department of Health have the subject matter experts on issues. So we would provide information, but these advisories would end up going over to the governor's team, his office, for review and also for -- all of them ended up with the legal team, General Counsel's Office there. And ultimately when an advisory was sent out, the final clearance came from them.

Q We're actually going to get to processes involving guidance later on here, but to conclude just this section, this is just very general, did you ever receive any instruction or direction from Governor Cuomo or anyone else in the Executive Office that you felt were contrary to your position, adverse to your professional obligations during the pandemic?

A So that's a complex question. I think there were times that there were members of the team who may not have -- took a different approach to things, and I would push back on issues. A lot of times these issues were not so black and white, particular with this pandemic, because we did not have all of this information, so decisions that had to be made were based on the facts we had. Every once in a while there was something which I felt pretty strongly about, and if I felt that this was not, we can go either way, I pushed, and if I felt really strongly I pushed pretty hard. And usually -- well, it really depended, you know. And I would never do anything that I felt was medically wrong, ethically wrong, or morally wrong, so I never felt that I was at a point where I was put in that spot.

BY MR. BENZINE:

Q I have one follow-up question. You said prior to the pandemic that the secretary to the governor was obviously critical in kind of your communications with the governor. Did that continue into the pandemic?

A Sure.

Q And was Ms. DeRosa the secretary your entire tenure, during the pandemic?

A During the pandemic, yes. During the pandemic.

Q Can you elaborate a little bit more on critical. Was it day-to-day interactions with the secretary to the

governor, or like what -- how was she critical in --

A So the day-to-day operations during the pandemic, if you recall, relatively early on those press conferences began. So we had the case in March in West Chester, and that week, or that day actually, we had several press conferences, and then it sort of escalated from there, and then it became a daily press conference. So the interaction at that point was every day because I was on that dais, as was she, and so there were conversations usually within the entire team. Now I did not attend every press conference but the vast majority I was at.

Q During the pandemic did anyone in the Governor's Chamber, Ms. DeRosa included, act as a clearinghouse of information?

A Well, everything ended up having to go through the Governor's Office. And when I use the phrase "governor's office" I refer to the entire, you know, the executive team, the second floor, however one wants to refer to it. But that's what I mean when I say "Governor's office."

Q What did that look like? Did you like a stamp of approval? Who gave the final stamp of approval on issuing something?

A Well, most things went through the secretary to the governor, Melissa DeRosa. That was, I guess, in a lot of ways, the voice of what the governor wants, right? And we

moved forward on addressing whatever the challenges were.

Q Thank you.

BY MR. EMMERS:

Q Real quick, what is your personal opinion of Ms. DeRosa? Do you have one?

A No. I --

Mr. Boxer. Do you mean professional, or was she competent, was she --

BY MR. EMMER:

Q First, was she competent, and second, we've heard various testimony of difficult to work with. How would you characterize your relationship?

A I think, from a professional standpoint, she was very driven to address issues, whether they were these issues or issue before. I really didn't spend as much time, particularly during this pandemic, thinking about all these personalities. And so everyone responds differently to crises.

Q Thank you. So we are going to move on to relationships, and you have mentioned a lot of these names, but I'm going to start by asking you if you spoke with or emailed any of the following people regarding COVID-19, specifically the pandemic, in nursing homes, or long-term care facilities, between January 1, 2020, and the present.

So Ms. Sally Dreslin?

A Sure. So let me just get this down. You are just going to run down a list of names --

Q Just running down.

A -- and you want to know whether I communicated verbally or through email or whatever?

Q Yes. This should be one of the easiest ones. So Ms. Sally Dreslin?

A Yes.

Q Mr. Gary Holmes?

A Yes.

Q Former Governor Andrew Cuomo?

A Yes.

Q Ms. Melissa DeRosa?

A Yes.

Q Jim Malatras?

A Yes.

Q Mr. Gareth Rhodes?

A Yes.

Q Mr. Rich Azzopardi?

A Yes.

Q Ms. Beth Garvey?

A Yes.

Q Ms. Jill DesRosiers?

A Yes.

Q Ms. Linda Lacewell?

A Yes.

Q Mr. Kenneth Raske?

A Yes.

Q Mr. Lee Pearlman?

A He worked with Ken Raske, but I don't think I ever actually emailed with him. I met him but I never interacted with him.

Q Since we -- so we'll stop there for the record. Can you describe where Mr. Raske and Mr. Lee Pearlman --

A So Ken Raske was the -- oh he is -- the president of the Greater New York Hospital Association, and I think Lee Pearlman worked with him. I never was really sure what exactly his title was, but I knew he worked with him. I ran into him in a meeting that we once had about COVID. I remember that meeting. But I don't think I emailed back and forth with him.

Q Moving on, Mr. Michael Dowling?

A Yes.

Q President Donald Trump?

A Yes. Well, that was just two phone calls.

Q Okay. Vice President Mike Pence?

A No.

Q Dr. Francis Collins?

A No, not during the pandemic. Not during the pandemic.

Q Dr. Anthony Fauci?

A Yes.

Q Dr. Robert Redfield?

A Yes.

Q Mr. Alex Azar?

A No, I did not directly communicate with him, no.

Q Ms. Seema Verma?

A Yes, once.

Q Dr. Deborah Birx?

A No.

Q Mr. Jared Kushner?

A No.

Q Dr. Lawrence Tabak?

A No.

Q Dr. Hugh Auchincloss?

A I --

Mr. Boxer. Do you know who that is?

Dr. Zucker. No, I don't.

BY MR. BENZINE:

Q I want to jump in just a little bit, and ask another baseline question and then unpack some of these. We urgently requested this interview on October 10th via letter to Director Cohen. Have you spoken to former Governor Cuomo or Ms. DeRosa since --

A I haven't spoken to them in 2 1/2 years.

Q Okay. Anyone else on this list?

A That I have spoken to?

Q Since that letter.

A Since that letter, no.

Mr. Boxer. Since that letter to appear and testify.

Dr. Zucker. Yeah, I don't think so, no.

Mr. Boxer. Yes, because I know who you [indiscernible] at all?

Dr. Zucker. No, no. Let me look at the list. I'll quickly be sure.

BY MR. BENZINE:

Q I think it's fine. The list is shorter than this list. We're going to unpack a lot of like New York officials later on, but I want to talk about the Federal officials a little bit. You said two phone calls with the former President?

A Yes.

Q That was it. Were those regarding COVID-19 as a whole in New York, or specific to nursing homes?

A No, it wasn't either. It was specifically related to the issue of hydroxychloroquine.

Q Okay. And understanding any -- I don't think there are any potential privileged questions here, but can you elaborate a little bit more on what those were?

A The questions, or the --

Q The conversations on hydroxychloroquine.

A Sure. The President called on a Saturday on my cellphone. I did not expect that call. And I actually asked him to call me back 10 minutes later because I felt that the -- I had my two kids in my arms and I also felt the courtesy to speak to the governor and tell him that the President was calling. And so I mentioned that he called. He said, "You can talk to him." He called me back. He felt that we should be giving hydroxychloroquine out.

Mr. Boxer. He is Trump. Not the governor.

Dr. Zucker. Yeah, right, right. Sorry. President Trump. President Trump felt that we should be giving hydroxychloroquine out. And he said he had read some article about that, and that he was going to send, I think he was going to send hydroxychloroquine and erythromycin, because I actually wasn't the individual -- I said that we did not understand yet whether that was even effective, and we went about, in New York State Department of Health, we actually did a retrospective study to show that it was not actually effective. And he, you know, former President Trump was saying that "Well, we might as well try it. It could help." And, you know, scientifically you don't just give medicines if you're not really sure.

So I heard him, and I conveyed that information

back to the governor. Governor Cuomo, former Governor Cuomo actually said to me, "I think he's going to probably want to talk to you about hydroxychloroquine." Then he called me a second time about the same issue, about hydroxychloroquine. And that was it.

BY MR. BENZINE:

Q Dr. Fauci, again we can probably stick to the topic of nursing homes. Were there any specific to nursing homes with Dr. Fauci?

A No.

Q Okay. And then the one conversation with Ms. Verma, I don't want to assume but I'm assuming that's about nursing homes.

A You know, I don't -- I'm trying but I don't think it was a conversation. I actually think it was an email or some communication about the nursing home or the CMS guidance. But I don't remember. I mentioned that I was in touch with her. I think it was through an email or I was copied on an email, because you had mentioned emails, texts, phone calls. But I don't recall speaking with her ever. I don't recall that.

Q Was that, to the best of your recollection, that email before or after the March 25th directive?

A I don't -- I think it was probably after. I bet you it was after.

Q And then Dr. Redfield, just anything on nursing homes?

A No. Dr. Redfield's conversations were really about testing and just in general public health, really. And numbers. Sometimes it was about numbers.

Q Did you find him to be pretty credible and --

A Yes.

Q Okay.

Mr. Boxer. You knew him?

Dr. Zucker. I knew him only because of a prior conversation about other public health issues, but I did not know him, you know, in my medical capacity. But I actually, you know, had good conversations with him about things.

BY MR. BENZINE:

Q My last baseline question, and I'll turn it back over to Jack. Throughout the pandemic did you use any encrypted messaging apps like Signal or WhatsApp?

A No.

Q Thank you.

BY MR. EMMER:

Q So similar to the names that we just listed, now we are going to go through entities or institutions that you have, whether you have spoken to them between January 1, 2020, and you leaving your position at the New York State Health Department. So first, U.S. Centers for Medicare and

Medicaid Services?

A This is during the time of the pandemic, you're saying?

Q Yes. January 1, 2020, to --

A -- 2020. So CMS?

Q Mm-hmm.

A Did I interact with them?

Q Yes.

A The team may have, but I don't recall, besides what I was mentioning before, possibly being copied on something. But I didn't really directly work with CMS. We had a person who handled all of Medicaid for the State of New York, and many of the things went through her office.

Q And we're just running through this list, and we'll be touching on it, or a couple of these in particular throughout our questioning. But just since you mentioned it, do you know who that person or their title would be, that would have been communicating with CMS?

A Well, from my office?

Q Yeah.

A Donna Frescatore was our Medicaid director.

Q All right. So moving on, U.S. Department of Health and Human Services?

A Yes. Well, there were conversations primarily with ASPR, which is public health and emergency response

team.

BY MR. BENZINE:

Q Any direct conversations with Dr. Kadlec?

A Yes.

Q About nursing homes?

A Not about nursing homes.

BY MR. EMMER:

Q U.S. Centers for Disease Control and Prevention?

A Dr. Redfield. But your question on nursing homes, it was not specifically about nursing homes. It was more about data and numbers and others at the CDC because they were, you know, obviously our national agency for these kinds of public health emergencies.

Q Okay. And the next few are all kind of similar, but the New York State Attorney General's Office?

A The AG's Office? No. Well, regarding nursing homes, I was on a phone call one time when Melissa DeRosa called their office, and that was the only time I had any communication with the AG regarding that issue.

Q And the issue that you're referring to, is that nursing homes?

A It was about the report that they had issued. The AG's Office issued a report, and that morning there was a phone call that she had, and I was on that call.

Q Can you recall what Ms. DeRosa, or what the

subject of the conversation was?

A It was that the -- we all felt that the report had inaccuracies in it, so that was her conveying that to their office. I don't remember who was on their side, who was on the line, and even if I heard the name I wouldn't remember it anymore.

BY MR. BENZINE:

Q For lack of a better way to phrase this, did Ms. DeRosa use colorful language on that phone call?

A It was a heated conversation. And I don't have the quotes in front of me. I can get them in the next hour. But I think in her book, and what the transcript of that call was, were a little bit different.

Q I'm trying to -- how it was reported the call went was that it was pretty profanity-laced, a lot of, like "How the fuck did you do this" kind of questions. Is that your recollection?

A You know, I don't recall the exact words, but do know it was a heated conversation. It was not what I would say to my mom.

Q Okay. That's fair. Thank you.

BY MR. EMMER:

Q Just since we're on this topic, obviously she was expressing her displeasure. Would you say it was more based on the conclusions of the Attorney General's Office or was it

the political ramifications of the report?

A I was focused on the conclusions because I also felt that this was, you know, not -- I did not -- well, first, I did not read the report prior to that phone call, because that phone call took place early in the morning and it was right prior to when the report was released. And the issue, if I remember correctly, was that she wanted them to hold off on releasing the report. The report had not been released yet, and it was almost like a head's up, I guess. And the conversation was why are you releasing this at this point, until we, New York State Department of Health, the Governor's Office, can look at some of the things that were written there. So that's what I remember of that.

BY MR. BENZINE:

Q Again, if you know, kind of you were in the structure of the New York government for a while, are the AG's Office and the Governor's Office supposed to be separate entities? They're elected separately.

A Well, as I -- this is just my understanding, they're supposed to be separate. But that's not from anything anyone told me, but that's my understanding of civics.

Q Thank you.

BY MR. EMMER:

Q So you mentioned at the time of that phone call

you hadn't had an opportunity to review that report, but it seemed like you did disagree with some of the report's conclusions. Can you just briefly go through those?

A Well, sure. There was this statement that basically, an inflammatory statement, that there was undercounting of nursing home deaths, which was not accurate at all. So I felt that was wrong, completely wrong, and I suspect the report, if I had read it, went into more of that as well.

Q Okay. And we will be returning to some of the numbers and the data. So moving on, again, interactions between January 1, 2020, and you leaving your position at the New York State Health Department, did you have any interaction with the Office of the New York State Controller?

A Not during that window of time, no.

BY MR. BENZINE:

Q Since?

A Well, since, it's been a different issue. It's been the issue of covering expenses, legal expenses, but it's not an issue relating to the nursing home issue.

Q Okay. Thank you.

BY MR. EMMER:

Q The U.S. Department of Justice?

A No.

Q And finally, the New York State Assembly

Judiciary Committee?

A I spoke to the committee because I did an interview with the -- was that the Judiciary Committee?

Mr. Boxer. I was just thinking that.

Dr. Zucker. I don't remember.

Mr. Boxer. It was a committee.

Dr. Zucker. It was a committee.

Mr. Emmer. For the record, the impeachment, the committee that conducted the impeachment investigation?

Mr. Boxer. Yeah. Howard -- Dr. Zucker is thinking of something else, I think. He gave sworn testimony to an Assembly Committee in roughly August of 2020. The answer to your follow-up clarification is yes, he sat for an interview with the Assembly's impeachment inquiry, and that had to be in 2021.

Dr. Zucker. Yeah. It was in Albany, right.

Mr. Boxer. We were in Albany, or maybe somewhere else in Albany, but I could get you the exact --

Mr. Emmer. Okay.

Mr. Boxer. I think they reflect it in their report.

Mr. Emmer. Yes, and we will be reviewing specific passage of that report.

BY MR. EMMER:

Q So real quick, and you kind of already touched on

this, but in the course of your time as commissioner, did you, for the following people that we listed that you had spoken to, and the entities, did you ever use a personal email or phone?

A No, not on this.

Q Okay. Thank you.

Mr. Emmer. How are we doing on time?

Mr. Benzine. Twenty minutes.

BY MR. EMMER:

Q So now we are going to kind of repeat ourselves or repeat what you were talking about earlier. I want to briefly discuss how the Department of Health issued guidance. So how was it usually initiated?

A And I'm going to just be speaking in generalities about this. So if an advisory needs to move forward the subject matter experts within the Department, whether it was an infectious disease issue or a chronic disease issue, would provide this information, put it together. It would go through a channel within the Department of Health to the deputy commissioner of that part of the agency. It would ultimately go through legal, and then it would go over to -- well, normally it would go through sort of the legal process within the Department, and then it would go over for clearance. However, many times, particularly with this pandemic, things did not go through our legal team on a

regular basis. Sometimes they did; sometimes they didn't. Often they were reviewed by the Office of General Counsel in the Governor's Office. And the reason I bring that up is because many times these things need to be moved in a very expeditious fashion. So the intrinsic bureaucracy of trying to move something forward needed to be streamlined a lot more. And if it was going to require clearance through the governor's general counsel then it often just went over there and was in their court. And then ultimately there was a clearance and then it would come back to the Department, the Department of Health guidance or advisory, and then it went out. Sometimes it went out on the Health Commerce System. There were certain systems that you could get information out to doctors. Sometimes it went out through other systems to hospitals or so. But the information then went out from the Department. And I suspect probably the same with other departments in government, but I can't speak to them.

BY MR. BENZINE:

Q Did you have visibility into the Governor's Office deliberations?

A On the guidance?

Q On guidances in general.

A I did not, but there were people -- you know, we had the experts involved, and in many ways a lot of these issues -- there were many issues happening at the same time,

so sometimes you sort of had to divvy this up and say, okay, you guys handle that. And it went over there and things that the governor's general counsel needed to review, you trust that they are going to look at this, making sure that the language was appropriate.

BY MR. EMMER:

Q So you kind of already touched on this, and you talked about how guidance was initiated, but how involved was the Governor's Office in just initiating guidance? Did they ever approach the Department of Health and ask you to draft specific guidance?

A Sure.

Q Okay. And before the pandemic was that the case too?

A It was. It was, sure.

Q Would you say that it might have been more the case once the pandemic started?

A Well, I think it was, but then again, just the sheer volume of issues that we were dealing with was so enormous that you would think that there would be more. It's almost like the denominator was bigger so the numerator was bigger. If the denominator was small, the numerator was small.

Q Understood. So did the Governor's Office ever provide input or edits of DOH guidance?

A Sure.

Q Did any guidance ever originate from the governor or the Executive Chamber?

A Well, see, often what happens, it would be, well, write an advisory for something. But I can't speak from my memory of something specific, but I suspect there were things that sort of generated from there, but I can't give you any specific example of things that were literally written there. Although we can get back to the March 25th issue, and we'll go into that a little bit more.

Q Okay. Did you ever include other agencies, or were other agencies ever involved in issuing Department of Health guidance?

A You mean other agencies that -- sure. Sure. Well, Homeland Security was involved in certain issues. I'm sure they issued guidances. And I suspect there were others as well.

Let me go back to the other question. We'll clarify that a little bit more about what started from the Governor's Office, because -- I just need to clarify a little bit more in the sense that there are guidances that began probably from there and then they needed our expertise from the Department of Health. But we can talk about it later.

Q Well, for the record, and we will be talking through the March 25th order, but was the March 25th order

one of the ones that --

A Well, that's one of those examples of subject matter experts from the Department, but there was also the general counsel from the Governor's Office, and what began from where and how that turned from concept into a document is a little murky on that.

Q Yeah. We'll tackle that when we get to that section.

A Okay.

Q Was it customary to seek input from stakeholders outside of the government?

A For --

Q For guidance. Sorry.

A Not customary. And I really can't speak to the details on this because sometimes the subject matter experts may have called someone to say, "Hey, I don't understand this issue," or a separate issue. So leave COVID aside for a second. Let's just go back to the issue of Ebola. So we were issuing guidances, and there were things about, you know, distance from an outlet to a bed. I mean, I don't know whether some of the members of my team, who were subject matter experts, called someone else who was a stakeholder, saying, "When an outlet is this size and does it have to be 5 feet?" They may have. So I can't answer the details of what some of our experts did.

BY MR. BENZINE:

Q I want to take a step back from the other agencies involved, based on some emails the Department of Finance was pretty involved in, March 25th.

A Sure, yeah.

Q Was that kind of odd?

A Well, the issue is that the Department of Finance, the commissioner that ran that was Linda Lacewell, and she was one of the members of the governor's team for COVID, and Gareth Rhodes was also in the Department of Finance. So it may be that if you are looking at emails and see that as the at-whoever, you know, it was going to show up that way.

Q Or it could have been that they were just working as kind of the COVID Task Force.

A As part of the COVID Task Force. Right.

Q And we are actually going to get to that now. So I'd like to introduce what will be marked as Majority Exhibit 1.

A Okay. And where is this from?

[Majority Exhibit No. 1 was marked for identification.]

BY MR. BENZINE:

Q Yeah, so I'm just getting warmed up here. This an excerpt of Melissa DeRosa's book entitled "What's Left

Unsaid," and we are looking at the bottom paragraph on the left, where it starts "Executive orders." Specifically, I want to direct your attention to the last sentence, starting with "But --." So it says, "But our Department of Health routinely issued directives independently in consultation with members of the COVID Task Force, and while it would run legal tracks through the Counsel's Office it didn't have to go to the governor to issue its guidance or mandates."

So we already sort of discussed this, but do you agree with Ms. DeRosa's characterization of the Department's practices in issuing guidance?

A I would say that during this pandemic everything ended up on the second floor.

Q Can you elaborate on that?

A Yeah, well, the second floor being the Executive Chamber, the governor's floor.

Q So it's --

A And there were times when we, the Department of Health, would say, "Where is that guidance?" and it still hasn't been cleared from over on the second floor.

BY MR. EMMER:

Q And when you say "second floor" --

A That is the Governor's Office. Sorry.

Q Okay. Would you presume that would include the governor himself being privy to --

A I can't answer how that whole process went. We knew that things needed to be cleared, and sometimes they were legal issues, which Beth Garvey was involved, and other issues, obviously, the secretary to the governor, Melissa DeRosa, was the one who signed off on it.

BY MR. BENZINE:

Q So Ms. DeRosa wrote that guidance, Department of Health routinely guidance didn't have to go to the governor. It was your kind of experience that guidance did end up in the Governor's Office.

A Right. Guidance went through there. Now, I mean, there were so many guidance documents that were being put out, and maybe I clarify that guidances that were something perhaps that were really minor, maybe they didn't. But given how many we put out -- 600 guidances, I think -- but things that were of a significant nature required clearance. And at one point we were sort of told that everything, you know, comes through the office there.

Q And again, we'll talk about March 25th in more detail in a little bit, you said sometimes the Governor's Office was -- "holding up" may be too strong word, but you were waiting on them to clear certain guidances.

A Right. And my feeling was that sometimes it was just frustrating. If I felt something was medically unsafe then I would push. But usually it was just frustrating.

Q Was the March 25th guidance one that was held up by the Governor's Office?

A We should go into sort of how that whole guidance was moved forward, and I don't think I can't comment if it was held up or not because the decision to do that, and when it was issued, was a relatively quick period of time.

Q Okay.

Mr. Emmer. How much time do we have?

Mr. Osterhues. We have 6 1/2 minutes.

Mr. Emmer. Okay. We'll try to get through this.

BY MR. EMMER:

Q So you mentioned the COVID Task Force, and we're focused on Melissa DeRosa's excerpt, saying that in consultation with the members of the COVID Task Force. Do you recall who the members were on that task force?

A On the COVID Task Force?

Q Yeah.

A Sure. It was obviously led by the governor. It was myself, Jim Malatras, Robert Mujica, Beth Garvey, Melissa DeRosa, and those are the key -- Linda Lacewell -- and those were the key. I mean, Larry Schwartz was involved. He was there and then he was gone and he was back. So I don't know whether he was formally part of the task force, although I think so. And that was pretty much it. Gareth Rhodes I think was.

Q Yeah. And Gareth Rhodes was a long-time aide to the governor as well.

A Yeah. Yeah.

Q So returning back to the excerpt from Ms. DeRosa's book --

A Do you mind if I just interrupt you for a second? I don't even know if it's written down anywhere who the task force was, so I'm just giving you sort of the general sense of the key players who were, on a daily basis, sitting there, as we discussed what was going to happen at the press conference. And so if it's specifically written somewhere I can't answer that.

Q But returning back to Ms. DeRosa's book, based on the portion where she says consultation with the members of the COVID Task Force, she would have been privy to all guidance issued by the Health Department in March of 2020, right?

A Sure. I mean, she would be privy to it, yes. Whether she saw every one, I can't speak to that. But she was privy to it.

