NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
FULL COUNCIL MEETING
JUNE 2, 2022
10:15 AM
ESP, CONCOURSE LEVEL, MEETING ROOM 6, ALBANY
90 CHURCH STREET, 4TH FLOOR, PSC HEARING ROOM, NYC
TRANSCRIPT

Jeff Kraut Good morning. I'm Jeff Kraut. I'm Chair of the Public Health and Health Planning Council. My privilege to call to order our June 2nd meeting. I'd like to welcome Commissioner Bassett,. Participants and observers at the outset of the Codes Committee, Mr. Holt described our requirements to comply with the record of appearance form, which is posted on the Department of Health's website. www.NYHealth.Gov under Certificate of Need. Please email the completed form back to the Secretary of the Council. He described our webcasting today's meeting. We're doing closed captioning. Please don't speak over each other. Please identify yourself the first time you speak. I particularly want to remind the public and those that are reviewing them that you should join the department's Certificate of Need listserv, where we regularly send out important council information notices such as the dates of our meeting, our agenda and other policy matters that may come before us. There is printed instructions on the reference table how to join that outside the meeting rooms today. Today's meeting is going to we're going to first hear from the Department of Health under Dr. Bassett, who will provide us a report on recent activities. Dr. Bassett will be followed by Dr. Bauer to talk about the Office of Public Health Activities, then Dr. Morley, and on the Office of Primary Care and Health Systems Management. We have a special presentation by Mr. Bret Friedman from the Office of Health Insurance Programs to provide additional information about the PACE programs and some of the changes that may be coming before us in the future. And then Mr. Holt will then present regulations for adoption from the Codes Committee, followed by Mr. Robinson with the Committee on the Project Review and Establishment Actions. As many of you already may be aware, after 15 years of dedicated service to the Council, Ms. Ellen Rautenberg has resigned. On behalf of the Council, I want to extend our appreciation to her for the dedication and the work that she did, the important role she played. She had an absolute passion for bringing public health conversations and serving local communities and making sure that was brought into this room in each and every conversation she participated in, and we were going to wish her well. We've created a resolution signed by Dr. Boufford and I. I just want to give you some of the highlights. Ms. Rautenberg joined us in June of 2007 and, as I said, served until this past Monday, May 31st. She served on our Establishment committee, the Health Planning Committee, the Public Health Committee, and the Ad Hoc committee to lead the state health improvement plan. She did a great job in really advocating for her particular areas of interest, which was promoting the public health of the citizens of New York State. And on behalf of the Council, we want to thank her and acknowledge the invaluable service she provided us for the past 15 years. I hope each one of you would take the time to write a note to Ms.. Rautenberg for what is clearly one of the longest serving tenures on the council and its predecessor organizations. Now, most of our guests that who regularly attend the meeting should be familiar now with our agenda and how we responsibly organize that for the batching of CON's. Before Mr. Robinson gives his report. If there's any changes that you want to be moved out of a batch, please let Ms. Leonard know and Mr. Robinson and we will change the agenda to reflect anything that you would like to do. My next item on the agenda is the adoption of the minutes.

Jeff Kraut May I have been a motion for the adoption of the revised April 5th, 2022 Public Health and Health Plans Council Meeting.

Jeff Kraut Motion by Dr. Berliner.

Jeff Kraut A Second by Dr. Torres.

Jeff Kraut All those in favor, aye.

Jeff Kraut Go ahead, Jo.

Jo Boufford I'd like to make some corrections that don't change the substance and the report of my report to the committee, if I may, after the meeting, but it doesn't change the essence of it. I think it just makes it easier to recall the specifics.

Jo Boufford Thank you.

Jeff Kraut Are you talking about in the minutes or the transcript?

Jo Boufford The minutes.

Jeff Kraut Do you want to make modifications to those minutes?

Jo Boufford That's correct. Just for the section where I reported to the Council on the Activities of the Public Health and Planning Committee. They're really editorial challenge changes. They don't affect the substance of what's said.

Jo Boufford Thank you.

Jeff Kraut Thank you.

Jeff Kraut We'll note that.

Jeff Kraut Next thing, I want to have a motion for adoption of the 2023 Public Health and Health Planning Council meeting dates. You received them prior to the meeting.

Jeff Kraut I just need a motion to adopt them and publish them.

Jeff Kraut Dr. Berliner.

Jeff Kraut Thank you, Dr. Torres, for seconding it.

Jeff Kraut All those in favor, aye.

Jeff Kraut Opposed?

Jeff Kraut Motion carries.

Jeff Kraut It is now my pleasure to introduce Dr. Bassett, who will give us an update about the Department's activities since our last meeting.

Jeff Kraut Dr. Bassett.

Dr. Bassett Thank you very much, Mr. Kraut. I'd like to add to the words that you've given. I know her well from my tenure in New York City and admire her not only for her service, but for her service to public health more generally and in New York City and the state. So, best wishes to you and thank you for the 15 years of service. It is a real pleasure for me to join you this morning. I'm going to give you an initial update on behalf of the department, as you've heard. You're also going to hear from Dr. Bauer and Dr. Morley. There's a lot that's happened and I'll just get started, much of which what I'll be talking about actually falls under the purview of Dr. Bauer, but we've coordinated our remarks, so I'm hopeful that we won't be repetitive. On May 6th, as you know, there was a case of monkeypox reported in the United Kingdom. This person had traveled to Nigeria, where the disease is endemic, but we've subsequently seen an extension of this virus infection to other individuals. It is a rare virus that doesn't usually give rise to serious illness, but it can result in hospitalization and death. It's related from the same family of viruses as the smallpox virus, but it is accompanied by a characteristic swelling of lymph nodes. It progresses with a rash, which is how it is usually recognized. The early data on this current