Q And more generally, at the very least, people within Governor Cuomo's orbit that were also on the COVID Task Force, they would have been privy to your --

A Sure, but I will clarify that because, as I mentioned before, if there was something which was pretty

minor, it could be -- and I can't say this for sure -- it could be that it just went out, that somebody said, "We need to be sure that there is X number of -- I don't know. I'll have to think of something. But there could be something that was relatively minor, and just say, "We'll get it out." But there were people within the Department, and there was also a protocol in place from within our legal department, separate from the governor's legal, our legal department, how something moved forward. And there was the executive deputy commissioner, Sally Dreslin, when she was there, where most of these things would end up going to her desk, and then it would move forward. So often these things did not end up necessarily on my desk, but big issues, you know, I'd hear about something.

BY MR. BENZINE:

Q One final question. It's been reported a lot, and it's pretty well known that Governor Cuomo keeps a pretty tight orbit, a pretty tight group. Would you have considered yourself part of that group?

A That orbit was very small and tight, yes. I had a very good working relationship with him, but I did not view myself as within that tight orbit.

Q Thank you.

Mr. Benzine. Go off the record.

[Break.]

Mr. Boxer. Thank you. Dr. Zucker, just wanted to clarify his answer to, I think, the last question before we broke.

Dr. Zucker. You had asked me about the orbit, so I thought maybe an example would be a good way to answer that. So on July 6th, when I did a presentation, prior to that I actually wanted to speak to, or share it with the governor, actually. Usually things had to go through Stephanie Benton, which was his executive assistant. But when I asked her she said, "You need to have everything run through Melissa first." So that was sort of the orbit. And in many ways my conversations with the governor, there were the rare conversations when we would just end up being the two of us, and those were very helpful in a lot of ways.

Mr. Benzine. Thank you.

BY MS. [redacted]

Q Thank you, Dr. Zucker. My name is [redacted] I am the Democratic senior counsel for the Select Subcommittee, and I also wanted to share our thanks for you coming in today, taking the time out of your busy life. But we do have some questions for you that we are hoping you can just illuminate us on what happened.

But looking back at the early months of the pandemic, so March and April of 2020, it seems fair to say that New York was one of, if not the first state to see large

numbers of COVID-positive patients and large-scale community spread. Is that accurate?

A That is accurate.

Q And can you tell us just a little bit about what that was like, being thrown first into that environment?

A So I think it's important to understand that even prior to March, the Department of Health started to address this issue very early on. So when I first heard about it in January, primarily through an article in the Wall Street Journal, my antennas went up, saying this could be a problem. And having actually lived through SARS as the deputy assistant secretary of health here, right across the street in that building, and the news reporting as SARS-2 -- that is how this began, SARS-2. That's how they were referring to it -- my concern was we need to address this because this could potentially become a bigger issue.

So we, in the Department, started to look at this early on, in January, and conversations I had with the public health experts in the country and also, actually, from my prior role at WHO, calls over to there about what was happening. And then in February, we were sending samples down to CDC, because that was the only place the test could be done, and our Department was also speaking with the FDA to get a test done to use in New York State, because our [unclear], you know, a superstar facility, so we were working

on developing our own test.

So a lot of this was already happening in January and February, so by the time February, end of February, which was leap year, so February 29th, by the end of February, when we had our first case of a doctor who had come back from Iran to the United States, we were already in motion, figuring out like what do we do and how do we tackle this. And the conversations with the Governor's Office was like, well, here is another case, a person who we are concerned about, who was negative-negative, and then ultimately there was the doctor who flew back from Iran.

And then we set in to motion a lot of things that we had already said we need to do, and then by March 1st, or March 2nd, actually, the gentleman who was at New York Presbyterian Hospital, who had originally been in Westchester, who was positive, then we realized that this is more concerning because he had not traveled from a country that had COVID cases, so it was clearly community spread, and we had learned had been at many different events prior to him becoming ill. And so our concerns were escalated, heightened. Oh, can I add just one other point?

Q Please.

A So the last week of February, I was down here, in Washington, and all the health commissioners were together. I was actually at the White House that day, on February 25th.

And I raised, with, actually, with the Administration, both HHS and also the Administration, saying that I had lived through SARS the first time and that this needs to be a national response, not just a statewide response. So that was something which I addressed with all my fellow commissioners from around the country, and said if we don't do in a coordinated fashion we are going to run into problems.

So that was February 25th, or so, and I also spoke to the principal deputy director for the CDC, because I think she was there as well. And then we put into motion, in New York State, about getting more money for potential outbreak, and at the end of that week, which was February 29th, I think, or right around that, and then March 2nd, when the gentleman got sick in New York, who ended up in New York Presbyterian Hospital, that, as I said, created much more concern. And then as the weeks went by in March, one thing led to the next. We had one case, one documented case, on the first day of March, and then the second day a couple, but by the end of March, or by the third week of March we had 70-something-thousand cases, and then at the end of March we had 83,000-plus cases and the numbers every day were increasing by the thousands. And I remember actually saying that this is everywhere. It's not in one hospital, another hospital, in one community. It is everywhere.

So those weeks were incredibly stressful because you're sitting there thinking about a disease that you don't even know what it is, you don't know how it kills people, or makes them sick, kills people. You don't know the transmissibility of it. You don't know the potential mortality of it. And we're working with a lot of unknowns, and that's not a way to do anything -- public health, medicine. You don't like to be walking into something with all those unknowns. And then the numbers kept going up, and we had a lot of modeling that was taking place to try to figure out how bad this could get. And I remember those conversations. Well, I'll stop there.

Q No, that was great. Thank you. So you talked a little bit about how you started preparing in January, when you first heard about this, and that continued into February and March. But as New York was starting to be hit by cases, there was not really a model that had been implemented for you to follow, was there?

A No. There was not a model. There was a system in the Department of how we responded to whether it was Legionella, Zika, or Ebola. So we did have a team within the Department that when there was a crisis they all gathered, three times a week, sometimes every day of the week we would sit down and we would run through who needs to do what. So that was in place. But again, this was moving at such a

pace.

And I will just share that when it first started, with Westchester, I personally thought that I could track like the cases. The academic in me sort of starts to say, well, if this person was with this person then maybe that's how this was transmitted. Then you realize this is just escalating at a point that is just, you know, unbelievable. And I'll just share one other thing. Because I asked my assistant. I said, "Can you just get me a bunch of pushpins" -- you know, those little pushpins. And I said, "Let's have the team upstairs make a big poster of New York State, like 30 by 40, and I will put a little pushpin in each case. And that surely was not going to be the way to address this. But at that's how initially, back in February, I sort of thought that maybe this will be a way to address it. And it just took off.

Q Yeah, I can't imagine the pushpins lasted for very long.

A Yeah, it was not going to last.

Q Yeah. So you mentioned having a team within the Department of Health to deal with these public health emergencies. Can you tell us a little bit about how they would operate, especially at the beginning.

A So at the beginning we had a former Marine, who was an absolute superstar, and he would convene the team and

sit down. We would walk through, okay, we had a team who dealt with public health. What are they doing? We had a team who worked with legal. We had a team who worked with communications. And they would just march through, this is what we did, this is where we are on trying to figure out what the lab is doing. And so we would hear about it and then we would provide that information.

That is how we usually operated. However, what happened with COVID early on -- we continued to have that, but the governor, after the Westchester case, and after we flew down there and listened to the community and recognized that this is obviously escalating rapidly, he pulled in that team that he had, and he had asked me, he said, "Just set up shop over here in their building," the Department was in another building, connected by another building. And he brought in those who he trusted and wanted around, and created this task force sort of to address a lot of the issues that were going to take off.

Q Separate from what your team was doing, in February, March, and April of 2020, it doesn't seem like the Trump administration was leading a coordinated and organized Federal response, as you said, you had suggested.

A Well, that's what I was saying, right, back on February 25th. Because I said this is what we need to do.

Q So was there any coordinated response to provide,

in those early stages, provide tests, PPE, or any other supplies needed to manage the spread of COVID?

A So within the state we recognized that this is a challenge, but as we all learned, all of this equipment was being manufactured in China. And so we started to look at this. So the governor charged different people within the team to tackle different issues. So one person was responsible to say, okay, figure out about the supplies, the PPE, the masks, and all of that. One of the charges that was given to me, particularly on the medical aspects of it, was this issue of ventilators. So as an anesthesiologist, I know what a ventilator is and what it's not, and there were many people who were just saying, "Here. For $20 million we'll give you all these ventilators." And then the question is are those ventilators or not? Larry Schwartz was involved a lot and started getting these calls, and he'd say to me, "Is this a ventilator or not?" I'd say, no. First of all, the outlets are never going to work, so no, we are not buying this. And then the issue was how do we find these ventilators? So these were some of the things.

And when you're a clinician you sort of know where some of these ventilators are on the hospitals, and that's where I sort of said, "Well, you could shut down the operating rooms because anesthesia machines are just basically ventilators with a vaporizer attached to it, you

know, an anesthesia part to it." So there were all those ventilators. There were all the transport ventilators. Research labs had ventilators. You know, all the colonoscopy offices around the state, you know, when they give somebody some sedation with those anesthesia machines, they are ventilators. So I started to say, "Here are ways we could find more and more ventilators," because we were concerned what the numbers were going to end up being, like how do you support all of these people who are going to get sick?

Q It sounds like all of that was being done on the state level.

A That was all being done at the state level, yes.

Q Okay. We know from public reporting that the Trump administration did send the USNS Comfort to New York City at one point, and the intention of that was to alleviate the pressure on hospitals. But according to the Navy Times it left after only a month and treated fewer than 200 patients in its time. Can you tell us a little bit about what happened and what the issues were there?

A Sure. So there are two parts. One is I will take the ownership for the decision about U.S. Navy Ship Comfort, because I mentioned it to the governor, and the governor called the President. And the reason I brought it up was because I was, as I mentioned in the beginning, I was here as a fellow when 9/11 happened. It was my third or

fourth day as a White House fellow. And the U.S. Public Health Service, you know, and the team that I knew, who I learned about, they said, "We're going to send up the Comfort." So I remembered that that ship came to New York Harbor after September 11, 2001. I said, "Well, maybe that's another way to get beds." So he asked the President and the President said, "Yes, we'll send it." So they sent the ship up.

The issue about this, and everyone talks about this issue about the Comfort, number one, it's a boat. It is a boat. And initially the plan was to have the non-COVID patients there. But you have to put this in the context of what was going on. So if you have all of these people with different medical conditions on that boat, who are the doctors and who are those subspecialists -- because remember, it's going to be people who are in a hospital -- that are going to be caring for them. So now you have a diabetic patient and someone with coronary disease, heart disease or diabetes, and there are different kinds of doctors who will be needed. And you could not sort of move all these doctors from the hospital systems, which were already stressed. So then the decision was why don't we just put the COVID-positive patients, where you have a little more control over it? So the governor called the President's Office, and they said, "Fine. We'll switch it to COVID-positive."

Now, the Comfort was actually managed by the Federal Government, so the guidelines of who was going to end up at the Comfort was not the Department of Health saying that. It was actually the Federal Government who decided some of those criteria. So that's one part of it. But then there's the part of who is going to go onto this boat, and this is where I always say that sometimes things sound great, but then there's the practical aspect of something. So now you have somebody who is 85 years old, has Alzheimer's, you know, is really confused, and you're going to sort of say we're going to put them on a boat and then they need to go to a bathroom, and how are you going to have them navigate through the hallways of this boat, and who is going to be caring for them. That's probably not the ideal situation for that person. And so that came into play, about the Comfort. So something which was a good plan, you know, sort of didn't pan out as well as one may have wanted, although we were trying to use those beds for individuals.

Q So I just want to clarify. It sounds like some of the issues were really, or many of the issues were really the Federal regulations related to the use of the Comfort.

A Of the Comfort. So that was part of the decisions of who could go onto that boat was part of USNS and that team.

Q And I know one of those regulations was that

patients need to be taken, at first, to a hospital to be tested for COVID, and then they could be brought to the Comfort. So that would involve multiple transfers and use of ambulances. Correct?

A Yeah. There's also another thing. Right. There's another thing people forget about, and even though we were in a crisis there's also something called transfer trauma, which is when you take people who are really elderly and move them to a place that they're not familiar with. It really affects their health, and it could really just be really traumatic. So we were trying to look at that and figure out how do we address that as well.

I will just mention, as an aside, that -- because I was thinking about this the other day -- whenever you move the clock forward or back, actually it really is disruptive to elderly people's health. There's a correlation there, their health effect in a crisis. Something as simple as a clock -- imagine moving them to a boat.

Q Thinking also about the early months of the pandemic, was there enough PPE and testing kits for hospitals and nursing homes to limit community spread, and what impact did that supply, or lack of, have on the safety of residents and staff?

A So we needed more. We clearly needed more, and that was a challenge. And it put staff in a difficult

position to try to do what they are committed to doing, caring for people, and recognizing that they wanted to watch out for their own safety and also the safety of those who they were taking care of. So it was problem not just at -- you know, everyone talks about long-term care facilities, but it was everywhere. It was a problem everywhere.

Q And as we talked a little bit about earlier, New York was trying to deal with the supply issues on a state level, but it took a long time for there to be a national effort on the supply chain issues.

A That is correct. I can speak to New York. That is what I read and heard. I could speak to what we were trying to do in New York, which was primarily figure out where we could get these supplies. And remember, initially it was, well, you don't need to wear a mask, even though we very quickly, in New York, said you need to wear a mask. But we're talking about February, right. And so every time a new decision was made, then all of a sudden people were, "Where do I get a mask?" And if you remember, even when the COVID test came out, the shelves were empty. So, I mean, people were really appropriately nervous.

Q Absolutely. Under President Biden, the Federal Government initiated a national vaccination campaign in the spring of 2021. Do you know if vaccines reduced the threat of COVID-19 posed to nursing home residents and staff?

A Well, clearly vaccinations will protect individuals from getting this disease, and for the record and for everything, it's like one of the most critical things that we could do. So the vaccines started in January of 2021, or maybe it was December. I think it was late December, the beginning of January 2021, and then at that point, you know, the more people that got it, the less the disease spread, although obviously we were concerned about variants, that kind of thing as well.

Q Absolutely. And through that vaccine rollout the elderly were one of the first groups to be able to gain access.

A Right. They had access to it. Though I think it's important to remember that when the vaccines became available the question was who gets this first, and this was not an easy decision among all those many decisions because we did not have 20 million vaccines for New Yorkers, or 350 million for the whole country. So the question was like who gets this first, and we were trying to tackle that issue as well. And it was a tough one.

Q Right. But elderly and the staff in the care facilities and the hospitals, they were all among those first waves of people to get the vaccine.

A Yes.

Q All right. Thank you. My colleague, [redacted] is

going to ask a few questions.

BY MR. [redacted]

Q Thank you. Dr. Zucker, I wanted to take a step back and get your view as a former state public health official on the role of the Federal Government in working with and coordinating with state public health officials. What should that relationship look like in a time of crisis?

A So I think this goes back to what I was talking about, about that February 25th meeting, because that was one of those pivotal moments for me, as the New York State health commissioner, because I felt the response I got, which was really, you know, the states will manage this, was disturbing, only because I felt we can't -- this is so big, based on what SARS, 2003 and 2004, taught me. Even though it did not end up being the problem here, SARS in 2003 and 2004 showed me that you need to have all these things coordinated. So it should have been a Federal-led response. When it wasn't, what we did, or what New York State did, is we decided that we needed to address the issues in New Jersey and Connecticut, because particularly in New York City, which is where this was really hitting initially, a lot of people live in Connecticut or New Jersey, or vice versa, and we said if we don't have a coordinated response between the three states we would have a problem. So regularly, every week, I was on -- I remember the calls -- 7 a.m. in the morning, a

phone call to my fellow commissioners, to try to figure out what are you doing and what are you saying to your governor, and how are we going to coordinate this? And we realized that if we weren't coordinated, at least at those three state levels, we would have a problem. Then we also, once a week, spoke to what's called Region 1 and Region 2, so all the way up to Maine, New Hampshire, and all the way down to Pennsylvania, I think was involved. Pennsylvania may have been the next region. We also spoke to Pennsylvania. But all the other states -- Massachusetts, Rhode Island -- we would speak on a regular basis as well once a week, as to what they were doing. Because it's just very congested, the northeastern part of the United States and states that small, so we tried to tackle that as well.

Q You say you left the February 25th conversation with the impression that the states were responsible for managing the response. Can you describe in a little bit more detail what exactly that looks like, what it means for the states to be managing that response?

A So after that meeting, I flew back directly to Albany. I remember the governor said to come back. And so he wanted us -- he wanted me -- to go to the legislature and to present, and I think it was that week, to present to them what is happening, in an effort, also, for their approval, for $10 million, I think -- I would have to check the number

but I think it was $10 million. Maybe it was $40 million -- but money from the state to have an emergency response and start looking at where do we have ventilators, what are we going to do about PPE. And also I suspect that by giving him the authority of having an emergency would open up, from probably legal channels, more opportunities to be able to do things. And don't quote me on it, although I guess I am already quoted on it, but that's how I actually understand it, that once you had the emergency authority then some of these other things can move forward. So I said, okay, now we need to start to tackle this. What are we going to do about testing? So we already were working to try to get that FDA approval for our test. What are we going to do about drive-through testing sites? What are we going to do about the hospitals? How are we going to address some of the [unclear] issues? How are we going to find PPE? So all of that started to become state-run operation, even the hand sanitizer issue, which we made. And it gave more of a control within the state to address this.

Q And so you mentioned in the last hour that you started as the New York State health commissioner and took on, obviously, during your tenure, a number of different crises, the pandemic included, but you mentioned, for example, Ebola, Zika, and a few others. I would appreciate your perspective as it relates to the Federal response,

recognizing, of course, that Zika and Ebola are different viruses than the novel coronavirus. How would you compare the Federal response to, say, Zika or Ebola to what we saw during COVID?

A I think it's a tough question because this was something which we had never seen before, at least in our lifetimes, or the vast majority of Americans' lifetimes. So it is a little hard. I did not feel the response was what I had wanted from the Federal Government about being coordinated. However, I will say that when I reached out to some of the people within the Federal Government I did get answers. So when I reached out to Bob Kadlec I did get a response from him about something that we needed, and he was the ASPR. This is the secretary for preparedness and response. But his response directly to me, and that we had a relationship previously, was, fine, but it wasn't the coordinated response that was needed. It obviously was lacking on that.

And back to the Ebola question, so I'm saying this is a little bit different. So Ebola is probably a better one to compare this to because Zika didn't take off, Legionella was localized, you know, measles was just in Rockland County and some parts of New York City. But Ebola had that same feel in America, like what could happen. And we did have a handful of cases, and we had the one case here

in New York. And the communication with the CDC was really good. It was really good when we were trying to sort some of that out. But again, it didn't turn into the multiple cases of Ebola. So I can't answer.

And then just going back to our questions before, but I did get answers from Dr. Redfield from CDC as well on this. But again, I think it's a hard question to answer, just because some of those things did not blow up into what happened with this.

Q Of course. And then just taking a step back, since it is a sort of public health term, and I just want to make sure it's understood for the record, when we're discussing the concept of community spread, could you sort of explain, just in sort of layman's terms, what community spread is as a phenomenon?

A Right. So basically if one person has COVID, or any infection or virus, and they give it to two, then it's just going to continue to spread. So if one person can only give it to one, or if one person isn't going to give it to another person then it's not going to spread. So basically the community spread is when one person has a disease and it is rapidly expanding to many other individuals, the rate of transmission of this disease. So early on we did not know the rate of transmission. So for example, measles is pretty contagious. Chicken pox, even though nobody gets chicken pox

anymore, but if you had a child and you brought your child into the pediatrician's office and he sat or she sat in the waiting room for 5 minutes and then someone said it's chicken pox, all those kids in that waiting room, who had not had chicken pox probably are going to get chicken pox, because the rate of transmission, it is so incredibly contagious. And we did not know early on with COVID whether this was the chicken pox scenario or other scenarios, of other illnesses that we have, where it doesn't really transmit or is as contagious with others. So when something is community spread it is going from individual to individual relatively rapidly.

Q And then when we're looking at community spread, obviously in settings where there could be medically vulnerable individuals -- hospitals, nursing homes, assisted living facilities -- what is the relationship between sort of the observance of community spread as a phenomenon and, you know, the ability to insulate or protect those individuals in those settings?

A Can you rephrase that? I'm trying to understand what you said.

Q So let's take, for example, staff at facilities, right, members of the community. If we're looking at community spread what would it mean, for example, for staff members who are treating those patients, treating the

vulnerable at hospitals, assisted living facilities, or elsewhere, and sort of potential pathways for individuals in those settings to become infected?

A So those who are vulnerable, if they are being cared for by somebody who is not taking the necessary precautions -- the masking, social distancing will obviously be a little bit difficult, but the hand washing -- then they are surely putting those individuals at risk. So when you bring it back to, I guess, the long-term care facilities and nursing homes and the staff that came in, so as I have said previously, that they inadvertently brought this into those facilities. The issue about community spread also, there's one other part which is important. You can have community spread of diseases where you already know that you're sick, and so if you have a runny nose and are coughing, you probably should not be going into work. The issue with this particular coronavirus and COVID-19 was that there was all this asymptomatic spread, so people were already contagious and shedding virus before they themselves actually realized that they were ill. And that was one of the hardest parts that we had to deal with, and it really is what contributed to the spread in these nursing homes.

Q And then so as it relates to the possibility of community spread, the idea that, as you were describing, you know, community spread, the spread of COVID-19 potentially

via staff into these settings, poses a sort of threat to vulnerable residents. Can you explain the role of testing in reducing the threat to individuals, say, in any of those facilities?

A So testing, obviously, was something we proposed on, because we felt that if you knew someone had the disease then you could sort of take them out of the area where they are working and keep them home and keep them basically isolated from others, then you will decrease that spread and you will basically try to stop the continued transmission of the disease. Initially we thought that, well, if you can control who is sick we will stop it, but at a certain you just basically, you can't control that anymore, and it's gone past the point of sort of prevention further spread. So those individuals who are caring for those individuals who are elderly or sick, then you only increase the risk of spread of disease.

Q And what about the role of PPE?

A Oh, so right. So that will obviously protect you, help protect the spread of disease.

Q And so then would you say that the lack of Federal coordinated response you were describing earlier in this hour, specifically as it related to the availability of sort of key measures, or COVID-19 mitigation measures, like PPE, put people in these vulnerable facilities -- nursing

homes, hospitals, or elsewhere -- at risk?

A Well, I think that in the big picture, yes, in the sense that coordination was needed, yes, that PPE would have obviously helped. And the answers to what could have been done to get more PPE is an issue where the Federal Government needed to be involved, stepped in.

Q Okay.

Ms. [redacted] Thank you, Dr. Zucker. That concludes our questions right now. We will reserve our time and go off the record.

[Break.]

Ms. [redacted] On the record.

Mr. Boxer. There was testimony about Dr. Zucker's presence on the second floor of the Executive Chamber, and I just thought you should clarify how long that lasted for.

Dr. Zucker. So that is an important point because initially I went over there and I was sitting there and trying to manage things, but it was hard because the Department was in another building, and some of the things that I had mentioned before about my executive deputy commissioner running things and sort of those operations were happening there. So after a certain period of time, probably about 3 weeks or so, I went back over to the office -- and I would be running back and forth -- but I felt that it was

more important to be able to be within the team and the Department of Health. And also my support systems were there. I had my assistants there, I had others there, and that was really important for me to be able to see them in the hallway and to be up to speed on what was happening. So I wasn't in the Chamber as much at that point because I felt I needed to be over there on that side.

Mr. Boxer. Thank you.

Ms. [redacted] Thank you. Off the record.

[Break]

Mr. Emmer. Back on the record.

BY MR. EMMER:

Q So Dr. Zucker, we are just going to get started right away by, I would like to introduce what will be marked as Majority Exhibit 2. This is the Impeachment Investigation Report to Judiciary Committee Chair Charles Lavine, and New York State Assembly Judiciary Committee published on November 22, 2021.

[Majority Exhibit No. 2 was marked for identification.]

BY MR. EMMER:

Q Do you recognize this report?

A Is this the report that I spoke to the Assembly about?

Q I think so.

A I've never seen it, but I think this was one that I spoke to.

Q Okay. And that was going to be my next question, so we will skip through that. So I want to direct your attention -- and we're going to be using throughout our question, but let's start on page 41, and it would be the second sentence. Have you been able to find that?

A Yep.

Q And I'll read it out loud here. It states, "The COVID-19 Task Force was comprised of senior state officials from various state agencies, as well as former state officials. There was only one healthcare professional on the Task Force, a senior DOH official, and that senior SOH official did not have regular meetings with the former governor during the pandemic and found it difficult to speak directly with the former governor, as senior Executive Chamber employees guarded access to the former governor."

Dr. Zucker, I am presuming that you are the senior DOH official referenced here. Am I correct?

A I believe so.

Q And that statement that there was only one health care professional on the task force, was that also correct?

A That's correct.

Q Okay.

Mr. Boxer. May I ask you, did they ever reveal,

like -- I see they have anonymized the footnotes. Did they ever reveal that? They probably don't.

Mr. Benzine. I don't know.

Mr. Emmer. Yeah.

Mr. Boxer. I mean, he answered your question. I was just curious if you had something that showed who they attributed that to.

Mr. Benzine. No. Just piecing together the press releases and the statements.

Mr. Boxer. That's good.

Mr. Emmer. And it just completely relates to the former governor.

BY MR. EMMER:

Q So I want to break the second part of that excerpt. Is it true that you didn't have regular meetings with the former governor during the pandemic?

A So the way it was set up was, as I mentioned earlier, we had the gathering prior to the press conferences, where everyone, or most everyone, was in the room. And at that point I could raise a question or so, and often after those press conferences there may be some follow-up from there. Sitting down with the governor by himself was not something that happened on a regular basis. There were occasions where I would find myself, you know, with him, just the two of us, during the pandemic, or even prior to that --

I read the rest of that paragraph -- and I felt it was easier to talk to him when it was just the two of us.

Q And the next question I was going to ask, and you just sort of answered it, so are you saying you would have preferred, at times, to be able to advise the governor without the rest of the staff there?

A Yes, I would have preferred that at times. And perhaps if I had pushed harder, maybe that would have happened. But I did, at times, say I wanted to talk to the governor, just alone, and often it was, "Well, what is the issue? Talk to Melissa."

Q Okay.

A And there were moments where we would be on a helicopter where it just ended up being the two of us, and I could have a conversation with him.

Q And for the record, you just mentioned Ms. DeRosa. Would that be the senior Executive Chamber employee that the paragraph referenced?

A Uh --

Q I can read it again too.

A I'm not sure which part you're referring to.

Q So, and I'll just read it out loud for the record. But it says, "There was only one healthcare professional on the task force, a senior DOH official, and that senior DOH official did not have regular meetings with

the former governor during the pandemic and found it difficult to speak directly with the former governor, as senior Executive Chamber employees guarded access to the former governor."

A Right. So that was -- well, it was her, but also sometimes there were others. I mean, there was his executive assistant, and there was sometimes the, you know, chief operating officer. That was sort of the crowd.

BY MR. BENZINE:

Q In these group meetings, leaving aside kind of like the odd-man helicopter meeting or one-on-one, was Ms. DeRosa usually present?

A Usually.

Q Ballpark on usually. Like the vast majority of the time?

A I would say the vast majority of the time, yeah.

Q Would she, in meetings regarding the pandemic, would she kind of control the meeting?

A It depended on the issue. Usually if he was sitting there he controlled it, but if there was something that she actually had the substantiative knowledge about she would raise it. Or if there was an issue that we were sitting there that needed to be raised with him, usually it all ended up channeling her and then she would raise it. He would often like direct the questions that he had to whomever

he thought was relevant. So if it was a legal issue he would turn to the legal team. If it was a medical issue, he would turn to me.

Q You also mentioned Governor Cuomo's executive secretary, if that's the right title, versus secretary to the governor, kind of the difference between --

A Right.

Q -- an administrative role and the chief of staff type role?

A Right. Right. So the Secretary to the governor was Melissa DeRosa, and then there was the executive assistant. I don't even know what Stephanie Benton's official title was, but she, you know, handled all the administrative aspects.

Q During the pandemic, especially like scheduling meetings, trying to get things in front of the governor, was it more often to go through Ms. Benton or Ms. DeRosa?

A Usually it was Melissa DeRosa. Can I just mention one other thing? Sometimes he would want to speak to me directly, and I'd get a call from Stephanie -- usually it came from Stephanie -- "The governor wants to talk to you." So that happened.

BY MR. EMMER:

Q So the next sentence on page 41, after footnote 335, it states, "Moreover, the senior DOH official did not

feel able to speak freely to the former governor or senior Executive Chamber employees, as advice that was contrary to the Chamber's views was often rejected. The senior DOH official felt that speaking up could result in an even more limited ability to provide advice going forward." Dr. Zucker, what advice contrary to the Executive Chamber's view, did you offer?

A That statement really refers to a particular situation, and it goes back to the summer of 2020, particularly June. And there was a strong push for me to open the sleepaway camps. And this push did not come from the governor. It came from some of the senior staff, particular the general counsel and also the budget director. They were pushing me, and others were pushing me, to just open the sleepaway camps. And this goes back to something we spoke about earlier, when I was saying that if there was something truly medically wrong, in a public health sense or a medical sense, that I felt was absolutely detrimental to the life of people in New York, then I was going to push. And this was one of those moments in time where I felt that I was sort of being pushed to do something that I did not want to do. And I also felt like, during those days when this was happening, that people didn't want to even talk to me [unclear] some of the plans involved. And ultimately, the governor caught me in his office in New York City -- he was

leaving his office and I was in the hall -- and he stopped me, and he said, "Doctor, you don't want to open the sleepaway camps, I hear," and I said, "No, I don't." And then I just explained the reasoning for it, and I don't have to go through it, but it was my public health reasoning. And then he just said, "Okay, don't open them," and that was the end of it.

And so when we go back to this issue about access, that was one of those times where it would have been nice to just be able to say, "I don't want to do it." Now, I probably would have gotten to that because I was so fixed on not doing this, because I felt this was one of those times were this could be a problem. And I remember I said to him, "This is going to happen where some COVID case is going to create a problem across the entire bunk. I don't want that to be New York." And it did happen, and I remember when it happened. He read it and he just looked at me, and sort of smiling, he realized what I said was going to happen, happened.

Q Okay. And the way that that sentence is phrased, advice that was contrary to the Chamber's views was often rejected, obviously you just testified, you provided us an example. But would you say there were other instances, maybe not as notable?

A Probably not as notable. That one is what comes

to mind for me. But sometimes I felt that I was bringing, like, the public health view forward, and in defense of Melissa, she would listen to me, and she heard it. I always wondered what other things might enter into her calculation about some of this -- this is for a conjecture kind of thing -- but there were times where I felt that many on the team felt I was just like this academic, you know, the public health people, and they don't recognize the bigger picture on this. And sometimes, you know, we were a little more academic than we should be and this was a little more complicated, but then there were those moments like the sleepaway camp, where I was not going to budget.

Q Okay. Well with that excerpt and the example in mind, do you feel that politics, those considerations, namely from the governor and his staff, restricted you from fulfilling your duties as commissioner?

A You know, it would be -- you know, I don't want to come up with sort of a theory of why I think some of these things happened, but I think that it was very hard, after the first handful of months, to think that all of these other political issues didn't have some impact from all sides. But I, personally, said what is the best decision that we need to make, and sometimes it was tough, and sometimes you sort of had to choose, is this a battle worth fighting? And going back to what I was saying before, is my basic question that I

would sit with in my own head was like, is someone going to die, is someone going to die if we do X or Y? And then I'd say, well, no one is going to die from this -- this is not what I would do or whatever, but no one is going to die. Pick a different battle to fight.

Q Thank you. So now you've already discussed a little bit of it, but we're going to pivot just to the beginning of the pandemic. Obviously, you differentiated between when you first read about it in the Wall Street Journal, and you said that would have been around January.

A The first week of January.

Q And at that time were you able to identify which populations would be most at risk to COVID-19?

A When that happened I called -- the first thing I did -- I was trying to get some answers -- I called the public health experts that I knew to try to get a feel of what the temperature is of this whole issue, you know, the basic temperature of this whole issue, and who was getting sick, and what we could learn from others. And then I spoke to some of my medical colleagues in other parts of the world who also had their finger on the pulse from their context, particularly in countries like China. So I said, "What are you hearing is going on?"

Early on, when this hit Westchester and we were looking at the case -- remember I said I was trying to look

at each individual case? -- so I was looking, and I said, all right, this one has asthma, diabetes, diabetes, and I'm saying wow, hypertension, hypertension, and then you start to try to figure out, is there a certain cohort of people that were more likely to get ill? I recognized that anyone who has any kind of immunocompromised state was going to surely be more likely to get ill. Anyone who is frail is probably more likely to obviously get ill. And then I also felt that little kids would probably get ill, although ultimately, except for one component, they actually fared pretty well. And then we were sort of saying, can we find some common denominator here? Can we find some common denominator to determine who we should be directing some of our therapies too and to reaching out. But ultimately it became so expansive it was hard to track down. A

Although I will tell you that I personally thought two things. One is why was it that more men were getting sick than women, in South Korea and other places early on? And so this goes to sort of when sometimes people ask, "Why were you not doing X or doing Y?" is because I said, "This is interesting. Maybe it is that women have two X chromosomes. Maybe there's some protection by, you know, the other X chromosome, or maybe their immune system is on there." So these are the kinds of things I started asking, because if there was something we could figure out early on

then we will save a lot of lives. So I was looking at all of that early on in this.

Q So to wrap up what we just discussed, when it comes to nursing homes and the elderly, in particular, can you provide an estimate of when you were able to identify them as particularly at risk to COVID-19?

A Sure. So somewhere in early March, or maybe it was late February, I don't remember the exact time, there were some cases in nursing homes out west, whether it was Washington State or Oregon, but somewhere in the Northwest there were a couple of cases I remember. And I said, affordable housing, if it's there, you know, even though we didn't have -- maybe we had a few cases but we didn't have any in the nursing homes yet, that we knew of -- I said it's going to be here. And so we obviously recognized that that is one of the populations, and we tried to address that by closing -- the governor closed visitation to nursing homes in Westchester very early on. I remember this because there was such criticism of us, saying, "I can't believe you're stopping the visitors from coming into these nursing homes," but we recognized this was a concern at that point -- the second week of March, somewhere around there. I don't remember the exact date. So we knew that this was a population which was at risk.

Q So I'm going to introduce what will be identified

as Majority Exhibit 3.

Mr. Emmer. I think we have -- we might be missing this.

Mr. Benzine. You can just read it.

BY MR. EMMER:

Q If it's okay with you I'm just going to read what the excerpt says, and we can provide it to the minority staff as well. It is just another excerpt from Ms. DeRosa's book, where she states, "Dr. Zucker advised a more sweeping action was necessary. Every day was a flurry of activity. While we understood very little about the virus, the medical community was certain it was especially dangerous for the immunocompromised and the elderly, a situation we saw playing in Seattle, Washington, where nursing homes were being enveloped by COVID spread. And so the governor took the devastating step of banning visitation to nursing homes while requiring health screens for all nursing home workers each day upon entering the facility, and requiring all staff to wear surgical masks to guard against any potential asymptomatic spread."

A That is correct.

Q And we already discussed guidances. But DeRosa wrote specifically that the governor took this devastating step of banning visitation to nursing homes. What do you think she's referring to?

A I think it goes back to this Westchester issue, that he said that we cannot have visitors come in because of the concern of the cases -- that was very early on. That was like the beginning of March, at some point in the first two weeks of March that we shut down the visitation. And we also started to monitor people.

There's one other thing I remember that we did. I don't know whether it's there or not. We also tested people for flu because we realized that if you have all of these symptoms, with fatigue and fever and cough, and it's not the flu -- because we didn't have testing, right, no tests for COVID -- then it probably is COVID. So by the process of elimination. I would have to check the details of that, but I do remember us actually thinking this would be a way to try to figure out who possibly has COVID, given that we don't have testing for it.

Q So do you recall a guidance from the New York State Health Department that was issued on March 13th?

A The middle of March, right. I don't remember. If you have it I'll read it again, but I'm sure you do.

Q So now I will be introducing what will be marked as Exhibit 3.

[Majority Exhibit No. 3 was marked for identification.]

BY MR. EMMER:

Q And running through this, just, I guess, a very general question here. Again, Ms. DeRosa's statement, "The governor took the devastating step." Would it be your impression or opinion that this March 13th order is, that's what she would be referring to there?

A I think this is because she -- I think she mentioned it right stopping visitation, right? And that was the only thing there. But I thought this was just in Westchester. Maybe it was everywhere. Maybe this was everywhere.

Q So it's clear that you would have remembered what exactly prompted this?

A Yeah. I think we started where we did this in Westchester and then we did it everywhere, and I think the Westchester was early on because that case was March 2nd/3rd. So I suspect knowing how he operates is like, we're going to do this right now, and so shortly thereafter. And then once the cases started to expand we did this everywhere.

Q Okay. So returning to Ms. DeRosa's statement really quick, would it be your opinion that when she writes the steps the governor took related to nursing homes she's actually referring to New York State Health Department guidance?

A I think so.

Q Thank you. So that's all. We don't need that

one anymore. So I'll fast forward to the March 25 guidance, the main reason we're here. I would like to introduce into the record what will be marked as Exhibit 4.

[Majority Exhibit No. 4 was marked for identification.]

BY MR. EMMER:

Q I will give you a second here to look that over.

All right. So first question, Dr. Zucker, did you or the Health Department draft the March 25th guidance?

A So this is probably the biggest question that everyone always asks about, this guidance, this advisory. So the way these things were put forth is a little bit more about what was mentioned before. There were the experts who dealt with long-term care. There was the Governor's Office that dealt with the advisories, particularly the general counsel's team. A combination of the two of them, whether it was first the governor's general counsel or if it was our team in DOH, of which one initiated sort of this report, I can't speak to specifically. But I do know that the guidance documents needed the expertise from the Department and they needed the legal clearance from the Governor's Office and the team over there. There is so much about this, and I'm sure you're going to ask questions and I'll wait for your questions.

Q So I guess if we were looking for the original

draft of this guidance, where would you suggest that we find it?

A I don't know because when this was an issue, and I was still the commissioner, I asked that question, and I could not get it, of looking for where this came from. So I didn't push it, but I just sort of said, "Does someone have the original draft?" and I never got that.

Q Do you recall who you asked?

A I asked our, at that time, you know, general counsel, I guess, but they didn't have it. I think, you know, it's important to know how this --

Mr. Boxer. You said you were going to wait for the question.

BY MR. EMMER:

Q Well, the general counsel that you're referring to, is that the Health Department's or --

A Yeah, the Health Department counsel.

Q Okay.

BY MR. BENZINE:

Q Did you ever reach out to anyone in the Executive Chamber regarding the guidance?

A No.

Q Was that situation kind of out of the ordinary that you would ask where something came from and would get an "I don't know"?

A I never actually asked. And it was one of these questions of almost like in passing, which was sort of, "Do you guys have the original document?" I don't remember what they said. "If not, I'll check," and I don't even think I ever followed up after that. And it was probably during all of these articles or whatever that were being written, and that was it.

BY MR. EMMER:

Q When you did ask questions did you ever ask what prompted the directive to be drafted?

A I know why this was drafted. I know why this was drafted.

Q Can you just briefly summarize?

A Sure. Sure. So it goes to what was transpiring at the time. So we have to put this in context. And now we're in March, the middle of March, and the numbers are going up. The third week of March the cases were escalating at a rapid pace, and I would wake up in the morning with 1,000 more positive cases, and unbelievable numbers of people being admitted to the hospital.

But a few days before this was drafted, or sent out I should say, the modelers came back with what is going to happen. So the governor asked for the public health expert modeling teams that were consultants to provide us with where this was going, and they predicted up to 136,000

people would be in the hospital at peak, which was X number of weeks away. I don't remember, 4, 6 weeks away from where we were at that point. And when I looked at the rate at which people were going to the hospital it made sense that we could end up there.

And at that point, we also had, around this same time, a crisis at Elmhurst Hospital, where they had about 234 positive people in the hospital with COVID out of their 400-or-so beds, and 13 had died in one 24-hour period. And the hospitals were getting overwhelmed. Greater New York Hospital Association called the governor and the team -- we were all there in a conversation; a lot of us were there -- and said that we have individuals who are better, they have recovered, and they are just sitting in a hospital bed but they need to go "home," quote "home for those who are in long-term care facilities or the other ones would just go home. And the long-term care facilities were not going to take them and that we needed to do something, which generated this document. At the same time around then we had all of these other issues where the hospitals were putting beds in the hallway, and the concern was that if we do not open those beds up and if these predictions are correct, the only other option is to take someone who is ill, whether from a nursing home or just walked into the emergency room, and put them in an ambulance or a helicopter and drive them or fly them up to

upstate New York, where the numbers were less, at that period of time.

And this goes back to what we were talking about before. The physician in me said that is not a wise thing to do. As one who has taken care of critically ill people, you're going to move this person in the ambulance, they are going to crash or get really sick, you're going to pull the ambulance to the side of the highway and try to intubate them, put a breathing tube in, and they will end up getting worse or dying, and you'll say, "Why did you send someone 300 miles when there is someone sitting there in a bed who actually could just go back to the nursing home where they came from" and make a bed for that patient, or for that matter, another nursing home patient who was sick that needed to go in.

So then one could say, well, you are sending them back and they were sick or recovered or whatever. But the fact is we followed the CDC guidance that was out at that time, and CMS guidance, and the guidance, the CDC guidance about transmissible disease at that point, said that those individuals were not infectious, based on the criteria. And this is probably at the core of so many issues that your committee and others need to understand, that the advice from CDC of 3 days after fever, 7 days after symptoms, they could go back, that was Federal guidance. In addition, the median

amount of time that they were in the hospital was 9 days, but you have to also remember that -- and oh, and CDC said that at 10 days your infectivity is zero -- this is in the documents -- and also infectivity is the worst in the first couple of days of illness. In fact, even in this asymptomatic period, which is part of the reason we have this problem with the pandemic.

But you also have to think about this from the standpoint of what is really just reality, which is you have an elderly, 85-year-old Alzheimer's patient sitting in a nursing home, and they wake up one morning and they are not feeling so great. Your reflex is not to take that person, say send them to the hospital. They way, well maybe they didn't sleep well, maybe they didn't eat well. But by that point it was already 2 days, 3 days, maybe even 5 days, based on what the science shows, of disease that has already been replicating and the activity has already started. Now you have them a day, maybe 2 days, in the nursing home, and someone says, "Maybe we should send them over." Then he spends 9 days, on average or median, right, 9 days over there. By the time they were going back to the nursing home they are not contagious, and this is at the core of this. So we followed the guidance, but also from the pure public health medicine part of this, and the science that we have, they were not going back to the nursing home where they are

going to be contagious.

Now people have said, and I know I'm getting into the weeds on this, and the science on this, the test was positive. But the fact is that the tests back then were PCR tests -- and I don't want to go into all the detail -- and the way those tests work is that they pick up the RNA, which the virus has, and it could be dead, it could be alive, it doesn't matter. It picks it up. It's not the same as the little test that we do today at the bedside.

So in actual fact, the individuals who were going back from the hospital to the nursing home were not contagious, it was not the driver of what caused the nursing home deaths. We have showed that. I did that in a presentation on July 6th. I marched through all of that in a July 6th presentation. And we also showed that we had all of these nursing home staff that were sick, and it's not to be critical at all. And I admire them, they worked really hard, and this was just an inadvertent problem. And if you're walking around you don't even realize you are asymptomatically spreading a disease, then they spread. And there were 37,000 staff, which was 24 percent of our nursing home staff, that were positive. And we did antibody testing also on many of them, to try to figure out how many were sick.

So that's what happened. So we followed the

guidance that was there as what would be considered a transmissible disease, we issued this to open up the beds so the system did not collapse, given what we had been seeing in that week before and also those numbers, and we put it forth as a way to prevent the system from collapsing.

Q We're going to be asking a little more detail as we move through, but I appreciate that summary.

BY MR. BENZINE:

Q So it was issued --

A The 25th.

Q -- March 25, 2020. You had it on the tip of your tongue. I should have had it on mine too. When did you first see a copy?

A So I actually do not remember seeing this advisory. I was there, along with the others, from the Governor's Office when the decision was made to issue an advisory, and then it was put into motion. So I do not actually remember even reading it, but I support the decision, and I will admit that I knew it was going to go out, but I don't remember actually seeing it because the emails that were flying in. And I once went back and looked, and there was one email to me with this on the copy, and that's all I know, and I just missed it.

Q Is that common? Like you're the commissioner. Would you not have kind of -- your name is on it -- would you

not have final authority?

A I know, and the answer is because of the speed at which these things were going, yes, it is possible. Normally, you know, when we were talking earlier, the team was asking about other diseases and Ebola. Normally when things were slower I would see something and sign off on things, although not every single advisory but probably something at this level I would have. But there were so many things happening at that time, and there was an urgency to get this moved forward, and I may not have seen it.

Mr. Benzine. Go ahead.

BY MR. EMMER:

Q I was just going to -- and I might be making you repeat yourself -- but what I asked, if you had any idea of where this would have originated from, you just mentioned that you were part of these meetings before, where you initially talked about it. So do you have a suspicion of who would have been involved in the drafting process?

A So it would have been from, we had a long-term care team at the Department, and we know that the governor's general counsel, you know, had to sign off, or her office needed to sign off, and it needed to go through them to be cleared. So both groups were involved.

BY MR. BENZINE:

Q We talked about like the inner orbit of Governor

Cuomo. Were any of those individuals involved?

A They knew about this because they were there when this discussion happened, about we need to open up these beds, because that phone call came -- that ought to have come to me but it came to their office, that we need be [unclear] some of these people out.

Q And then -- and again, I apologize if we are asking the same question, just kind of in different ways, but what was kind of the time frame there? When did that phone call happen, to the issuance?

A That was probably all within a handful of days. I mean, the 25th, I think, was a Tuesday, I'm pretty sure, so the models that were coming out were only a couple of days before that. There were no weekends, so it could have been Saturday. I mean, I worked 572 days without a day off, so it could have been on a Saturday or a Sunday, and then we moved forward and did it.

Q Do you recall -- and you didn't necessarily recall seeing the final version of the report before it went out. Do you recall seeing any iteration?

A No. No, I don't. I actually don't. My feeling was, okay, we need to do this. Let's do it. And there were many other advisories also, so we said, we need to issue it, issue it. Some I looked at. Sometimes they ended up on my desk. Sometimes it was a lull for a moment, so should I have

a glance at this, and I didn't.

Q So obviously there was kind of the clearance process through the Governor's Office, through general counsel and then through, on some issues, the governor himself. And then a clearance process through the Department of Health. If you aren't the one saying okay, publish, who would have been?

A Well, the executive deputy commissioner, a lot of things went up the channel there as well. But --

Q I'm asking --

A I understand. You're asking who had the sign-off on this.

Q Mm-hmm.

A And I guess that's a question to ask, like sort of -- I guess we could ask the executive deputy commissioner. But it is possible that someone said to me -- and this is conjecture -- say, Howard, they want to send the advisory out about the nursing home residents going back. Are you all right with it? Yeah, but not actually reading it. You know, it could have happened that way that someone said, "They're ready to send this," "Yeah, send it" and not actually sat down, because I was doing five other things at the same moment. I wasn't worried. I made the decision it was fine to do.

Q I guess I'm kind of wondering if it was possible

that the Governor's Office executed this on its own.

A I would think -- well, I know that the legal team was involved in it, and I know that our team had to provide some of the science aspects or some of the information. But I can't answer as to whether they just said, "We're just doing this." But the fact is it has to go through the Health Commerce System. I think that's how most of these go out. And it has to come through the Department. So at some point, you know, if it's a Department of Health advisory, someone has to literally sit down and say, "Take this, put it into the system, and send it out." So it would have to come back to the Department of Health in some manner. It may be through the administrative channel or something else, and only like the executive, the Governor's Office, the Executive Office, would go without us seeing.

Mr. Boxer. Can I have one second to speak --

Mr. Emmer. Off the record, please.

Mr. Boxer. Thanks.

[Pause.]

Mr. Boxer. Thank you.

Mr. Emmer. We can go back on the record.

BY MR. BENZINE:

Q Again, to the best of your recollection, did you or anyone that you were aware of, through any of these conversations, consult with the nursing homes prior to

issuing this?

A So this -- I don't remember. I remember talking to the nursing homes, the kind of phone call, and I don't remember if it was about this or -- and it may have been. I had a couple of phone calls with them, but I don't remember what it was about. But, I mean, one of the issues with this is that everyone reads this, and it's worth mentioning because it's underline. Everyone believes that this was -- that they had to do this. There's a whole discussion with the nursing homes that said that they had to do this. This was not something that they had to do. They could interpret it that way. All that was written here, on this issue, is that you can't deny them admission.

I do remember why, when this whole thing was started, one of the thoughts in my head -- and I actually shared it with the others in the team or in general -- was that we don't want to go back to something I remember when I was in medical school and residency, which was when HIV started, and people were saying, "I'm not going to take that patient in the hospital." And I remember it because I was in training at that point. It was the beginning. And I said, "We don't want to do that. So we've got to be sure that people aren't going to start discriminating against these COVID, you know, people that have had COVID. The science was saying they're not infectious." So I said, "You can't

discriminate." So that was the issue.

So the nursing homes felt that this was mandated to them to do, but that was not the case. It was not a mandate, and if they had a problem they should call me. And in actual fact, I do remember saying to them, "If you have issues, call me." And of the 613 nursing homes, I got one phone call, which was someone who said, "What do we do if we have a problem?" and I said, "Are you having a problem?" And they said, "No, I just want to know what to do if we do." I said, "Then call me. You know how to reach me." The Department, apparently, I think, got maybe five or six questions, and I'm sure they resolved them. But my line was open. They knew how to reach me.

So it was not a mandate to do, and by law, they knew that they could not accept people if they could not take care of them, and they knew that from other issues long before COVID. And they had spoken to me once about that on other issues as well.

Q As best as you are aware, did anyone -- you said the former governor said a number of people have said that they followed CDC and CMS guidance. Did you have any conversations with either of them prior to issuing it?

A No. I think, not about all of this. We spoke about it at that moment, to say we need to open up these beds, and there was a discussion. They were better, and then

it was sort of, okay, let's do it, kind of thing. And then --

Q CDC and CMS?

A What? No, not with CDC and CMS. I'm talking about internally. No, I did not have a conversation with CDC. But CDC had already issued guidance documents about transmissibility and at what point can someone no longer, or no longer considered that they are transmitting disease. So it was like 3 days, or 72 hours without fever, 7 days since symptoms began. And so that was one thing I mentioned before. Also what is the infectivity. At 10 days if it's zero, well, that answers a lot in knowing how long they were in the hospital.

You know, also I mentioned before that the modeling showed 136,000 potential cases in the hospital at that point. And again, it should be put in the context of what was going on. So we had, in the state, 53,000 beds. A little over half were downstate, which was where the problem was primarily happening initially. And we did not have the ability to deal with this, and this was one of those when -- you were asking me before about private conversations where you talked to the governor alone. And I remember, this was prior to this memo, I remember saying to him, when that model came out with 136,000, I said, "We don't have this capacity." And I said to him -- I guess he looked and was like, "Well,

then what?" kind of thing. And I said, "I see this scenario of us with people in like makeshift whatever, hospital, with a breathing tube, and with some National Guard presence squeezing the bag because we don't have enough employees. We can't do this." I said, "This is a real problem." And, you know, he heard me, and I was really concerned about that, what would happen with 136,000 people in the hospital? What were we going to do?

BY MR. EMMER:

Q Do you recall whether anyone ever consulted with hospitals or hospital associations regarding the order?

A So the hospital association was [unclear] to the governor sort of saying that we have these patients who have recovered and they need to go back, but these facilities don't want to take someone who had COVID. And so that was how it began. You know, that's how we learned about all these people who had recovered.

Q Were there specific hospital associations that you heard from?

A Well, there are two in the state. There is Greater New York Hospital Association, and Hospital Association of New York State, HANYS and GNY.

Q So I would like to now --

Mr. Boxer. Did you make clear which one was it?

Dr. Zucker. Yeah, but it was Greater New York

Hospital Association, because that's primarily downstate. HANYS is really upstate and it was not a problem, really, in upstate New York.

BY MR. BENZINE:

Q After -- I was asking for like water cooler talk. So if there wasn't any water cooler talk then you don't need to answer the question. After it came out, it was in, you know, there was a lot of public reporting on it. There was a lot of New York congressional interest. There was a lot of all-over congressional interest. Did you have any conversations with anybody in the Department or the Executive Chamber that was like, regarding that level of interest? Did anyone express any concerns to you after the fact?

A Not that I remember. I can't remember, no. Now it was only later, you know, when there were all these articles, whatever, that you can start asking.

BY MR. EMMER:

Q So I would Ike to direct your attention back to the Impeachment Report. We are looking at page 41, the second paragraph of Subsection G. And I'll read out loud. It says, "During testimony before the New York State Senate in August 2020, a senior Executive Chamber official, who was in the room where a senior DOH official was remotely testifying, wrote a message on a whiteboard suggesting that senior DOH official testified, in effect, that the March 25th

directive was authorized by DOH and the Executive Chamber was not involved. This statement was not true, and the senior DOH official did not make such a statement in the testimony."

So, Dr. Zucker, were you the senior DOH official who was remotely testifying?

A I was.

Q And do you recall who the senior Executive Chamber official was who wrote on the whiteboard?

A It was Melissa.

Q It was Melissa? Do you believe that she was acting under the governor's orders?

A I don't know. I can't get in her head.

Q And why did you refuse to testify to -

-

A Because as it said, it's not true, and I was going to make a statement that it wasn't true.

Q Yeah.

BY MR. BENZINE:

Q Generally, so this issue has been investigated by Congress, DOJ, the New York Attorney General, the New York Assembly, your department, all sorts of people. Outside of this issue, were you ever instructed by anyone in the Governor's Office or anyone else in the New York State government to provide false testimony?

A No.

Q Just this one time.

A This statement.

BY MR. EMMER:

Q So I would like to introduce what will be marked as Exhibit 5. This is an email chain with Ms. DeRosa.

[Majority Exhibit No. 5 was marked for identification.]

BY MR. EMMER:

Q So this is an email chain from Ms. DeRosa, senior executive staff, and you on May 17th. The subject reads, "Please give this a read. Send back any edits you have, and then we should place in the New York Post from Dr. Zucker tomorrow."

Dr. Zucker, do you recall this email?

A I don't remember this, and I am trying to remember when this even got put in the New York Post. So I don't remember this.

Q And if you go to the last page, that is the actual substance of the op-ed, I mean, based on the email you didn't draft the op-ed. Correct?

A No, I did not.

Q And to your knowledge did Ms. DeRosa draft this op-ed?

A I don't know who did.

Q Okay. Was it common for op-eds to be drafted in

your name during the pandemic?

A Well, there were only a handful of op-eds, I think, that even came out in my name, but often others wrote op-eds that then they asked that I would approve them. Although I don't remember even if this was published or what ultimately happened to this.

BY MR. BENZINE:

Q Were those op-eds usually written by Department of Health employees?

A It depended on the issue. I mean, COVID, I don't think there were many that I put out. Other op-eds I usually, prior to COVID, I would work on with the Department of Health Public Affairs Office.

Q So notwithstanding whether or not this went out, it would be kind of out of the ordinary to have Ms. DeRosa drafting an op-ed for you?

A Yes, yes. But I -- I shouldn't speculate, but it takes time to write these things, and I think that everyone was really busy. So usually the people who do this on a regular basis usually end up writing them.

Mr. Boxer. You don't recall it?

Dr. Zucker. What?

Mr. Boxer. You don't recall it?

Dr. Zucker. No, and I actually don't recall it. I remember someone saying, "Well, you should write

something," or "We need to write it," but I don't remember the whole thing.

Mr. Emmer. We can go off the record.

[Democratic Minority Counsel had no questions at this time.]

[Pause.]

Mr. Emmer. We can go back on the record here.

BY MR. EMMER:

Q So fast forwarding to April 20th, that is the date that Cuomo was asked about the March 25th guidance, and answered that he wasn't aware of it, specifically stating, "It's a good question. I don't know," when asked. You followed up at the time, and I'm going to read you the quote. "The policy is that if you are positive you should be admitted back to the nursing home. The necessary precautions will be taken to protect the other residents there." In response to a follow-up question you further clarified that "We are working closely with the nursing home, both the leadership and the individuals who are there, working in the nursing home, to protect those individuals who are coming back, who had COVID-19, and were brought back to the nursing home from where they came." And before I ask you a question I will mention that we do have copies of the transcript, if you do want to refresh your recollection. But do you remember that statement?

A Yeah, I remember that.

Q So is it true, by that time, April 20, 2020, that Governor Cuomo was not aware of the March 25th order?

A I would say -- I think you'd have to ask him because I would think he would be, only because there were all of these discussions about this at that point in the paper. But you'd have to ask him. I mean, he's saying that he was unaware. But I remember these questions. This was from a press conference, and I will say I wasn't as clear as I would've liked to have been when I answered then. It was sort of a little caught off-guard.

BY MR. BENZINE:

Q Was Governor Cuomo in the room when the Greater New York Hospital Association called?

A Yes. Well, the call was to him.

Q So he would be aware of the general issue.

A Right. That's what I'm saying. Right. But I don't know, when you're reading that, what he's referencing, so you'd probably have to ask him.

BY MR. EMMER:

Q Yeah. He was just asked whether he, or a question specific to the March 25th order, how it worked. And, I mean, reading that underlined portion is what --

A I would say when that conversation happened the issue was we need to open up these beds. We need to get

people out of the hospital, back to the nursing home. So that he was aware of because of that discussion, right. This was going to sort out a little bit more of the details of the process and the questions about positive patients.

But I do want to bring this point up that I mentioned before, which is so central this. Just because someone is positive does not mean they have COVID, or that they are contagious with COVID. And I think this is where the science part of this is so important, because there's a narrative that has been put out there which just keeps perpetuating itself, when in actual fact, if you start to look at the science you can say, "Well, you can have a positive test and it doesn't mean much." And in fact, there were many people who were doing these tests, and they said, "Well, I'm still positive and I really want to go to X place or Y place," and you'd say, "Well, you probably don't even have -- you're not infectious, but these things pick up this dead RNA, and I don't know how long you'll be positive for." And I know it's sort of nuanced, but it's really important because it drives home the point that this narrative was incorrect that's been perpetuated.

BY MR. BENZINE:

Q You're talking about specifically the PCR testing?

A Right. The PCR testing picks up dead RNA. So

some people clear it. Other people don't clear it as fast. And so now you're sitting around with a positive test.

Q Are rapid tests PCR tests?

A No. So those are lateral flow tests. The ones that we do today are not.

Mr. Boxer. What kind did you say? Something flow test?

Dr. Zucker. Lateral flow tests that we do today are not a PCR test. PCR tests are run by machines.

BY MR. BENZINE:

Q Does that problem still exist in PCR testing?

A You can do PCR testing. Yeah, sure.

Q No, no, no. Does the problem of picking up dead RNA -- like testing positive --

A Not on the tests that we do, the ones that we do, no. The PCR test will pick it up, yes.

Q Okay.

Mr. Boxer. So if you did a PCR test today you'd have the same issue.

Dr. Zucker. Right. You'd have the same -- yeah, that's correct. That's correct.

BY MR. BENZINE:

Q So I guess what I'm trying to understand then is, I mean, that would render, at least, the beginning and end of your sickness, PCR test, rather useless, or at least the end.

A Well, not the beginning.

Q The end.

A The end. The end would be unclear. The beginning is, okay, I have symptoms and I have positive PCR. I have COVID. Then, at some point you're going to clear that whole RNA. But it may take a little longer. So that's why you go back to the CDC guidance, and say, well, when are we not picking this up in the nose? This is what some of the CDC guidance was saying, that early on there's a lot of virus that we pick up, replicant virus that we could pick up. Later on, after 10 days, it's essentially zero. And that's how they made the criteria to decide when someone is not transmitting virus, not based on just the PCR test.

Q There were a lot of regulations, or mitigation that were based off testing, and based off the flaw that you just said, there would be a lot of restrictions put on people on a flawed premise. Is that correct?

A Yes, that is -- well, if you're going to say, well, we want to wait until your PCR test is absolutely zero, is negative, then yes, you would have people who are probably fine and are still not able to partake in whatever they want to do. And, in fact, one of those early cases -- and this is from memory but I'm pretty sure I'm correct on this -- one of the very early cases, or one of the relatives of one of those early cases that was in the hospital, who was really sick,

wanted to go in and see some of their relatives, and their test continued to be positive. And they said, "You can't go until your PCR test is negative." And we were saying, "But she's been now 2 1/2 weeks out from" -- you know, whatever it was -- "weeks out from her illness. She doesn't have COVID anymore, and just wants to see, you know, her relative." And we sort of said, "Well, I don't know what to do, but we'll wait." I remember who it is. I just don't want to go on -- but I remember exactly who it is, and the case and the story is just that we were sort of stuck because they were saying, "Well, that's what the rules are."

BY MR. BENZINE:

Q Again, and I appreciate your kind of expertise in this area. It's not necessarily about nursing. But one of the things we're looking at is how to prepare for a future pandemic.

A Right.

Q And when you said this it kind of brought up a substantial issue, that we had -- I mean, I remember PCR requirements to get on -- I mean, I had to take one in order to get on an airplane to go on official travel. I mean, those kinds of requirements but then maybe improperly limit people.

A Right. But now we have these other tests, so those are pretty clear. Now, they're pretty accurate,

although not 100 percent, but I suspect as time moves on we will get more and more next generation of these tests where sensitivity and specificity will be improved.

BY MR. EMMER:

Q So I'm just going to shore up. Obviously we diverted a little bit. But back to the April 20th date, almost a month after the March 25th order, I asked you whether the governor knew or should have known at that time. But would it be safe to say that the staff in the Executive Office, at the very least, knew about the March 25th order at the time?

A Sure.

Q Okay.

A Well, I will say he knew about the advisory, but the specific question that they were asking him about who is going back and positive, he may not have known that detail.

Q Thank you. So now I want to return to the March 25th order. Do you have it in front of you? Now we'll get into some more specifics. So starting at the underlined section, where it specifically states "no resident shall be denied" -- so it specifically states "no resident shall be denied readmission or admission to the nursing home solely based on a confirmed or suspected diagnosis of COVID-19. NH's are prohibited from requiring hospitalized residents who is determined medically stable to be tested for COVID-19

prior to admission or readmission."

Dr. Zucker, can you briefly explain to us how a nursing home was to interpret that requirement?

A So -- and this is where words really matter, and I just want to say, sitting around with a lot of lawyers, we understand that -- is that it said that they could not deny readmission or admission. It did not say you have to accept them. It was specifically worded this way to say that based on their COVID test, or their COVID illness, and what their test is, or the fact that they were positive, they can't say, "Well, we're not going to take you back into the nursing home," because it goes back to the conversation I had at the beginning as to why this was issued, which were these individuals who were in the hospital, who had recuperated, who needed to go back home. The nursing home was their home, and that we were concerned that they were just going to say, "We're not going to take them. We don't want these patients. We're not going to take them."

So it's worded to say that should not be the criteria to not take them. It didn't say, like, you have to take these patients. And then regarding the hospitalized, they are prohibited from requiring hospitalized residents to be tested. Again, it's not saying that you can't test them. What it really is sort of saying is that you can't require that this patient get tested. And the reason this came out,

that part, is because we did not have -- it's only March 25th at this point -- we did not have the number of tests that we needed. We were starting to pick up the speed, and, you know, the testing that was done in the state lab, I mean, ultimately expanding this to elsewhere, but the state lab can only run so many of those PCR test at a time, that it took a certain number of hours. There was a little dish, and there was, 96, or 120, I don't remember exactly how many actual samples that could be run each time. So it's issued to say you can't use that as a criteria not to bring someone back.

But it goes back to what we were talking about before, is that we're not sending someone back to that nursing home who is contagious and will spread a disease, based on the CDC and CMS guidance, well, primarily for that part the CDC guidance, because that's looking at the science part of it.

BY MR. BENZINE:

Q Functionally, first you said it was specifically worded that way to do it on purpose. But you said that you weren't involved in the draft.

A No. I'm not saying -- I'm saying afterwards, when I spoke to people I said to them, like with this, like it's written that way, and one of the lawyers said, "It's written this way because we wanted them to understand that this was not a requirement to do this. It was just you can't

discriminate against it." Because it was underlined when we had a conversation, and I said, "This memo is shown a lot. So why is that underlined?" And they said, "Well, it's written to make sure that they recognize you cannot use that as a criteria not to bring someone in."

Q Functionally, what's the difference between "shall not deny" and "must admit"?

A So I think it's a big difference. Saying you can't -- "must admit" means you, there's this patient sitting in a bed and you must take that person in. "Shall not deny" means that the person is in that bed, and you can't say, "I don't want that patient because they have COVID." I think there's a difference. One is saying you have to take the patient, and the other thing basically says you can't say no to that patient because they have this disease.

So going back to other illnesses you can sort of say you can't deny -- I'm thinking back to the days of when I was in training -- a school could say you can't deny that child a seat in that classroom because he's HIV positive. That's one thing, versus saying you must take that patient, or that student. There's a difference. And I think it's important, the words, because I think they interpreted, or I guess they interpreted it saying we have to take these patients. But that wasn't what was said. It says you can't say no to that patient simply because they have COVID.

Mr. Boxer. Solely. I think it says solely.

Dr. Zucker. Right. Solely. Solely. That's right. Solely.

BY MR. BENZINE:

Q I guess the proper interpretation then would be a nursing home could deny the readmission or admission of a patient based off of a criteria other than COVID?

A So the nursing home could deny a patient admission if, let's say, they do not have enough staff. So I can give an example. What if it's somebody who has severe cognitive problems and they do not have enough people to assist that person and make sure he or she doesn't get up and start walking all around the nursing home? They could say, "Well, we can't admit this person because we just don't have the team to take care of them." You can't not take that person just because they were a COVID patient. That's a different story.

Q Under this guidance, would a nursing home be able to deny a patient if they didn't have enough PPE?

A Well, the nursing home should make that decision. If they feel like they don't have the equipment, you know, whether it's protective equipment or just medical equipment, they should be able to say, "I can't take this patient," and then they should be able to call the Department and say, "Here's the situation we have, and we can't take them." And

that was one of the things that was mentioned to the nursing homes, like if you can't take them, let us know.

Q Same for if the nursing home doesn't have the ability to quarantine or isolate?

A Same thing.

BY MR. EMMER:

Q I just want to unpack a couple of things here. Obviously we discussed a lot about where or who drafted, where the guidance was drafted. And am I correct, did you mention that you did have questions regarding this advisory when you first saw it, as far as how it worked?

A No. Yeah, no. I asked them why -- and I don't remember why -- why this is underlined, because they underlined, you know, as I understand this it means that they can't admit them.

Q So would it be safe to say that, I mean, at the very least, considering what the policy was, what prompted it, would you have drafted it differently if you had drafted the March 25th order?

A I guess, if you're looking back in retrospect, right -- I wouldn't have drafted this differently. Maybe I would have added a sentence to say, "Please call us." Or maybe it does say that. There are general comments about the advisory, maybe add in "Please call us if there are specific issues about your ability to take care of patients." But

otherwise, you know, it's an advisory that the nursing homes knew, like any other advisory, if there's a problem to call us. And this is COVID. But there were issues long before COVID, and questions, and they would pick up the phone and call the Department about it.

BY MR. BENZINE:

Q I want to ask about the testing line as well, how they are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or readmission. I want to unpack the structure of that a little bit. I mean, we've talked to any number of people in the public health space, and I think you heard in the minority that testing is important. Prohibition on testing seems contrary to most public health guidance. I would just like your interpretation of that sentence.

A So my interpretation is that it goes back to the timing, that at that point in time if there were not enough tests to go around, in general, then requiring all of these people leaving the hospital to be tested, then we may not have enough tests. The other challenge goes back a little bit to -- and I'm not saying this at this point, but it goes back to what we were talking about with PCRs, that if every person shows up with, you know, 15 days out, 20 days out from illness, and they're still sitting with some residual dear RNA and PCR test, they're going to be sitting there for a

long period of time.

So I guess you have to go back to whoever drafted, you know, that and ask.

Q I guess my like overarching question is the CDC, in addition to the kind of like viral transmission CDC guidelines, they had quarantine and isolation guidelines too, that were based off of test positivity.

A The CDC did.

Q If the nursing home is prohibited from testing, how do they know whether or not they could quarantine?

A Well, they had two. They had guidelines based on test and also not test, if I remember. One was, you know, transmissibility based on positive test, transmissibility based on without a test, and then it went through that 3-day, 7-day issue, if I'm correct, 72 hours since fever and 7 days since symptoms. So there were two criteria there on that.

Q I don't know. It reads as a -- and I understand a little bit where you're coming from -- but if I'm a nursing home and I have to quarantine patients that are COVID-positive, or isolate patients who are COVID-positive, if I did it correctly I have a COVID-19 ward. I've got nurses that are set up in a COVID-19 ward. And I get a patient that comes back from any institution, let alone if the patient was hospitalized for COVID, but at this point in time I think it was a safe assumption that you were around COVID. I can't

quarantine them unless I know, and the order prohibited them from knowing.

A Well, you could quarantine them for exactly what you were saying, that they were coming out of a hospital, and if you were worried that they had COVID, or were still with COVID that could be transmissible, then you could sort of say, well, I'm going to put them in a certain area, right, based on those criteria, the CDC criteria.

But it also goes back -- and I know I keep reiterating this point, but it goes back to the thing I was talking about before, is that this all sits on the premise that these individuals were going back to the nursing home with COVID that could be transmitted to others, and that's why I go to this main point about the fact that this was not the driver of deaths in the nursing homes, because of the science. And once you start with one assumption then everything that follows would be in accurate.

So I understand what you're concern is, but if the person is coming back and they're not transmitting the disease, it really would not necessarily matter that they were in a separate part of the nursing home if they don't have the disease to transmit.

Q The CDC guidelines that you've been talking about, or you've been discussing, like after 10 days they are, at this point --

A They were, right.

Q But did the CDC guidelines touch on like how they should be sent from a hospital to an outside location?

A I don't remember. They sort of said that -- I think in the guidelines it says about those who are transmissible, disease is transmissible, you need to isolate and do all the precautions that we were just speaking about. But they say here are the criteria for what transmissible disease is (a) with test, or (b) without testing. I have to go back and look.

Q They are really long documents from a really long time ago, so I understand.

BY MR. EMMER:

Q Okay. So to wrap up, I guess, well, to move from the mandatory section, I just want to look back at that March 25th order and look at the first sentence of the third paragraph. "During this global health emergency, all nursing homes must comply with the expedited receipt of residents returning from hospitals to nursing homes."

Just really quick, and you sort of answered this already, do you read that? Can a nursing home read that and believe that that is optional?

A I'm looking at it, and the way I interpret that means that if the patient is coming in from the hospital -- well, not the patient -- the resident is coming in from the

hospital, then they need to comply with making sure they get that resident and move forward and facilitate whatever needs to be done to protect them. But I don't read it saying you have to take that patient. And I guess that one sentence sort of has to be put within the context of all of these paragraphs and not just pull one sentence out.

Q And you just brought it up. I mean, that sentence, you know, the first sentence, or the first or the second, you know, it being referred to as a directive, using more prescriptive language such as "shall" and "must" rather than permissive, such as "can" or "should." And the underlined portion, I mean couldn't you see how a nursing home would interpret it as mandatory, whether or not you agree with that interpretation?

A I don't know how the nursing homes would interpret it. I really don't. I think there were many variables that came into play as to why they made the decisions that they made, or that they have said what they have said, that, oh, the state required us to do that. I think there's a lot more, which probably would require a conversation with the nursing home managers of the nursing home associations about that.

Q Do you recall the Cuomo Administration arguing that the guidance was optional under preexisting laws and regulations?

A I don't remember specifics. Which preexisting laws?

Q The relevant section would be New York Code Rules and Regulations, Title 10, Section 415.26, which stated to the effect that a facility operator may accept and retain only those nursing home residents for whom it can provide adequate health care.

A I know that. I do know that. I don't know what former Governor Cuomo said, but I do know that that was part of the criteria that needed to be met. And he may have mentioned that at some point in one of the press conferences, but I don't recall.

Q Were you aware that that section was suspended on March 18th, so prior the March 25th order?

A Which, that particular section that you just read?

Q Yeah.

A I didn't know that.

Q Okay. So if you weren't aware, obviously you weren't consulted on that executive --

A What was the executive order? What was it -- was this part of the emergency or --

Q Yeah, it was a part -- it was not specific to just that regulation. There were numerous, and I actually do not have the executive order in front of me, but it suspended

or modified that section for a short period of time during the pandemic.

A But how -- I'm unclear how that would be interpreted, based on that paragraph. I'm not sure how that suspension would tie into that. I guess I'm just not familiar with that.

Q Yeah, and that's fine. The argument that was made by members of the Cuomo administration, again, I do not have a transcript in front of me, but it was to the effect that the March 25th order was always optional, and it was always optional under that Regulation 415. That's why I was asking if you were aware of that on March 18th, there was an executive order that, among other things, temporarily suspended that regulation.

A I don't know.

Q Okay. So we can move on from that. Unfortunately we're not done with the March 25th order. So let's go back to the March 25th order and just discuss how it was supposed to work practically. So in the third paragraph, it directs that residents are deemed appropriate to return to a nursing home upon a determination by a hospital physician or designee that the resident is medically stable for return. Dr. Zucker, what is the definition of "medically stable"?

A Well, I can answer that as a doctor, you know, versus a commissioner of health, because this is, these are

the kinds of decisions that I would make about sending somebody home separate from a nursing, as a doctor. Medically stable means that someone could take of -- that they do not have a life-threatening or an even risky condition that would put their health in jeopardy when they left the hospital. I mean, that's not a specific definition. That's just what I'm thinking about in my head as to why and when I would send a child out of the hospital, you know, when they were ready to go home, one of my own patients.

Q So would it be safe to assume that, you know, throughout any given hospital, a physician who is making this determination, they are going to use their best medical judgment, which may be different from another doctor.

A From another doctor. That's correct. That's correct.

Q But to be clear, you know, as we just described it, there was no set definition of medically stable within the guidance.

A No, not in the guidance, no.

Q Okay.

A Because I think it is an individual doctor's judgment, because every person may have a specific medical condition that would make them considered stable, whereas another patient may not be considered as stable, even with the same condition.

Q Absolutely. And I just want to get this on the record, and obviously you kind of already explained it. But a medically stable patient, or a resident, could still be considered, or could be considered medically stable but still testing positive for COVID.

A Sure. Yes. Sure.

Q And we already discussed --

A We went through this whole discussion of what is positive and dead RNA and positive, yes.

Q I just wanted to save you from having to explain that all again.

A But I want it to be clear that if you are saying that, well, they were medically stable so therefore they were able to go back to the nursing home, but they were positive, but we just had a conversation that positive, that doesn't necessarily mean that they are contagious, and I think that's important.

Q All right. So we already touched on it, but we want to discuss the CMS, CDC applicability to the March 25th guidance. You and the Cuomo administration argued that the March 25th guidance was consistent with CMS and CDC. Correct?

A Correct.

Q And just for the record, yes or no, and I believe you already answered this, but did you consult with anyone at

CMS or CDC prior to issuing the directive?

A I did not, and I don't know if anyone did.

Q So I want to -- okay.

BY MR. BENZINE:

Q We had a transcribed interview with Dr. Birx a couple of years ago at this point, and as we have discussed this has gone on for quite a while. She was the COVID-19 Task Force leader at the White House for the entirety of the pandemic. And we asked her if the March 25th advisory violated CMS guidance, and she said yes. Do you disagree with Dr. Birx?

A I do. I am curious as to why she said it violated CMS guidance.

Q At the time, too, Secretary of the Department of Health and Human Service, Alex Azar, said, and I'm quoting, "There is no CDC guideline saying that you should be taking COVID patients and putting them back in the community, in nursing homes."

A You mean CMS guidance, not CDC guidance.

Q He might have said CDC guidance in the quote but he meant CMS guidance.

A CDC guidance is clear, and CMS guidance, I'd have to go back, although I see you have it, I'd have to go back and look at that guidance and see what it says there.

Q And then CMS administrator Verma said, "Under no

circumstances should a hospital discharge a patient to a nursing home that is not prepared to take care of the patient's needs." So you're saying that the qualifier of they are able to deny a readmission or admission based off their needs would qualify.

A Well, but what I'm saying is that I concur, if the nursing home cannot take care of something, an individual, they should not accept that individual, and that goes along with CMS or CDC guidance. But it even goes along with what we've said long before COVID, and they knew. All the nursing homes knew that if they cannot take care of someone they need to let us know. I mean, I would be curious to hear what some of these nursing home directors and leaders' comments on some of this are.

Mr. Boxer. Dr. Birx's testimony was COVID patients. That phrase, was that defined with any specificity?

Mr. Benzine. I'd have to look at the transcript.

Mr. Boxer. Okay. Because you would agree that someone who is on Day 4 of COVID with raging symptoms shouldn't go back.

Dr. Zucker. Right. Yes. I agree. If you're really sick you shouldn't be going anywhere. But what we're talking about are people who are completely recovered from COVID. They probably have many other challenges. And

they're ready to go back, and their physician in the hospital says they're ready to go back, and they've reached a point where they are clearly not contagious, and they should be able to return. And if the nursing home cannot accommodate them, for whatever reason -- it may be that they just don't have enough staff, period, right -- they should say "we can't accommodate this person."

Mr. Benzine. And for Dr. Birx, the question asked was did New York's guidance violate CMS guidance, and the answer was yes. She had all the documents in front of her.

BY MR. EMMER:

Q So I want to introduce what we marked as Majority Exhibit 6, and this is the CMS guidance.

[Majority Exhibit No. 6 was marked for identification.]

BY MR. EMMER:

Q Again, I can give you a second, but the easiest question of the day is do you recall this guidance?

A No.

Q Okay. Do you recall I guess the sections that -- I'll give you a second to --

A No, no. I mean, there's just so much here that to really do justice to it is to really sit down and read through it, since I'm not familiar with it [unclear] when I

was more familiar with it.

Q Absolutely. All right. So I'll direct you to the fourth page, which relates to readmitting residents. And it is that last paragraph that is highlighted.

A Mm-hmm.

Q It states, "A nursing home can accept a resident diagnosed with COVID-19 and still under transmission-based precautions for COVID-19 as long as the facility can follow CDC guidance for transmission-based precautions. If the nursing home cannot, it must wait until those precautions are discontinued." The March 25th directive did not include any similar contingency language, right?

A I'm just reading. I was reading. All right.

Q The March 25th order did not include any contingent language such as that second sentence.

A No. No. But in that statement it says, right, that a nursing home can accept a resident diagnosed with COVID, right, which is obviously these individuals, and still under transmission-based precautions. But we did not send anyone back as long as the facility can follow CDC guidance for transmission-based precautions. What I interpret this to mean is that if somebody is still COVID-positive, contagious, not just positive, that then when they go back they need to be in the facility in the right place. And number one, I've said that people were not going back with contagious disease,

but if the nursing home is concerned about that then they should take the necessary precautions to put that person either in a separate room. And there were nursing homes that said, okay, we're just going to put these four residents in one area if they were concerned, and then they know what they need to do to protect residents if they are concerned.

Q And this is kind of a hypothetical question, considering you weren't the drafter of the March 25th advisory. But why not? Why not say "consistent with CDC guidance" in the directive?

A I don't know. I don't know.

Q I mean --

A I don't have an answer. I mean, right. But you know, everything was rushed. So many things were happening at one time. But I can't answer that. I can't answer that.

Mr. Boxer. I'm not so sure, for what it's worth, the CDC guidance they're talking about in this CMS guidance is the same CDC guidance Dr. Zucker has been testifying about. Where they're talking about the infectious --

Mr. Benzine. The transmission-based precautions guidance?

Mr. Boxer. Yeah.

Mr. Emmer. Should I introduce --

Mr. Boxer. Well, this seems to be talking about something in 2019. Maybe I'm --

Mr. Benzine. No. The transmission-based precautions guidance is reference on the bottom of page 4.

Mr. Boxer. Right. And this is March 13th, right?

Mr. Benzine. Mm-hmm.

Mr. Boxer. I think the one he's referring to is subsequent to that, but before March 25th.

Mr. Emmer. Are you referring to the actual CDC interim guidance that is referenced here?

Mr. Boxer. I'm saying I don't think what's referenced here is what Dr. Zucker has been testifying about, the CDC guidance about how long you are until you are infectious.

Dr. Zucker. Well, there is one guidance that they had which said CDC transmissible disease based on COVID test, transmissible disease if no COVID test. That's what I'm remembering.

Mr. Boxer. I think that's --

Dr. Zucker. Different?

Mr. Boxer. No. I think, well, it's like a week plus at the most.

Dr. Zucker. Oh, that's a good point.

Mr. Boxer. Maybe this is apples and oranges to the point you're trying to make, but --

Dr. Zucker. Yeah. That's a good point.

BY MR. EMMER:

Q Okay. I want to introduce what will be marked as Exhibit 7.

[Majority Exhibit No. 7 was marked for identification.]

Dr. Zucker. Can I just bring up what Nelson said? That was a good point. This is March 13th, and I don't know if that other document from CDC came in after that or not?

[Simultaneous speaking.]

Dr. Zucker. Because I remember it came in around the time that we put our, the 25th out.

BY MR. BENZINE:

Q So Dr. Zucker, this guidance is what you're talking about, the test-based strategy and non-test-based strategy?

A Right. Thank you.

Q And this one does reference transmission-based precautions, which we think are --

A Does it?

Q Yeah, at the bottom of page 2, this continuation of empiric transmission-based precautions. So I think --

A There is another one. There is another document that I remember that talked about transmission-based on the top of the page and transmission-based without a test. I

don't remember the --

Q It could be this one. I think the transmission-based precautions document is the like testing, quarantine, isolation one, and then this is the when you can drop those precautions.

A I don't remember.

Q But this is what you're -- the non-test-based strategy on --

A Yeah, non-test-based. Right. Right.

Q Three days, 7 days, and symptoms.

A Right.

Q It does say CDC guidance. It does say a testing-based strategy is preferred, understanding no CDC guidance is mandatory. But they do prefer a testing-based strategy, and you eliminated a testing-based strategy.

A Right, and part of it is the amount of tests, the availability of tests, right, and part of it was also the need for expeditiously opening up bed, what we were talking about. And I'd have to go back and figure out how many of these tests were we able to do at that moment in time, back in the third week of March. You know, if we were running them at Wadsworth then I know it took a while to run one of those gels. It took a couple of hours, and then you put another set in, so that may have its own challenges. I wish I could give you more details, but this is 3 1/2 years in the

past.

Q No, I know.

BY MR. EMMER:

Q So it is your testimony, when it comes to the CMS guidance you don't -- none of the arguments for why the March 25th order was consistent with Federal law relied on that CMS document that we handed you?

A Right, but this document references CDC. So in many ways CMS -- it relies on CMS because CMS is touching upon some of the things at CDC, which we focused on.

Q So I'm going to read a quote from Melissa DeRosa on May 23rd. What she said was, "The policy that the Department of Health put out was in line directly with the March 13th directive put out by CDC and CMS that read, and I quote, 'Nursing homes should admit any individual from hospitals where COVID is present,' not 'could,' 'should. That is President Trump's CMS and CDC."

So how I, when she makes that statement that, again, if you don't know obviously you didn't -- this is Ms. DeRosa speaking. The way that we understand it has to do with that CMS guidance. And then I'm looking at the note section on page 5.

A Mm-hmm.

Q Where it states, "Nursing homes should admit any individuals that they would normally admit to their facility,

including individuals from hospitals where a case of COVID-19 was/is present."

A Mm-hmm.

Q Would it be your impression, based on Ms. DeRosa's quote, that that is what she is referencing when she argues that it's consistent?

A Can you read her quote again?

Q Yes. "The policy that the Department of Health put out was in line directly with the March 13th directive put out by CDC and CMS that read, and I quote, 'Nursing homes should admit any individual from hospitals where COVID is present,' not 'could,' 'should. That is President Trump's CMS and CDC."

A Well, she is quoting that there. I can't speak for her, but I'm just saying that it seems that that's what she's referencing.

Mr. Boxer. The quote on page 5?

Dr. Zucker. Yeah, the quote on page 5.

BY MR. BENZINE:

Q That's a different parameter than a patient that has tested positive for COVID. Correct?

A That nursing homes should admit any individual that would normally admit to their facility. That?

Q It said including individuals from hospitals where a case of COVID-19 was or is present, not including

individuals that are currently testing positive for COVID.

A Yeah. Well, the thing is that in reality what was present in those hospitals were all COVID patients. I mean, the entire system was, you know, envisioned by COVID-positive patients. I mean, if this CMS guidance is trying to refer to the person who was in a hospital who did not come in for COVID but came in for heart disease or something and then needed to go back to the nursing home, that would be a rare number of patients.

BY MR. EMMER:

Q I'm just going to read the second part of that note, and this is after. It says that they should admit -- it says "also, if possible, dedicated units/wing exclusively for any residents coming or returning from the hospital. This can serve as a stepdown unit where they remain for 14 days with no symptoms (set up integrating as usual on short-term rehab floor or returning to long-stay original room).

Just a very simple question. Well actually, does that make her statement that is consistent misleading if she is referring to that note and omits the fact that there was language that said that they should take precautions?

A I can't speak to her on this. I can say that in reading that my first reaction was more in the sense that the nursing homes knew that they needed to do the necessary things if they were concerned about COVID. That's how I read

it as sort of saying you should put them in a certain area. And my reaction, the first thing that popped into my head was that we communicated to nursing homes all along that do whatever is the safest for your patients, and if you can't, let us know. So every one of those nursing homes is a little bit different. Some of them had whole wards, sometimes, that were closed that they could have opened up. Others had areas where they should move certain patients.

So in many ways it goes back to the specifics of that individual nursing home. My role was sort of like what's the science here, what's the public health here, and who are we sending back, and how safe is it.

BY MR. BENZINE:

Q So kind of trying to piece together the puzzles, to the best of your recollection, you were there at kind of the initiation of the idea, not necessarily through the drafting process.

A That's correct.

Q And then somewhere, if not on the publication date, maybe a little bit before, you became aware of the final text.

A The final text, I don't recall seeing. I just know when we said let's put something out, and then it went through this whole process. And then it is possible that somebody showed it to me or said, "We're ready to send that

guidance to the nursing homes, the advisory to the nursing homes, about patients returning," and I could have said, "Okay, great." That is more likely how these things transpired during that time.

Q After the advisory was put out and published, did you receive any briefings from any of your staff on the execution or the language?

A No.

Q Did you receive any briefings from the Governor's Office on the execution or the language? And this isn't -- I don't know how else to phrase this, but for someone that wasn't really involved in the process, your and the Governor's Office's taking points are the same. And if you weren't briefed on the language, you weren't briefed on CDC/CMS guidance, how did you get up to speed that this directive was in line with all the guidances?

A So maybe I misunderstood your question about briefed. I thought you meant briefed in the sense that this document went out and then they discussed the document with me. I'm not sure what you're asking.

Q No. Like did you ever get, after the document went out, did anyone on your staff or in the Governor's Office come and say, "Dr. Zucker, here is what we put out. Here is the underlying CDC and CMS guidances. Here is why."

A What happened was when these questions were being

put forth in these press conferences, you know, prior to those press conferences they said, "Well, they're going to ask about," and then there was the discussion, well, this is what the CDC guidance showed as we knew. And that's when there was more of a discussion about it. So if the notes are similar it's probably because the discussion, all the parties were in the room when the discussion happened, and so the same facts were presented to everybody.

Q Who was presenting those facts in those discussions?

A I don't remember. I mean, it was probably conversations between their team and, you know, me, and I may have asked people. I don't really remember the details on that, but I suspect that that's how these things unfolded.

BY MR. EMMER:

Q So I just want to read one of your quotes from April 22nd, the briefing. Here you say, "We are working very closely with the leadership from the nursing homes both to get more staff to help them out. Obviously, the supplies. We are working very hard on that. We are also looking at how they could help cohort patients a little bit better so that those who are positive are cohorted within the nursing homes to address that."

Dr. Zucker, the way I read that, and this is April 22nd so almost a month after the March 25th order.

Actually, before --

A One point. That is in response to what was -- it sounds like that was me answering a question that was raised at some conference, right?

Q Yeah.

A So I wonder what the question was.

Q We can -- does this refresh your recollection?

A Yeah. So let's see, Part 1. Do you want to answer the doctor? [Reads document.] And what was his question. And what day was this?

Q April 22nd.

A So should I read the question in here or not?

Q Well, it's more so that last sentence. "We're also looking at how they could help cohort patients a little better so that those who are positive are cohorted within a nursing home to address that." I'm just getting back to, you know, what is consistent with CMS, CDC. They had their precautions that they had adhered to. The way I read that, and what I'm going to ask, is, well, the way I read that, it just seems like there wasn't a plan between the Health Department and the nursing homes to cohort COVID patients immediately following the March 25th order. Do you disagree with that characterization?

A I don't have an answer to this because there were many people involved in these conversations, because you're

not getting into sort of the nuance of conversations to the nursing homes. And our whole long-term care team spoke to them on a regular basis. So it is possible that there were many more conversations about what they are doing to help cohort patients and to make sure that they remain safe if they have COVID, and not necessarily just because of how she phrased the question which is about readmissions and admissions. But the fact is that the COVID virus was in these nursing homes, so it may have been that Resident A was fine one day and the next day they're sick, and then another resident is sick, and they never even went to a hospital. So where are we putting those two residents, Resident A and B, who are sick? So there was a conversation about what to do about them, completely separate from any readmissions or admissions. And I think that those questions were often addressed with our experts within the Department.

But as I was mentioning before, there were many people involved in dealing with these long-term care issues, and those were the ones who had been dealing with them long before COVID ever came to New York.

Q Thank you. We can go off the record.

[Break.]

Ms. [redacted] On the record.

BY MS. [redacted]

Q Good afternoon, Doctor Zucker. I just have a

couple of questions that I wanted to address with you right now. Are you aware that in 2019, the Trump administration proposed to relax a Federal requirement that nursing homes employ onsite infection prevention specialists, and according to public reporting Trump's proposal led some facilities to cut corners in infection control.

A No. I am not familiar.

Q Is the maintenance of firm infection control standards and compliance with those standards important to preventing viral infection and spread in nursing homes?

A Sure. We all agree with that.

Q And does relaxing infection control standards in nursing homes hurt the preparedness of staff and residents for dealing with the pandemic?

A It could.

Q And when we're looking at the COVID-19 pandemic, the staff who was working in most nursing homes, assisted care facilities, those types of place, they were not in the facility 24 hours a day.

A No. They would go back home and come back. That's correct.

Q They might engage in other community activities --

A That's correct.

Q -- that would be outside of their jobs.

A That's correct.

Q And that could also lead to spread within a facility.

A It could. In fact, one of the comments that was brought to my attention was sometimes the staff at one nursing home would sort of moonlight at other facilities, you know, on weekends or evenings, to supplement their income.

Q Sure. And earlier, when we were talking about community spread earlier today, you mentioned how, you know, one person passing to two people, and then it extrapolates very quickly from there. You also mentioned you had this idea at first of using pins to note the cases, but that eventually became unworkable, and that was just because the disease was replicating so quickly that it became hard to track.

A Yes, it became difficult to track.

Q And I recall, back at the beginning of COVID, contact tracing was a very prevalent mitigation measure that we talked about.

A Right. Yeah. Contact tracing is one of those phrases which, yes, surfaced back in my head just now. That's correct. We were trying to figure out how we could track individuals, and we actually worked with different apps to try to figure out that if you came near someone who had COVID it would send a message. We were working with some of

the IT community experts on that.

Q Sure. But that contact tracing had significant limitations.

A It did.

Q Can you explain a little bit about that?

A Well, it was hard to identify exactly who saw who and how many people they were exposed to. And they had to make sure that they were registered on some of those IT platforms. You had to be sure that you were registered and the other person was registered.

The challenge here is that one of the things that the pandemic taught all of us is how interconnected our society is. And one thing happens and you try to sort of say, well, we could track this person but then the next day you don't know where they went, and if someone is in a school, a teacher gets it, then who were they exposed to, and did they expose the children in their classroom. You know, all of these things, really, we started to see. And then when we had the conversation about closing schools they said, okay, well, if we close the school who watches these children, and what if it's a single parent, and then they are home and there's no income coming in, and then they lose their job. Every one of the decisions we made was the tip of a pyramid, that there were 20 other questions and decisions that had to be made as well.

Q And thinking about any single one of those decisions, the information you were getting in order to make those decisions was changing very often, right?

A It was, both the information that we were getting from multiple sources in the community but also the scientific information that was coming in. Because at one point early on, if people remember, they said wash every package you bring into your house, right. So everyone is washing everything. And then it was don't wash the packages. Then it was wear a mask, and then it was wear two masks, right, and put a barrier between the kids in school. And then it was like, no, the barriers are worse because of the air flow. And every one of these issues raised dozens of questions, and I felt my job was also to be as up to speed on the science on this, because I never knew what the answer to what question was going to be incredibly relevant to making sure other people didn't get sick.

Q And you've spoken about this already, but one area where the information was very quickly evolving at the beginning was figuring out when somebody was sick and then realizing they were probably infectious before they realized they were ill.

A Right. That was the whole issue of asymptomatic spread, which made this much more difficult than other issues. And I will mention one thing. We were talking about

this before, that when this began, everyone said this was SARS, and I've thought a lot about what happened and why did we handle this a certain way versus other things. And I think there's a psychology component to this, that they said, well, this is like SARS-2. And then everyone starts thinking, including me, that, well, that was concentrated in a couple of cities, and they got control over it, and it quieted down. Whereas if someone used the phrase "influenza," and said this is like rapidly spreading influenza, people may have attached the word pandemic influenza to it. Nobody thought pandemic SARS. That's just how people think, and I think initially everyone was saying, "Oh, this is like that SARS thing that happened 10 years," or 8, you know, at that point, whenever, 20 years before.

Q Very quickly realized it was spreading much more.

A Right.

Q Thank you, Dr. Zucker. Those are my questions for right now.

A Oh, that was fast.

Ms. [redacted] So we'll go off the record.

[Break.]

Mr. Emmer. We can go back on the record.

BY MR. EMMER:

Q So Dr. Zucker, the first question that we have, are you aware of any nursing homes transferring residents --

or excuse me. Are you aware of any hospitals transferring residents to nursing homes that the nursing homes were not capable of caring for?

A No.

Q Do you recall the Department of Health facilitating transfer of residents?

A The transfers were done through the hospitals. I mean, the Department of Health regulates the hospitals and the nursing homes, but they are independent bodies. Their communications are usually between the hospital and the nursing home, and vice versa.

Q So you mentioned earlier that, you know, as far as the March 25th order was concerned, if a nursing home had concerns with it, if they had process concerns, if they weren't capable of housing COVID-positive patients, you had said earlier that they could call you.

A Or the call, right. They could call us. I mean, you were asking before about transferring. That's a hospital to nursing home, communications go that way. But if there is a problem they should call and say, "We can't accommodate that patient," and then we would figure out something to do, or try to figure out how we could address that.

Q And I don't want to spend too much time on it because I think you already answered it, but did you say earlier that you didn't have, or you're not aware of any

nursing homes reaching out and saying that they weren't --

A What I remember is one nursing home calling me with this hypothetical, like what if there's a problem? And I remember saying, "Do you have a problem?" They said, "No, no, we don't have a problem. We're just wondering, in the future, what if we have a problem?" And I said, "Then you call me or call Mark," some of the people on my team who dealt with the nursing home issues. And subsequently, when some of these investigations were being done, when I was still in the state, you know, I once asked, "How many nursing homes called?" and someone said to me once, "Oh, there were five that called us, four or five that called us." So I said to myself, 613 nursing homes and we only got 4 or 5 calls of concerns. That's pretty small.

Q Okay. This is another kind of general of questioning, but did the Department of Health ever perform a survey in March 2020 on how many of its 616 statewide nursing homes could accommodate COVID-19-positive patients?

A I don't know, though I do know there were so many surveys that were being done at that time. So that's a question for the long-term care team.

Q Okay. So let's talk about admissions. I want to direct your attention -- do you have the March 25th order in front of you? And specifically we're looking at the first paragraph, and again, I get that we are probably repeating

ourselves here. But the sentence states, "This directive is being issued to clarify expectations for nursing homes receiving residents returning from hospitalization and for nursing homes accepting new residents." Do you have any idea how many of the transfers were new admissions?

A I don't remember, no. They may have mentioned it to me but I don't recall.

Q But transfers of newly admitted residents did take place, though, under the directive.

A Right. There probably were. Under the directive they could, and I'm sure there probably were.

Q And I guess my question would be, and this relates a line of questioning that we'll get into later, but do you believe that the administration tried to conceal the fact that some of these transfers were new residents rather than people returning back to the nursing homes?

A I don't think so. I don't know. And until you raised this it never even popped in my head or thinking about that. There were people who were being readmitted, who had gone from the nursing home to the hospital, and then what often happened with COVID, you had all these people who probably said, "I don't know if I want to bring my relative back and deal with all the other things I have to deal with back at home. Maybe we should put him in a nursing home." So I suspect some people who were in the hospital, who were

ill, and then had rehab or couldn't get to a rehab facility, probably ended up in a nursing home at that point. So I don't know. I can't answer that one.

Q Okay. We'll move on. Do you recall how long the March 25th directive was in effect?

A Well, it stayed in effect. I mean, all this discussion about how it was rescinded in May, but in actual fact that's not what happened. There are all these narratives out there that they got rid of it. What we did was when we had more testing we put into place somewhere in the first of May or somewhere around there to say test people before they went back. But at that point, we had all these tests, and the rapid tests were coming up. And also by May, the first week of May, we had already hit our peak -- of hospitalizations, I should say -- and we were on our way down. April 12th or 13th, we hit 18,825 in the hospital, and then by May we were not all the way down but were on the curve down, so it was a completely different situation. We felt that we definitely had control of this virus in New York.

Q And we'll return to more specifics regarding the termination and the order -- or well, I guess, how you see it, how it was amended, right. Is that how you'd kind of describe it?

A Well, it wasn't changed. It was just a May 7th

or 3rd or 10th, somewhere around the first week of May when we put out another advisory saying that you should test before you go back, maybe once, twice. I don't remember how many tests. I think it was one test.

Q So in between that time after the March 25th directive, or once it was issued on March 25th, what kind of feedback were you receiving from stakeholders?

A I didn't receive anything, specifically because none of them called me. I know they may have called the team, but no one picked up the phone and said, "I want to talk to the commissioner about the situation in the nursing homes and this advisory." So the issue was not brought to my desk.

Q So I want to introduce what will be marked as Majority Exhibit 8. This is a statement from the American Health Care Association, warning against sending COVID-19 patients back into nursing homes, issued on March 28th. 22, 2021.

[Majority Exhibit No. 8 was marked for identification.]

BY MR. EMMER:

Q I am just going to read you a line, if that's okay.

A Mm-hmm.

Q It says, "This approach will introduce the highly

contagious virus into more nursing homes. There will be more hospitalizations for nursing home residents who need ventilator care, and ultimately a higher number of deaths. Issuing such an order is a mistake, and there will be a better solution." Do you recall this warning?

A No, but I will say that that is not what we found to be the case, and we did do a report to look at this whole issue because my concern -- again, as wearing a doctor hat and not a commissioner hat -- was that what happened in the nursing homes that so many people are sick. And so found that that is not the case, that there were more deaths in the nursing homes, because in actual fact, you know, after this advisory went out, the admissions and the number of deaths do not correlate. The deaths reversed, and then afterwards there were increased admissions, if I'm remembering correctly. So basically it's not like this advisory, from an epidemiological standpoint, correlated with an increased number of deaths. So when he says this, or she says this, that's not the case. It's just not what we found.

And it goes back to that underlying premise. See, this is why I always keep bringing this point up. It goes back to the premise that the person who went into that nursing home had COVID, was infectious, contagious, and spread this disease in the nursing home, and that premise is wrong. And so if you start with that premise then a lot of

things will follow. But if you look at the science and say that premise is wrong, based on what we found and what we looked at, then many of things that followed are just not accurate.

Q So I want to introduce what will be marked as Majority Exhibit 9. This is another statement against the nursing home order by the American College of Health Care Administrators, April 22, 2020.

[Majority Exhibit No. 9 was marked for identification.]

BY MR. EMMER:

Q Do you recall this warning?

A No.

Q Okay. And I guess I could have asked, were there any other -- did you receive any warnings from any other organizations that you can remember around this time?

A I don't recall receiving them, and if they were sent -- and maybe they were sent to my email, although I don't recall. But they may have been sent to the people who work closely with the nursing homes within our program, and that is possible. But I don't remember speaking or -- and I don't even remember their names, with these organizations.

Q All right. I just want to get that on the record. All right, I know I'm throwing a lot at you right now. I want to introduce what will be marked as Majority

Exhibit 10, and this is the long-term care advisory from April 7th.

[Majority Exhibit No. 10 was marked for identification.]

BY MR. EMMER:

Q Do you remember this guidance?

A No, I don't remember it, but I remember there was an advisory. This is the adult care facilities, right?

Q Yes.

A Yeah, I remember that we put something out to them.

Q So similar to the March 25th directive, or what was your involvement in this April 7th one?

A Probably. I don't remember this one as well, but I'm sure that probably someone had mentioned to me that the adult care facilities, we have to put something out for the adult care facilities. And I suspect the conversation was something to the effect that, well, what did we do for the nursing homes, the other long-term care facilities, and they probably wrote it. But I don't remember who. I'm just thinking from the standpoint of what was someone normally say to me. That's probably what happened.

You have to remember, we put out over 600 advisories. That's a lot.

Mr. Benzine. It is a lot.

BY MR. EMMER:

Q Absolutely. So I want to move on to introduce Majority exhibit 11. This is an article entitled "Cuomo doubles down on ordering nursing home to admit coronavirus patients," from April 26, 2020.

[Majority Exhibit No. 11 was marked for identification.]

BY MR. EMMER:

Q I want to direct your attention to the quote from Donny Tuchman, where it says, "There is no way for us to prevent the spread under these conditions." He continued, saying, "I made specific requests to transfer patients and it didn't happen."

Do you recall hearing from the Cobble Hill Health Center?

A See, now I will tell you that, if I remember correctly -- and again, this is my recollection, that one place that I received that call from -- remember I said to you there was one place that called and I asked them, "Do you have a problem?" and they said, "No," just hypothetically. I believe that was Cobble Hill. So when I read this article -- and I remember this article -- I actually said to myself, they called, and I asked them if they had a problem and they said no.

BY MR. BENZINE:

Q You don't remember getting any requests from Cobble Hill to transfer patients?

A No.

Q Just the one call?

A No. No.

BY MR. EMMER:

Q And for the record, if they did have, if they said, "We do have problems," what would have been your --

A What would have been my response? I would have called the part of the Department that deals with long-term care, and then we had some incredibly talented people there, and I would have asked them to please help figure out what we can do for this facility. And given who worked and led that team, they would have made that happen.

Q So I want to direct your attention back. We obviously talked about the May 10th -- excuse me. I don't remember how you phrased it, but it was more of a changing the --

A It was just a new advisory. And you're talking about the --

Q Yeah, on May 10th. What would have prompted the administration to change that?

A Well, what happened was that, as I was saying before, the numbers were coming down, the testing capacity was expanding, and the feeling was, well, you know what?

Just tell them to test people before you send them back. And that's pretty much how it went.

BY MR. BENZINE:

Q Were you, from my understanding the evaluation probably occurred, testing capacity was going up, you did the evaluation. How did it come up that now that we have testing capacity we can alter this other guidance?

A Well, what was happening was there were all these criticisms that were being thrown out, in this particular newspaper of note, and the feeling was, well, what can we do? And the issue was that they're fine to go back, based on what we originally said. They said, "Well, do we have the testing capacity, the increased testing capacity? Just test." It was almost really, let's do this. Just test them.

Q Where did that idea come from?

A That was in the Chamber, but I don't remember who. It was a Governor's Office-driven thought.

Q And you think driven more so in response to criticism than actual --

A Yeah. I think -- well, no. We did have more testing. We really did. But there was a lot of criticism. And the feeling was that the March 25th advisory, it was not the driver of the nursing home deaths, but it was at that point, you know, we have the capacity, the numbers are down, we're not taking a test from someone else to do this test, so

just do it. That's how I interpreted it.

Q I guess my kind of overarching question is if -- and you've kind of just answered it -- if the March 25th guidance wasn't wrong, then why change it?

A It was not changed because of this guidance. It was changed more because there was such criticisms about something which we felt there shouldn't be criticism on, as I was just saying. But it's not going to hurt anyone, and we're not sort of, you know, jeopardizing someone else's care by running a test on this person.

Q Okay. Did you have any like direct role in implementing that, or was it kind of, for lack of a better phrase, like dropped on your desk again?

A Sort of, yeah.

BY MR. EMMER:

Q So I would like to introduce what will be marked as Majority Exhibit --

A That's fine. If you want to test them, test them.

Mr. Benzine. No, I understand. I'm just trying to figure out the cadence of the changes.

BY MR. EMMER:

Q I want to introduce what will be marked as Majority Exhibit 12. So Bates number 0006966, from the New York State Health Department.

[Majority Exhibit No. 12 was marked for identification.]

BY MR. EMMER:

Q This is an email -- let's make sure we have the right -- in the middle of the page, from Stephanie Benton, on June 7th. Benton forwards an article seemingly critical of the March 25th order, and writes, "This is going to be the great debacle in the history of books. The longer it lasts, the harder to correct. We have a better argument than we made. Get a report on the facts because this legacy will overwhelm any positive accomplishment. Also, how many COVID people were returned to nursing homes in that period? How many nursing homes? Don't you see how bad this is, or do we admit error and give up?"

So do you remember this email?

A Yes. It's hard not to.

Q And I believe we already discussed her, but who is Ms. Benton?

A She is the executive assistant to the governor. I don't know her official title, but that's --

Q Okay. And what is the "great debacle" that she's referring to, or what do you believe she is referring to?

A So this goes to this whole issue about March 25th advisory and the concept that that triggered these increased deaths in the nursing homes and then the articles that were

being written in the paper about this. And that is what he viewed this as, like we need to clean this issue up, or not clean it up but just address this issue, I should say.

BY MR. BENZINE:

Q You said "he."

A The governor, because I suspect Stephanie wrote this, or he wrote this. That's how I feel.

Q I want to ask this clearly then. This email from Ms. Benton you believe was either directed by the governor or written by the governor?

A Now I can say, but there were emails that she sometimes sent that I feel were probably sort of coming from him. Now maybe she wrote it because he said something to her, but that's my take.

Q Again, asking a little bit for speculation, the tone of the email, the multiple questions, is that more in the theme of Governor Cuomo or in the theme of Ms. Benton?

A No, it's more in the theme of the governor. That's why I was saying it probably came from him. But the email is from her, so it's not for me to surmise something. But that is the way he usually directed questions.

BY MR. EMMER:

Q So what do you think, and I guess putting aside the previous question, but what do you think she meant when she stated, "The longer it lasts, the harder to correct. We

have a better argument than we made"?

A Well, the way I interpret "the longer it lasts, the harder it is to correct" is what I have spoken about, and we have been talking about all day today, narratives go out and they become fact when they are really fiction, and it becomes very hard to correct something that the public starts to believe is the fact. And whether you give them the truth and share the information and say what you're hearing is fiction, if they don't believe it it's going to be very hard to change their opinion. And I have to tell you, it's one of the things that is the most frustrating to me, when I look at the science, I look at the data, and I know that this was not the driver of nursing home deaths. So that's what I think "the longer it lasts, the harder to correct," that's how I interpret it, and it's just my interpretation. You'd really have to ask the person who wrote it.

"We have a better argument than we made," to me goes to what we are talking about now, of where this is what the numbers were, in the sense of 136,000 people that end up in a hospital. This is what the CDC showed. This is how long they were in the hospital. So that is what I interpret "a better argument," and we did not share that clearly at that point in time.

BY MR. BENZINE:

Q You said you remember this and you know it well.

A Yeah, because of how harsh it is.

Q About almost exactly a month later the Department of Health Report that you have been referencing came out. Did this email start that report?

A No. Actually what started the report had nothing to do with this. It started as a result of me curious about -- it was not the report. I was curious as to what was happening in the nursing homes and what we could do to prevent further problems, not just for New York but for the rest of the country. So I asked one of my senior staff, who I trusted, I said, "Let's put together an article for one the leading medical journals. We'll look at this. We will analyze it," in the same way you analyze other medical problems that surface in hospitals. So her team sort of started to work on this.

This was in the beginning of June, around this time, maybe a little before this, probably a little bit before this. And then the articles started to keep getting published about the nursing home issues, these issues, and the decision was to put a report together about this. And that came from Melissa to -- that was the charge, from Melissa to Jim Malatras, who was involved, and our team obviously had the information, and the ask was to pull all this data together.

So we had what we were working on as a paper, and

we had a lot of graphs and tables, and I believe the ask also came from Linda Lacewell, to bring all this stuff together. And, you know, Eleanor from my team pulled all of these documents together and provided them to the governance team to look at this. I recognized, and I said to our team, that there will not be a medical paper ever from us because once this information is public knowledge no journal is going to publish it. But I said whatever, you know, and I felt a little badly because the team was working on it, but it's okay. It's the way it is.

And so then the team, our team, provided these graphs and tables, and a paper was put together to address a lot of these issues, particularly this March 25th issue, and it goes back to the question that was asked before about the timing of the deaths versus the peak in nursing home admissions. And so that was being done in June. And I said at some point I'll present this, so that was July 6th, although the ask was to get it presented a little earlier, but I didn't feel we were ready. There were many conversations back and forth about this, and our team, who was involved from the public health side of this, you know, when they saw drafts of what was put together and felt there were errors, there were conversations with me, and then I pulled in the Chamber team that was working on this to say that we need to correct these things. Because I did not

understand at that point a lot of the nuances of these issues of some of these aspects until I finally sat down and started to look at that.

So then the document, that paper, that I'm sure, given the files you have, is probably in there, was put together, and then I wrote a presentation, which I delivered on July 6th, which laid out exactly what I had always believed to be the case, but now we had it. Now I'm not going to be able to publish in the medical journal, but it's there, and it was sound. And there were some things you could always say, well, you could work a little bit more on that, but it gave the science and the public health that we wanted. And I delivered that.

Q You've used the phrase "someone I could trust" a couple of times now. Were there people in the Department of Health that you didn't trust?

A No, I guess maybe that's not the right phrase. It's somebody who I felt understood the way I thought, as a fellow physician I felt the conversations I could have, it started at a certain level where I didn't have to go through all the other details, like, okay, this is where we're at. And she understood what my concerns were, and that was very helpful, given the speed at which things were moving. And she understood the long-term care community well, so I wanted her to review that document, just because logistically I did

not have the time.

And this is what we were talking about before, and I just want to bring this up a little. It's June of 2020, and remember I was talking about the sleepaway camps? Well, that's June of 2020. That was the week after. So now people wanted to open those camps at the end of June, and I'm dealing with that issue at the same time as this issue. It's also June when shortly before this all those kids started to have these multisystem inflammatory syndrome, and suddenly kids were now getting really sick. And that was an issue, which I will just mention it -- I know it's a long day. But when I read an article from London saying that there were kids that were sick over there with this MIS-C, I called my colleagues, because there are many of them I trained in New York's Pediatric ICUs, and said to them, "What's going on? Are you seeing this?" And then they said, "Yes, we are." And then the next thing I know, similar time, I said, "Guys, we need to come together and figure out a definition of this," which ultimately we published in the New England Journal of Medicine, the definition of MIS-C, and we had over 150 kids -- I think it was 169 kids -- with this.

So now that was, to me, that's a priority. The sleepaway camps, a priority. At the same time we said that we need to have a vaccine rollout plan. That's a priority. And shortly after this was also what are we going to do about

opening the schools? That's a priority. And also at this time, in June -- and this is why I say you have to remember in context -- mid-June was when George Floyd situation happened. So there were protests in New York, and then the question is should they be wearing the masks? Should we be testing? Are we going to have an increased amount of cases as a result of that? That became a priority.

So this is why I say, you know, then I'm sitting there saying, okay, I've got to write this July 6th presentation. So there's only so many hours in the day, and that's what I'm sort of trying to say, to keep it in perspective.

BY MR. EMMER:

Q So the email at the end, it says, "Do we admit error and give up?" Was that a consideration within the administration?

A I don't really understand what whoever -- if he wrote it or she wrote it -- what that means.

Q So further up the page, and because this is a notable email I am going to ask, it says, from Melissa DeRosa, it says, "Linda and Tracy, please set a call with this group for today after the press conference to go through." Do you recall meeting regarding this email?

A I don't recall meeting about the email, but I had so many meetings to discuss this issue of the presentation in

July. It was like, where are we? And there were discussion about where are we with this paper. And at one point, you know, Melissa had asked and said, "Well, get a medical journal out," or something. But as I've explained to others, you can't get a medical journal to just publish a paper in a week, unless it's something which literally is going to affect people's lives and everyone sees. No, but this is not of that nature. So even if I got on the phone with the editor of the Journal, they would say, "Fine. We'll send it through the peer review process." So ultimately it needed to be done in a different format, which was a paper and then my presentation.

BY MR. BENZINE:

Q I want to kind of bifurcate the timeline of when you were thinking of the medical journal and then when the Department of Health report happened, and we'll have more questions about the Department of Health Report. So before this email, before June 7th, you and the Department of Health were working on what you hoped were going to be a medical journal paper.

A Yeah, we were going to try to figure it out and write it. It would be a little hard to do because the numbers and the data is really hard to figure out.

Q So that was already in the works. Is this email, is this conversation where that shifted to a report and a

presentation?

A Around that, whether it's this email or it was a conversation the day before, but somewhere in early June, around this time, it was let's get something out, and the conversation about can you do this through a medical journal, and what I just conveyed, saying it's not possible, generated the issue of let's get a paper out, which generated the issue of get all the information that you had, that you were using for a person, and all the tables that you were working on over to us, the Chamber, and then we will work on writing this and then communicate with your team about that.

Q I guess I'm just wondering, and you said that you didn't really recall, but I'm just wondering if this phone call that Ms. DeRosa set up was when that change happened.

A Right. So that is where I suspect it was around then. I can't say whether it's that phone call or it's the day after that or the phone call generated, well, go figure out whether these medical journals can publish this. But around June, early June, was when we switched into moving it forward. I do think that I probably thought about, well, maybe I could call a journal or whatever, but then I think pretty soon thereafter I realized that's not going to happen.

Q Thank you.

BY MR. EMMER:

Q To quickly conclude this session, on February 19,

2021, you defended the state's decision to issue the March 25th directive, stating, "We would make the same decision again." For the record, do you stand by that, still?

A I do.

Q Okay. Then we'll move on. So we're going to now discuss the data for nursing homes that the administration was reviewing. So I would like to introduce what will be labeled as Majority Exhibit 13. This is an article entitled "New York didn't count nursing home coronavirus victims for weeks, then a stumbling rush for a death toll," published on May 19, 2020.

[Majority Exhibit No. 13 was marked for identification.]

BY MR. EMMER:

Q I want to direct your attention to the bottom of the second page. It says, "On Wednesday, April 15, operators of New York State stated 613 nursing homes received an urgent email from the State Health Department. They were ordered to dial into a mandatory call with Dr. Howard Zucker." Do you recall what the purpose of that call was?

A I remember the call. I don't remember what the purpose of it was. It may have been to talk to the nursing homes. I do remember there was a call that I was on with Larry Schwartz about the nursing home community, but I don't know if it was this call. I think it was, actually, but I

don't remember when it was. So it probably says it right here, right?

Q Correct.

A I assumed that was the case.

Q On the third page, fourth paragraph from the bottom, it says, "State officials started asking nursing homes to report their deaths daily, on April 16th." What prompted the Health Department to start counting nursing home deaths?

A I don't remember. I remember this call. I don't remember why we were rushing to do this. I suspect that there were questions about numbers.

You know, I just want to say something about this. You're talking about numbers, right. It's important to realize that this -- you know, I did not understand this whole thing with these data numbers and systems. There were other people involved. Now, granted, it's my department, but there are people in the Department who did the tracking, did the online information about updating deaths, illnesses, positive tests. There was also, from the nursing home standpoint, there was Linda Lacewell who was involved, who was charged with that responsibility to oversee a lot of the nursing home data that was coming in and information.

So from my perspective, one was I was interested in all this and wanted to understand it better, and asked the

team to help me understand it better, particularly the different data systems, but I was looking very much prospectively about what are some of the problems that can occur, that we need to be sure we address the medical problems, health problems, so that something doesn't happen that is detrimental to people. But I'd have to read through this whole article to figure out what this was about and to understand it a little bit more. But I see my name is all over this. So if there is a specific question.

Q Yeah. Well, I guess, just thinking through your previous answer, so would it be safe to assume that as far as the data is concerned, what the Department was asking from nursing homes, that is something that you may not have been privy to?

A So I was not privy to all of this. There were many conversations, and I think this -- I looked at one of the paragraphs here -- I think this was an ask to go back and try to find out all the deaths in the nursing homes and all the numbers and the positive cases, and to look over a period of, you know, days. And I remember what came out of this. Sometimes people were sending notes back or sending information back from December, saying, "Oh, we had this number of cases." And a lot of information started flowing in, and sometimes there were days where there were a lot of cases. But it really wasn't that there were a lot of cases

on that particular day. It was someone came into the office there and said, "Oh, I'm the one in charge of this. I've been off for the last 2 days, and here are the numbers. I'll send them over to the state." And the next thing you know, we get a whole list of positive cases, or whatever. So I think that is the case.

Regarding these numbers, there were many different data systems that were involved, and I'm sure you know this. There was a HERDS system, there was a SPARCS system, there was the MDL system. There were a lot of different systems that brought in information. It was not coordinated, and it was not very organized in some ways. And this was one of the flaws that we realized in this whole pandemic. And everyone was checking constantly to be sure that that isn't the same patient as the other patient, and that name is not the initials to this one. And it required a fair amount of teasing through this. But it was really the charge of others within the Department, and I asked them to sort of try to keep me updated.

But there was a call. I do remember. And I suspect what happened was that I was -- someone from the Chamber probably said, "Get the nursing home administrators on the phone." Because it wasn't like my purposeful nature to just say I'm going to pick up the phone and call all of them. And in reality, I really could not do that without it

being cleared through the Chamber. You know, I could not just get on the phone and call all of them. I could call individual ones. The hospital CEOs I could call, and I did that frequently. But usually, you know, calling 613 nursing home administrators without the Governor's Office knowing would be probably not the wisest move on my part.

BY MR. BENZINE:

Q Would you have been told or directed by the Governor's Office to do this data call, or would it have been a, hey Governor's Office, advising you that I'm doing this data call?

A No. It was more likely I would be directed to go do it, the data call, than me, hey, Governor, I'm doing this.

Q Do you recall, in this case, if you were directed?

A Yeah. I think that I was told to get them on the phone, yeah.

Q And Jack might have more specific questions about this, but part of the data call for deaths. And there's been a lot of hubbub surrounding nursing home deaths and the definition thereof of whether or not they died at the hospital or died at the nursing home. And I believe, and you can correct me if I'm wrong, that at the time New York was collecting those that just died at the hospital, not at the home?

A They were collecting all the data -- died in the nursing home, died in the hospital. The issue that people had was that there were people who died at the hospital who may have started at the nursing home, but they were counted as a hospital death. People who died at a nursing home, that would count as a nursing home death. This goes back to that other report, that AG report, on saying there were more deaths. That was where it was inaccurate.

No, the number of deaths were always what we reported. The question is where they died. And this whole issue of COVID is complicated because it's not just where they died but it's also did they die with COVID, did they die from COVID, were they a presumed case early on before we had testing, were they an informed case, New York City versus New York State data, because some of the city sometimes could go in separately, because there are a couple of cities in the country which can report data into CDC separately. There were all those issues. There were all of these data issues that surfaced early on and just continued through a lot of the pandemic. But we had a team. We had a team working on data.

BY MR. EMMER:

Q So back to the article, just a reminder. Only answer what you can recollect. But it says further that nursing homes were -- and this is page 3, and I'm looking at

the sixth paragraph from the bottom. It starts, "When the coronavirus hit in March --." So the second sentence states, "Nursing homes were reporting daily --"

A Page 3?

Q Page 3.

A Mm-hmm. I got it.

Q "Nursing homes were reporting daily how many residents had COVID-19, how many masks and face shields were on hand, and other important data. They also reported how many of their residents had died in hospitals, but until the call with Zucker they were never asked about residents who died at their facilities."

Can you explain why the Health Department wouldn't be asking that type of question?

A I think that's incorrect. I think we knew about who died in the facilities because I think one of those systems, the HERDS system is a hospital-based system. I think it's called the MDL system. There's a different system that numbers come in from nursing homes to the state, or maybe they come in to the Federal Government. But there was a system in place. So I do know that we had the numbers of who died -- not who but how many died in the hospital and how many died in the nursing homes. I'm pretty sure. I'd have to ask the team, but I'm pretty sure. But I'm not sure about that.

Q So on August 3, 2020, you declined to provide the New York Legislature the number of nursing home residents who died --

A This is not from the article.

Q No, sorry. So skipping ahead, and this is just a quote. On August 3rd you declined to provide the New York State Legislature the number of nursing home residents who died in hospitals, stating, "I know that you want the number and I wish I could give you the number today. I need to be sure it's absolutely accurate." You also declined to provide a ballpark figure. Do you recall that testimony?

Mr. Boxer. I don't think the word "declined" really characterizes the testimony accurately, but you can ask. When someone says, "I want to give you an accurate number," that's not declining.

Dr. Zucker. Yeah, that's true. I did not decline.

Mr. Emmer. Okay.

Mr. Boxer. More or less, was that close to what you testified?

Dr. Zucker. Yeah, that's correct. So I think this goes to what we were talking about before, and just keep moving from July. So we have the July 6th presentation, and then after that there was an ask by the legislation to come in and speak to them. I still did not understand all these

data systems, and as I mentioned before, of all these other things that were transpiring, the focus wasn't on something from the retrospective. We were doing very much a prospective concern.

But the legislature asked me for these numbers. In prep for that, there was a discussion of whether these numbers, there was double-counting or not, and I could not answer that for sure because I really had not looked at it. So what ended up happening is Melissa said that after the hearing she was going to send Gareth Rhodes over to the Department of Health and work with me to just figure out what all these numbers were. And so at the hearing I was not ready to give them an answer, but after that hearing -- there were two hearings, but primarily the first one, that August, was the one that was relevant -- then he came over and we looked at the numbers. And then finally, when they all felt comfortable with the numbers, a letter was written that was sent, signed by me, that I read, that was sent back to the Governor's Office, saying this is the letter you need to send to the legislature, in response to their question, which was in October. And by that point I understood it better. I did not really understand all these systems and data until early 2021, before my budget hearing, and then I wanted to be sure I was ready to answer these questions.

So that was how this process unfolded, and then

it was October. So that letter went over, but that letter never -- I mean, it went over to Chamber -- it never actually went back to the legislature.

BY MR. EMMER:

Q So I want to redirect your attention to that Impeachment Report. Do you have that in front of you?

A I would like to add, this is a Syracuse paper, and it's also a Syracuse article from, I think, the same paper, talking about how March 25th guidance did not drive the nursing home deaths. So you pull the articles out that you like. But there is also a very strong article in there talking about how it teases through all of this, saying this is not what drove the deaths in the nursing homes.

Q So we are looking at, under Subsection G, the third paragraph.

A What page?

Q On page 41. So it reads, "Around August 2020, the same senior DOH official also prepared a letter to members of the legislature reporting the full nursing home death numbers and provided it to the Executive Chamber for approval. To the senior DOH official's knowledge, the Executive Chamber never authorized releasing the letter. A task force member also advised releasing the full dataset at this time, but the Executive Chamber did not do so. The task force member believed that it was because the Executive

Chamber wanted to audit the data further."

Were you the senior DOH official that recommended releasing the numbers?

A I am the senior DOH official, yeah.

Q And do you know who the task force member was?

A I can only speculate.

Q Can you, please?

A I wonder if it was Gareth Rhodes.

Q So based on the Impeachment Report, does it follow that there were nursing home numbers that included residents that were transferred to the hospital that the Executive chose not to release in August of 2020?

A But the numbers -- I'm unclear. I'm unclear what the question is. What I'm reading here says that the letter that we put together, which had all the numbers, and it did not go back to the legislature. That's how I determine it. I'm not sure about what you asked me about August 20, 2020. Right, that was the letter. Right, there were letters that were sent over there. There were, I think, two letters. Well, there was one official letter, and I think that was information that went over there as well, saying these are the number of deaths, and that came from the Department, you know, from the Department probably prior to -- put together prior to my August testimony.

BY MR. BENZINE:

Q At this point were you comfortable when you sent the letter over, were you comfortable with the numbers?

A The letter that I sent over in October, I was totally comfortable with. That was the number of deaths at that time.

Q Do you believe that it needed to be audited further?

A No. No. I felt that this letter should go.

Q And again, this is in your personal opinion. At this point any delay in releasing the numbers was just a delay.

A Yeah, I felt it was a delay. I felt it should go out, and I will be the first to say that I raised it multiple times about getting them out, and had some days that I thought if they were so worried about something then they should put it out on X day or Y day. So like Thanksgiving.

BY MR. EMMER:

Q All right. Now we will move on to the actual July 6th report. So I'd like to introduce what will be marked as Majority Exhibit 14. And this is the New York Health Department report issued on July 6th.

[Majority Exhibit No. 14 was marked for identification.]

BY MR. EMMER:

Q And briefly, because you already described, or

you already went into it a little bit, but just for the record can you quickly summarize your role in drafting this report?

A So the report started, as I mentioned, as what we wanted to do, when we wanted to do a medical journal paper, and then the information that my team had been putting together for that paper was sent over to the team in the Governor's Office, and from there that information was provided over to Jim Malatras, and he worked on it with, I guess, others, to put together the paper, using what we had, the science we had, the epidemiology we had, the tables, the graphs, all of the information we had, to put together this kind of a paper.

Now I will say that the original document that we had was not in the kind of format that any journal would take, because they're not going to take 12 different tables. And so when we sent it over we sent over, as I remember, everything over to them and said, "Here's all the information." And then this document required edits, where there questions that were shared with me, and I showed it to Eleanor Adams, I showed her, and if she had questions then I actually brought that back to Jim on the phone and marched through all of the edits. And then it was revised again and revised again. And ultimately at some point it was done, and I used this as the framework for me to prepare my July 6th

speech.

Q Okay. And you mentioned -- and I missed the last name -- but Eleanor --

A Adams.

Q So she was involved in the drafting of the report?

A She was working with me on the paper.

BY MR. BENZINE:

Q All right. To get it clear what the division of work here was, so you had started on gathering the tables and the information for what was going to be a medical paper.

A Right.

Q The Chamber asked you to produce something, some kind of product.

A Right.

Q And that came from Ms. DeRosa?

A Yes.

Q When you got that, you and Ms. Adams worked on that.

A Dr. Adams.

Q Dr. Adams. Excuse me. I don't want to take anyone's degree away from them. You and Dr. Adams shifted what you had previously been working on over to the Chamber.

A Right.

Q The Chamber used that to draft Version 1 --

A Right.

Q -- and sent Version 1 back to you.

A Well, a version. I don't know if it was Version 1 or not. I just know at some point a draft came back for us. I can't speak to how much -- because I had only seen one version of what we were working on, because the team was primarily working on it. And there was introductory information there, which, you know, may have been part of the beginning of what we did and some of the issues of limitation of a document and some of the results and conclusions, and our tables in there. But that information was what was packaged together that was sent over, and I think it was also sent over to Linda Lacewell, but I'm not sure. But I know that I think that she had an ask for some of this information as well.

Q Again, would you characterize the Executive Chamber as the primary drafter of this?

A So I feel that they were the drafter of this document, and I will say that the public health, the epidemiology, came from the Department, so I don't want to dismiss the tables, the graphs, the data, the information. I mean, that came from, the curves -- this is public health epidemiology that obviously the public health team worked on. But there was the sense that this was being put together by the Chamber, the Governor's Chamber.

Mr. Emmer. We can go off the record.

[Democratic minority counsel had no questions at this time.]

[Break.]

Mr. Emmer. All right. We can go back on the record.

BY MR. EMMER:

Q So I'd like to direct your attention to the Impeachment Report, and it is page 37 that we are looking at.

A Yep.

Q All right. It is the first paragraph and the first sentence, and it states that the report, "The evidence obtained in our investigation establishes the while the DOH report was accurate in its disclosures it was not fully transparent regarding the total number of nursing home residents who died as a result of COVID-19." Do you disagree with that characterization?

A I think that, well, it said in there that there were 6,000 or 6,800, and like I was saying to you before, I did not follow this, understand this well enough on some of these numbers in these systems. There were additional deaths that I ultimately understood, that were these nursing home patients that went to the hospital, and that is sort of at the crux of some of these issues, of people who started in the nursing home, went to the hospital, and died. Where are

they counted?

Q And for the record, what you're referring to was -- and you can walk us through it -- but the initial, what's been widely reported as that the initial drafts had a number of 9,842 cited death, whereas the released draft, on July 6th, had 6,432.

A Right, and that's the stuff that I can't answer, like how did the number change and where did that happen. That's what I was saying. When you asked me about some of these edits and versions, I did not necessarily see every version or edit that came through. When there were a lot of public health things that needed to be addressed, and say this is the question, then we addressed it. But often what happened was we read the entire paper and we found our own questions that we had, and then went back and forth.

BY MR. BENZINE:

Q I guess, do you recall what the number was in the version the Department of Health sent?

A No, because I don't think we had -- what we sent over was more a paper. I don't think there was even -- I don't even know if there was a number in that. I don't remember. Because I don't even know where that original manuscript type was anymore. I have not seen it in a long time. Once this was done, I don't even remember where that was. So I don't know if there was an actual number.

The focus of this paper, this white paper, from my perspective -- and even what I presented on July 6th -- was to really address the issue that was out there about this March 25th advisory being the driver of nursing home deaths. And that's what I addressed, and I don't know if you actually saw what I said on July 6th. I don't even know if it's recorded. Maybe it's out there. But I went through an entire analysis of this to explain that issue, and that is what the focus of the paper was.

BY MR. EMMER:

Q So to summarize it, would it be safe to assume that you had no part in the changing of --

A That's correct.

Q -- or the final number that was reported, or the determinations surrounding it? Okay.

So on page 4 of the July 6th report it states, "The survey" -- and this is the second sentence of the second paragraph -- it states that "a survey conducted by the New York State Health Department shows that approximately 6,326 COVID-positive residents were admitted to facilities between March 25, 2020, and May 8, 2020." Were you involved how that number was determined?

A See, this is all where I was saying the weeds of stuff, of the team sort of saying this is what we have, and so I was not necessarily involved in that. But I trusted

what the Department did. I trusted. And when the final version came out, and I asked our team, I said, "Are you comfortable with this?" and they said, "Well, it's like a couple of things we'd want a little differently, but I'm fine with it." And so I suspect that is the correct number.

Q That framing is correct, that it was a New York Department of Health Survey.

A To the best of my knowledge, I would say.

Q And again, what has been widely report, that the 6,326 number omitted 2,279 patients who were readmitted to the nursing homes, where they were already residents. Is that something that you were aware of, or the allegations after the fact?

A No, I'm not aware but I do remember a discussion about readmissions, and this was one of those moments in time where there were a lot of conversations about it, but I don't remember the details. And I know there was a group in one of the conference rooms addressing this, and I just was so overwhelmed with so many other things, I said, again, this is about data and numbers, retrospective. At some point we need to sit down and look at this. But I've got all of these other issues I have to juggle and deal with. So I said, I'll deal with it. I'll deal with it.

Q So just to conclude that line of questioning, you were not involved in any -- well, you weren't involved in the

--

A On this readmission, no.

Q -- determination of whether to count readmissions or admissions in the report?

A No. No. I mean, that was not within my scope. And if it was brought to my attention I will tell you that it went right over my head and I was not really focused on it, if it was brought to my attention. But I don't remember that issue, but I do remember that there was a discussion about readmissions at some point down the road. And remember, this report, when this was finishing up, I also realized I need to get this presentation together, and I wrote it, no one from my department. I literally sat down, hand to the keyboard, and wrote my presentation myself. And so I was trying to do that while still the document was getting through its final versions.

Q Do you care to speculate who you think may have made that determination?

A I don't know. I don't know. I really don't know. I've always wondered about like what transpired with some of this, but I don't know what happened, so I don't want to guess.

Q So on page 40 of the July 6th report --

A 40? There is no 40.

Mr. Benzine. Impeachment report.

BY MR. EMMER:

Q Excuse me. Page 40 of the Impeachment Report. And I'm looking at the first paragraph, the second sentence.

A Mm-hmm.

Q So this is similar to our questions before. The report states that "The July 6th report cited data from the New York Times and described the data as representing deaths in the nursing homes and at these facilities. Witnesses have stated that the same senior Executive Chamber official who served as the key point person for the book made the decision that only in-facility deaths would be included in the DOH report."

Again asking you to speculate, but do you know who the senior Executive Chamber official would be referring to?

A Well, it's a decision that had to be made, right, and I would put the whole sentence together, because it says "key point person" for the book. And tie that with "made the decision" so it has to be someone who has that authority. So then it goes back to the only person I can speculate, is back to Melissa, because -- but I don't know. She is one of the people who can make a decision. The other people who were probably involved were probably not at that level, and I assume she was probably key point person, but I don't know. But that's what I would assume.

Mr. Boxer. Is this talking about the governor's book?

Dr. Zucker. Yeah. Yeah.

Mr. Emmer. Referring to the --

Dr. Zucker. Right.

Mr. Emmer. -- governor's book, and we'll discuss the book in more detail later on.

Mr. Boxer. Not too much to discuss.

Dr. Zucker. Yeah. I know.

Mr. Emmer. It makes our job easier.

BY MR. EMMER:

Q So page 40 continues.

A So I was saying before that a lot of these like in-facility, out-of-facility, assumed, you know, confirmed, a lot of these numbers and all the different systems were stuff that, at that point in time, was still very unclear in some ways to me. Like I said, I trusted the team. We had a really great team in the Department, and I trusted them if they said, "Well, this is what this number is," or that number. But I still didn't understand, and I wasn't really focusing, and my focus on this came when I realized I am going to go before the legislature again at the budget hearing, and the budget hearing is not going to be about the budget. It's probably going to be all about this other stuff. And I said, you know, just sit down and really get a

good grasp on this. And by that point we already had vaccines, we had a plan, so a lot of those other things had already quieted down. We had come down on the curve, the second wave was there but we were doing fine with it.

Q Thank you. So I want to direct your attention to page 40 of the Impeachment Report. It is the first sentence of Subsection 2. It says, "As noted, the evidence obtained in our investigation demonstrates that former Governor Cuomo directed officials from the Executive Chamber, task force, and DOH to prepare a report from DOH in order to combat criticism of the March 25th directive. The report was initiated by the then-governor and influenced by members of the Executive Chamber and task force, and released under the auspices of DOH."

For the record, the report does not credit the governor, members of his office, or the task force for authoring the July 6th report. Correct?

A That is correct.

Q And we'll actually skip ahead. But would you say it was unusual for the then-governor to direct officials to prepare an official DOH document in order to combat criticism?

A Well, I guess the question was it unusual for him to sort of direct people to do things, look into things, no, that wasn't uncommon. You know, he would sort of, long

before COVID, say, "I want you to do X and Y," "I want you to put together this issue or that issue." So he was very proactive and hands-on type of governor, so I'm not surprised. Although I personally did not know that, until actually looking at this, that it's saying that he was the one who directed it. I mean, I suspected that it was Melissa who basically said, "Put this together." And maybe, in retrospect, thinking about it, maybe I do remember him once saying, "We need to put a report together."

But, you know, I actually thought it was important to do this, and if I didn't then I would not have been working on a manuscript to start with. So I thought it was very important to get this information out and to explain what we have spoken about all day today, why some advisory was not the driver of nursing home deaths. And I thought that it was worth doing. So, you know, I supported that, although sometimes the process was another story.

Q So the next sentence, or the last sentence of that paragraph on page 40 in the Impeachment Report states, "Throughout the drafting process the former governor reviewed and edited the draft DOH report on multiple occasions and made edits to strengthen the defense of the March 25th directive. DOH officials who worked on the DOH report expressed a number of concerns regarding the drafts of the report, including that drafts of the report used data that

could not be independently verified by DOH and that drafts included statements of causality and drew oversimplified conclusions and did not explain the limitations of the data used in the DOH report. More generally, DOH officials were concerned that the DOH report was directed by the Executive Chamber and task force and was not, in fact, a scientific or medical report."

Dr. Zucker, I guess this goes to our last question, but was it unusual for the governor to personally review and edit DOH-issued documents?

A So I did not know that he looked and edited. I would not be surprised because, like I say, he was very hands-on on a lot of issues. But I did not actually know that until this document.

Mr. Boxer. What's the question?

Dr. Zucker. Yeah. What's the question.

Mr. Emmer. That was the question.

Dr. Zucker. Okay.

BY MR. BENZINE:

Q I have a kind of like what you saw through the process question in your inbox. Did you see reports come back with tracked changes in them, or was it just here's the new version of the report?

A No. I saw maybe one with tracked changes, but usually I saw a version, a new version. And then I think our

team sometimes would make notes. I don't remember. There may have been a tracked-change version once, but there were many times I saw a final version, and sit down and tease through that. There was another thing in here. Right, so that was my one point.

BY MR. EMMER:

Q So to be clear, you don't know what areas of the report that the governor would have made edits to?

A No. No, I don't.

Q Got it.

A That second paragraph, I mean, I asked our team in DOH, because that paragraph references DOH, "Are you comfortable with this report?" Granted, you could say, well, there should have been a little bit more about limitations as a normal medical journal paper would have, and "Are you comfortable with the conclusions and everything?" and they were. So I realize that the importance of making sure this gets out, and the fact that the conclusions were accurate was the most important for me, because I was going to go out there on July 6th, the day this was put out, and present to the public what we found, and I wanted to be sure that they were comfortable. I was comfortable with it, but, you know, the technical experts may say, "Well, there's this little thing here." And I asked them, and we went through it and we discussed it at length, and they were comfortable.

BY MR. BENZINE:

Q Do you recall if the number of deaths in the Department of Health report was the same number as the letter that you drafted to the Executive Chamber?

A The letter was in October, so by that point there were additions -- right, there was August, and many more deaths that had accumulated in that period of time. So that number was 9,000 or something. I don't remember. I would have to go back and look. But it was in the 9,000s. There were three more months.

Q That's one of the, I think Jack touched on, of it was reported, and I think it was in the Impeachment Report too, of the number that the Department of Health put in the report before it went to the Chamber, and it was in the 9,000 range, and when it came back it was in the 6,000 range. Do you have any recollection of that?

A I don't. That's what I was saying. I can't get to the bottom of that one.

Q All right.

A I had one thing about, since you're asking -- and I know the witness should never volunteer. But the July 6th presentation that I wrote, that I did send over, you know, to the Governor's Office, and I specifically asked, like, Stephanie, to please, you know, show this to the governor. But she said it needs to go to Melissa. So I sent it to

Melissa, but I copied Stephanie, because I just had this sort of feeling that the governor would probably want to read something that I'm going out there and talking about, though I never heard back from anyone except through the grapevine someone saying, "The word is that it is really well written." I suspect that may have been from him.

BY MR. EMMER:

Q So in regard to the second part of that paragraph, from the Impeachment Report, that says that DOH officials who worked on the DOH report expressed a number of concerns regarding the drafts, were you one of the DOH officials that that would be referring to?

A I didn't -- my concerns on this were always a reflection of the concerns of those who worked with me, because they were the experts on it. So if someone said, "I'm concerned about this table with that number, and I've been looking at it closely" -- not me, they; I'm speaking for them -- then I would bring that concern back to Jim, who had the pen or the computer on this. And there were many conversations about making sure things were accurate.

Q And you mentioned that your concerns reflected the staff. Do you have the names, or can you list the names of the people you are referring to?

A Well, mainly it's Dr. Adams, but it's she and I, because initially the ask from the Chamber was that I'm the

only one to review this. But I did not feel that I had the time nor, in some ways, the detailed expertise on some aspects of these things, so I wanted my team to look at it. And I felt like if I read it very quickly I would skip over things that you really would pick up if you're reading it with a fine-tooth comb.

Q And finally, that last sentence, which is just says, "DOH officials were concerned that the DOH report was directed by the Executive Chamber and task force and was not, in fact, a scientific or medical report." Did you have similar concerns?

A No. You know, that's an interesting question. I'm looking at that. There are ways you put together scientific reports, and the format and other aspects of reports, and it may not parallel that exactly. However, it goes back to what I was saying before. Were the conclusions correct? And if the conclusions were correct, presenting something in a way that would be the clearest for the general public who are not medical or public health specialists was fine with me. And so I was comfortable with the report, that it conveyed the information, as long as it was not -- as long as it was accurate, I should say.

Q So I want to direct your attention to page 7 of the July 6th report. And we are looking at the second sentence of the first full paragraph, and it states that "The

New York Times analysis found that in terms of percentage of total deaths in nursing homes, New York State ranked 46th in the nation, meaning 45 states had a greater percentage of fatalities." This is also a stat that Governor Cuomo uses in his book. Can you just briefly explain where that data came from?

A I don't know specifically, but I do know that the Kaiser Family Foundation had done many reports on nursing homes -- or I shouldn't say many -- several reports on nursing home numbers, so it may be from there. And I would, just as a point of reference for you, I would look up some of that with the KFF, Kaiser Family Foundation. Perhaps it comes from there.

Q Okay. But as far as a public report issued by the New York State Health Department, would it be standard practice to cite conclusions, opinions, data that are made by the media, in this case the New York Times?

A You mean in a medical journal? Is that what you're saying?

Q Well, I know that we started with a medical journal and then this became -- I guess I'm more interested in --

A You know, it is a very interesting point because in years past -- or maybe more than year past, citing the lay public or media was not normally considered acceptable.

However, as the years have gone by, I have noticed it's much more common, even in other publications that are more professional, medical professional documents. But I would have to go back to that analysis and article and see where they found that.

Q Would that have been something that you would have included in your report?

A You mean a medical --

Q Yeah. Initially how it started.

A What I would have done in a medical journal is I would have found where this came from, not cited in the New York Times but gone to the original cite, and if I found the original cite was like a Kaiser Family Foundation, I would cite that. I'm not saying that that is where this is from -- and I just want to be clear, I don't want to say KFF is who wrote this -- but I'm saying whoever was the source of that, it may be actually a journal. It may have been someone wrote something of that nature, maybe a foundation or organization that was credible. For example, in New York if there was something that was put out by the New York Academy of Medicine that did the report, I would say the New York Academy of Medicine put this out, and I would be willing to cite it.

Q So to wrap up that section, a real quick question. Do you stand by all the conclusions of the July

6th report?

A I do. I do.

Q So around the same time that the July 6th report was published, July 6th, and obviously widely reported, and we've already touched on it just briefly, but were you aware when your staff was preparing the July 6th report, when there were drafts going back and forth, that the governor was also preparing or writing a book?

A No. I found out about the book through the media, when everyone found out about the book. To the best of my recollection that was when I learned about it.

BY MR. BENZINE:

Q So you didn't participate in any drafting or -- and I use the term a lot -- no water cooler talk around the office that the governor is writing a book?

A No. No. There was one time someone asked about how the pandemic began, and I don't remember what it was, and I shared a little bit about the beginning, and that was it.

Mr. Emmer. We can go off the record.

[Break.]

BY MS. [redacted]

Q Thank you, Dr. Zucker. I am going to ask you some questions related to some things that our majority colleagues were going over with you. You talked about the data reports coming out of the Department of Health. Just to

clarify, how big is the New York State Department of Health?

A I don't know. I think it was like 5,000 people, 6,000 people.

Q Employees?

A Employees, yes.

Q And was there staff who was devoted solely to data analysis?

A Yes.

Q Do you know how big that department was?

A I don't know. There was a handful that were involved. Some left. There were a few that stayed through most of the pandemic.

Q Great. And we talked a lot in the last session, or the last hour, about the Cuomo administration's Executive Chamber and sort of how they used the data analysis and put their own context around it. Is that an accurate representation?

A They looked at the data and presented facts as they interpreted the data.

Q And some might call that the politicization of science. What would the drawbacks of the politicization of science, in regards to public health, be?

A Well, I think that this pandemic really showed us how much there was an intersection between politics, public health, and the press on addressing a pandemic, and I think

that created challenges for the public health community.

Q And I think you are aware that the New York Attorney General conducted an investigation into the nursing home situation.

A Yes.

Q And issued a report titled "Nursing Home Response to COVID-19 Pandemic," that was released in January 2021.

A I saw that.

Q And the New York Attorney General does not report to the governor. Correct?

A That's correct.

Q So this was an independent investigation and report.

A Correct.

Q The report found -- and I'm just going to read a quote here -- "Discrepancies remain over the number of New York nursing home residents who died of COVID-19. Data obtained by OAG shows that DOH-publicized data vastly undercounted these deaths." And the report recommended that DOH, and again, quote, "ensure public reporting by each nursing home as to the number of COVID-19 deaths of residents occurring at the facility and those that occurred during or after hospitalization of the residents, in a manner that avoids creating a double-counting of resident death at hospitals and reported state COVID-19 death statistics."

Does that sound --

A Well, that's what the report said, but I don't agree with their interpretation.

Q Okay. But that was the Attorney General's independent investigation analysis.

A That was what they wrote.

Q All right. Thank you very much, Dr. Zucker. I am going to turn things over to my colleague.

A Excellent.

BY MR. [redacted]

Q So I would like to revisit Majority Exhibit 6, which is the CMS March 13, 2020, guidance. Before you look too closely at it, I would appreciate if you could offer me your perspective. What is the role of CMS as a Federal agency in guidance documents like this for your work as a state health official?

A Well, I have always viewed CMS as home primarily within the Department for the work that we do on Medicaid at the state level, because they deal with -- because individuals who are, that CMS sort of pays for, like Medicaid and Medicare, and many of those patients are in nursing homes, I can see where they have some responsibilities and concerns to be sure that those patients are safe.

Q And as it relates to guidance documents like this, this document that was issued, how did you and your

staff, or the public health community in the state of New York, use this document?

A Well, I can speak for how I did. I did not really turn to the CMS guidance as much as my team did. And when I asked them to make sure whatever they prepared were consistent with Federal guidelines, I expected them to take a look at those in CMS and CDC, and if it was something else, NIH or AHRQ, whichever agency that they were working with, or FDA.

Q Understood. So as you were operating as a state policymaker, as you were leading a team of state policymakers, you were endeavoring to be consistent with Federal guidance such as this.

A Correct.

Q So looking at page 4 of the Federal guidance, which my majority colleagues helpfully highlighted, starting at "A nursing home can accept a resident diagnosed with COVID-19 and still under transmission-based precautions for COVID-19, as long as the facility can follow CDC guidance for transmission-based precautions."

I just want to be clear. At this point in time, this document from the Federal Government, this guidance, was not barring the admission or readmission of COVID-positive patients to nursing homes. Is that correct?

A That is correct. It said that you could not --

that COVID-positive patients can't come back to nursing homes.

Q And so functionally, just to make sure this is clear for the record, this document is premised on the notion or the idea that COVID-positive patients could be safely returned to nursing homes with adequate precautions.

A That's correct.

Q And recognizing, of course, that times sort of have changed and our knowledge of the COVID-19 pandemic, of the novel coronavirus grew, is it fair to say that as you were operating as a state health official, as Director Verma was operating as the administrator of CMS, that everyone was working with limited and constantly changing knowledge about how COVID-19 spread in making these policies?

A That is very true.

Q Okay. Shifting gears slightly, I want to revisit something that you raised during the first hour, or first 2 hours. And this was specifically two calls you received from the former President relating to the use of hydroxychloroquine as a potential COVID-19 therapeutic. You actually, if I recall correctly, believed that the conversations pertained to both hydroxychloroquine and Ivermectin. Is that right?

A No. hydroxychloroquine and erythromycin.

Q Okay. Perfect. Thank you for the clarification.

Looking back on the evidence that was available for those two specific potential therapeutics or treatments, can you explain what evidence was available to suggest that they could be used to treat COVID-19?

A There wasn't much evidence. I don't recall how this came about that people felt that hydroxychloroquine would be beneficial for these patients, and I have to go back and remember how this began. I do remember how we sort of decided it's important to go look at this. We also were concerned that there would not be enough hydroxychloroquine to treat individuals who actually need that medication for their underlying chronic medical conditions.

Q I see. And if I recall correctly, in the previous sort of round, you had mentioned that President had called you believing that hydroxychloroquine should be administered to patients.

A Right.

Q And based on what you just described it sounds like there was not ample or sufficient evidence to suggest that that was the case.

A That's correct.

Q What would be the implications of continuing to sort of press forward with this idea that hydroxychloroquine should be prescribed or used to treat COVID-19 patients, even when, at that point in time, the evidence did not suggest

that it would be safe and effective to do so?

A Well, you know, as a scientist I would not push forward the understanding that -- well, the way the former President presented it was that, well, if it's not going to hurt somebody, why not give it? But what I explained was we don't know that it may not hurt somebody, and there weren't cases or concerns of some of the effects that medicine has on your EKG and other aspects of your physiology.

Mr. [redacted] Those are my questions for now. We can go off the record.

[Break.]

Mr. Emmer. We can go back on the record.

BY MR. EMMER:

Q Dr. Zucker, we briefly discussed former Governor Cuomo's book. Just a general question. I know that you were not aware of it. Do you believe that it is problematic that at the same time that they were editing this July 6th report they were also preparing -- they were also writing a memoir?

A Well, I didn't learn about that until many months later, when I read about it in some article. So it was -- it's troubling, and I would hope that one is able to separate the two issues, the report and what they are working on.

Q Okay. So we discussed what prompted the March 25th order, the threat of overcrowding hospitals, capacity issues. I just want to give you the chance to briefly

describe what measures the administration took early on to accommodate a potential influx of COVID-positive patients.

A So the governor really took charge of addressing this and created a surge and flex system to make sure that the hospitals increased their hospital beds by 50 percent, pushed them to all work together, all 200 private and whatever, I think 13 public hospitals we have in the state, to work together. We set up an emergency evacuation system with helicopters and ambulances available to move patients from New York City upstate. He set up a large volunteer system for, I think it was 90,000 or 80,000 people to help out. We worked on rapid testing and set up all these different places to get your tests, and then ultimately we set up places to get vaccinated. We used the Javits to vaccinate an incredible number of people after it was initially for COVID patients. And we put into place an incredible operation to address this virus as it went through New York State, and then to address it, ways to prevent it, as well as initially to treat it.

Q And I am just going to quickly run through these because I know that you already touched on it. But in regard to the Javits and the Comfort, initially they were not able to accept COVID-positive patients. Is that correct?

A Initially, that's correct.

Q Okay. And do you recall when that policy

changed?

A Shortly thereafter. I can't say whether it was a week or 10 days, but it was shortly thereafter when we realized the challenges of trying to put many non-COVID patients in there and trying to streamline this a little bit more. The one thing is that once we started use it only for COVID-positive patients you had to split the number of possible beds in half. So what was originally X amount divided in half.

Q Okay.

BY MR. BENZINE:

Q Why?

A Because of precautions and distance and making sure that they were not next to another patient, and so forth.

Q I'm sorry. Even though they were all COVID-positive patients?

A Yes. Those were the protocols.

Q Okay. Were those U.S. Navy protocols?

A I suspect for the Comfort it was the Navy protocols. It came to us saying that you have to cut the number of beds in half.

BY MR. EMMER:

Q So when you did accept, or when the policy changed, was that -- whose idea was it? Was it the

Department of Health, or was it --

A It was all of them. We all sort of spoke about it and sort of said that it would be easier to have it just COVID-positive.

Q So I want to introduce what will be marked as Majority Exhibit 15. This is the admission criteria for the Javits and Comfort, issued by the New York State Health Department on April 7, 2020.

[Majority Exhibit No. 15 was marked for identification.]

BY MR. EMMER:

Q Do you recall this guidance?

A Another one of these guidances that I probably was told about. I knew we were putting this together, and I do remember us putting down sort of all of these different kinds of criteria, but I don't remember actually seeing the document.

Q So it's obviously safe to assume that you had no role in drafting that. Do you know who did?

A We had a team that worked on guidance documents, and I suspect this would probably be part of the team that worked on our focus on hospitals. We had a whole team that worked on hospital issues, and so I suspect that they were involved in this.

Mr. Emmer. Can we go off the record for a

second?

[Break.]

Mr. Emmer. I'm sorry. Back on the record.

BY MR. EMMER:

Q Dr. Zucker, to your recollection, after the issuance of this guidance -- I believe you already answered this, but how much were these facilities utilized by COVID-positive patients?

A So I think the Comfort ended up having 182 patients there, and the Javits had 1,095. That's what I think the numbers ended up being.

BY MR. BENZINE:

Q Do you think they were used to their fullest potential?

A I think that one would have liked to put additional patients in, but by that point the hospital capacity, although tight, was not as severe as it had been a couple of weeks earlier, and as I mentioned before, theoretically it sounded like it would work well, but when we started to try to work through the practical aspects it became hard, and if we were able to bring those patients elsewhere or patients residence elsewhere, that would be fine, and patients, as a matter of fact, because it was not just nursing home patients' presence.

Q I don't actually remember. Did New York cross

the 100 percent threshold. Did you ever exceed your hospital capacity?

A I think some of the hospitals did, sure, because they had the patients in hallways, and they had the operating rooms and recovery rooms used. So the hospital capacity had reached its maximum, and the emergency rooms were filled. It was a real horrific time.

BY MR. EMMER:

Q So I want to move on and discuss what will be marked as Majority Exhibit 16. And this is an email chain from Vice Admiral Mike Dumont to Melissa DeRosa on April 7, 2020.

[Majority Exhibit No. 16 was marked for identification.]

BY MR. EMMER:

Q I'm looking at the first page here. So April 7th, the Vice Admiral writes, "We could use some help from your office. The governor asked us to permit use of USNS Comfort to treat patients without regard to their COVID status, and we have done so. Right now we only have 37 patients aboard the ship. Further, we are treating only 83 patients at the Javits Center." And then on the bottom, the third paragraph, or fourth, he writes, "Our greatest concern is twofold: helping take the strain off local hospitals and not wasting high-end capabilities the U.S. military has

brought to New York City."

Do you recall this email?

A So you bring up a good point here about some of this with the Javits, and it's worth mentioning. The Javits management was really -- and Michael Kopy, he was sort of the one in charge of that. So I don't remember that email, although I do remember him saying -- well, not USNS, but can we send more patients over there. This was very individualized as to what patient could move to Javits. The Northwell Health System also was involved in this with Kopy's team as to decide the criteria, how to move them in, who should be moved in. So intermittently I heard like, "Well, they haven't used the number of beds that they have." And so this is a question which would be better asked of Kopy, about that.

Q Okay. So I will try to ask you things that you are able to answer.

A And I was also -- I will mention that he said to me, "Let DOH deal with some of the other stuff. Let Kopy deal with Javits. But it's not like I wasn't aware, because I needed to be aware of everything. But there were others. It was sort of delegated to others.

BY MR. EMMER:

Q What was his role?

A I think he was with the Homeland Security part of

the Department, not Department, of the state.

Ms. [redacted] Jack, there's no Bates number on this.

Mr. Benzine. It's a FOIA.

Ms. [redacted] Thank you.

Dr. Zucker. Let me clarify. Not of the Department of Homeland Security but part of the state, not the Department.

BY MR. EMMER:

Q So on the top of the page it's an email from Melissa DeRosa that states, "They are setting this up to say that we are the reason the ship and the Javits are empty. I am going to loop you guys on the email. We need to make clear, in writing, that what he has written here is not true." Looking back at Vice Admiral Dumont's email, did you interpret it as some sort of political ploy?

A Honestly, until you showed me this email I don't remember this, so I'd have to go back and read the entire thing to try to figure out what I think was being done. I don't even remember who Vice Admiral Dumont is.

Q Okay. Well, I'll just direct, because there's not much more from [unclear] but on the very next page, the second page, there is an email from yourself to the group. "On the phone with Northwell right now, and just called the Vice Admiral. This about staffing, and Northwell is saying they can't take more." So do you recall your call with the

Vice Admiral?

A I don't remember my call with the Vice Admiral, but I do remember a conversation with Northwell and about staffing, and how many people they have to help us out. But the details I don't recall. This is why I said it would be good to read through all of this.

Q I will give you some time here, just in case you want to clarify your answer.

A Remember I mentioned before that Northwell was involved in this?

Q Mm-hmm.

A And that was Michael Dowling's operation. And they were involved in sort of the criteria and also helping to staff that facility. So I do remember them saying they could not take additional patients. But then it went back to Kopy and others, and the Chamber said, "Let them deal with this, Howard. You've got plenty of other things on your plate."

Q So for the record, you don't recall discussing with the Vice Admiral anything related to sending nursing or --

A No. I can't remember.

Q I may be asking you to speculate here, but as far as you are aware, would there be any financial reasons for the hospital systems to not send patients to the Javits

Center and the Comfort versus keeping them within the state hospital system?

A I have no idea. You need to ask the hospitals. My decisions I made never involved money as a criteria, so you'd have to ask these hospital systems.

Q And you never heard -- that was never something that you heard being discussed?

A No.

Q Okay.

A No.

Q I guess along the same line, would there be financial reasons for the March 25th directive, that is, moving patients to the nursing home versus keeping them within the state hospital system?

A For whom? For whom? For the --

Q For the hospitals.

A The hospitals? I have no idea. But again these money issues were not where my head was focused, and it never has been in medicine, and it never has been in this situation. So you'd have to ask the nursing homes about whether there was a reason to take patients, right, and you need to ask the hospitals whether there was a reason to keep patients.

Q And just to close that section, you were never --

Mr. Boxer. I think he answered it a few times.

I think it's closed.

Mr. Emmer. All right.

BY MR. EMMER:

Q All right. So I'm going to move on to another part of our questions here. So I'd like to ask you whether you -- I'm just going to introduce Majority Exhibit 17.

[Majority Exhibit No. 17 was marked for identification.]

BY MR. EMMER:

Q This article is entitled, "Cuomo gave immunity to nursing home executives after big campaign donations." It reports that the bill offered extensive immunity to any health care facility, administrator, executives, supervisor, board member, trustee, or other person responsible for directing, supervising, or managing a health care facility and its personnel or other individual in comparable role.

Are you familiar with this clause that was included in the spending bill to provide immunity during the pandemic?

A I am familiar with it but not the details of it. But I do know a little bit about this in the sense that the concern in the hospitals -- and I can't speak to all the details -- the concern from the hospitals was that the staff were going to turn around -- the nurses, the doctors -- and just say, "This is just not worth it. It's not worth it to

my health. I'm out of here." And we would not have people. And one of the concerns was with all these patients coming in, people rushing, they did not want to end up in a situation that if they did something which was not negligent but just they did something, as they didn't get the x-ray in time, that someone would end up suing them. And that I heard not only from the Hospital Association but also from personal colleagues and friends who worked in there, saying, "I don't want to end up stuck with a lawsuit when I'm trying to take care of many more patients than is even humanly possible." That's the extent of what I know about it.

Q So DOH was not involved in drafting that clause?

A No. Not that I know of, no. I mean, does it say that the Department was? I don't remember it.

Q No, it does not, for the record. So we will move on from that section. Finally I would like to ask some questions, and you were talking about it before, at the beginning of COVID, you know, there was a movement towards creating a -- to increasing the capacity of the state to test, right. And too, just for the record, testing was by no means readily accessible during the early stages of the pandemic, right?

A Yes.

Q So do you recall how testing was facilitated in New Rochelle, in March 2020?

A So early on, early on, we had the tests that the FDA approved on March 1st, so we would get samples and then we would run them up to Wadsworth, and we could run them at Wadsworth, and like I said, it usually took a couple of hours to run those samples through. And then after that we ultimately expanded the testing when the governor had a conversation with our team and said, "How could we get other labs across the state that we work with regularly to start to do testing?" So then we were able to expand, and then ultimately we expanded it quite significantly.

Q So early on, one of the first epicenters in New York, did the Cuomo administration and New York Health, did you use some sort of door-to-door testing to try to isolate the disease?

A So we tested at the hospital. Then, very early on, we tested the relatives of somebody who was around, and then we tried to find out not just testing but we also tried to just find out if someone had symptoms. And this was a lot of the legwork, the epidemiology of someone saying, okay, if you were exposed, you were at X event, who else at that event was sick? What about your spouse and your kids? And I remember the first case. And he drove you to the train. Did you test him? And then when you were on the train, you know, where did you sit? And this is all like epidemiology, and early on you could do it with 1, 2, 5, 10 cases. But then

when this issue took off it became extremely difficult. So we realized that we can't control it that way and we were going to have to take a different approach to this.

Q So I'd like to introduce what would be marked as Majority Exhibit 18. And this is an article published by the Washington Post entitled, "Andrew Cuomo's family members were given special access to COVID testing, according to people familiar with the arrangement," published on March 24, 2021.

[Majority Exhibit No. 18 was marked for identification.]

BY MR. EMMER:

Q Are you familiar with these allegations?

A I am.

Q Okay. And is it true that the governor's family, friends, and people tied to him were provided tests early on during the pandemic?

A So what I can say is that there were asks to test some people. The way I made the decision about who would get tested, if I was asked, was whether I felt that that person posed a risk to the governor. Because the last thing we needed was the leader of this pandemic in New York State, you know, sick. And so that is how I made those decisions, based on purely a clinical perspective.

BY MR. BENZINE:

Q Did the Department of Health facilitate the

testing?

A They helped, yes.

Q You said some individuals. Who were they?

A See, this is one of those things where I actually -- I, unlike others, I can't answer that because as a doctor I'm sort of bound by the HIPAA rules. So if I say that, someone is going to say, well, you, as a physician, have violated the HIPAA rules. So I can't actually give the names of who. That's why I just sort of said that it was those who I thought would put him at risk.

Q Were there requests that you denied?

A There were. Yeah, I can't think of who, but there were things that I said, "No, I'm not going to do that."

Q Do you remember any of the names of the people that you denied?

A No, because it would be the same issue. I don't remember it, but it would be the same issue.

Q Of the people that were granted tests, were there any outside of his immediate family?

A Yes. Yes. But, you know, some of the denials were not necessarily anything to deal directly with the governance team. There were people asked that were in the administration or whatever.

Mr. Boxer. And I would just say, there were

people that I'm aware of, through privileged communications, that were outside of the family but still epidemiologically close to the governor.

Dr. Zucker. Right. That's right. It goes back it, right, and thank you, Nelson. It goes back to the issue that if I thought it put him at risk, it didn't necessarily have to be a family member.

BY MR. BENZINE:

Q So I'm trying to word the questions carefully here. So did the -- I'm going to use "priority testing." I don't want to put a bad connotation on it. It's in the record now that I won't do it.

Mr. Boxer. I mean, there could be somebody, theoretically, in the Executive Chamber, who --

Mr. Benzine. That's what I was going to ask.

Mr. Boxer. -- with the governor who has a spouse or somebody --

Dr. Zucker. Right. That's exactly right.

Mr. Boxer. -- who is exhibiting very strong symptoms of COVID, very sick, or sick enough that theoretically Dr. Zucker could say, okay, let's test that person. Let's test the person that comes between that person and the governor, that kind of thing. Is that correct, Howard?

Dr. Zucker. That's correct. That's correct.

Thank you.

BY MR. BENZINE:

Q I'm going to reword one of my previous questions. So I understand your kind of criteria, and I think that probably makes -- I mean, I went to the White House during the summer and I got tested. It was probably a similar situation. Were there any requests that came in for a test in this category that you thought were inappropriate, beyond the like health data?

A I don't know what you mean. People, or just in general?

Q A particular person.

A Not within those who dealt with the governor, no. I thought they were reasonable.

Q Anyone outside the governor's orbit?

A No. Sometimes people would just ask, "How do I get a test?" and that's like no, we're not doing it.

Mr. Boxer. I feel like you used to remember a few that you said no to.

Dr. Zucker. I'm trying to think, yeah, but I don't know which -- yeah, I do know. Yeah. But I don't want to go through names.

Mr. Boxer. There were also a lot of reported tests of like the judges, the legislators, in New York, and Dr. Zucker wasn't in the middle of that.

Dr. Zucker. Right. Yeah.

Mr. Boxer. It was very anecdotal, you would describe it as. Is that fair?

Dr. Zucker. Yeah, that's fair. Even sometimes media asked.

BY MR. BENZINE:

Q One of the media was also in the governor's orbit.

A Well, one of the press people that we worked with that was on the governor's team.

Q No, I'm saying that you said some of the media asked for a test. One of the members of the media that asked for a test is also a family member of the governor.

A Oh, I see. I wasn't thinking of that. I was thinking more like people who sat in the room.

Mr. Emmer. Yeah, just real quick --

Mr. Boxer. I didn't mean to cut you off, so please, go ahead. I was trying to be helpful.

Dr. Zucker. Yeah, I just don't want to provide -- I'm being careful.

[Pause.]

BY MR. BENZINE:

Q I have kind of one final question. There was a press conference, or not a press conference, a media appearance by the governor. First, were you ever involved in

prepping for media appearances or writing talking points or anything?

A For him?

Q For him.

A No. I mean, I was there at the press conferences before. We always had a meeting where they went through that PowerPoint, and usually I showed up somewhere during the PowerPoint or immediately before they went through that. But that was the prep that I did.

Q But when the governor would go on TV or on radio or do a press interview, were you involved at all in those?

A No, no, not -- if he had a specific question about something I'd answer it, but I wasn't sitting there with his, you know, public affairs team, no.

Mr. Benzine. That's all I have. We can go off the record.

[Whereupon, at 5:25 p.m., the interview was concluded.]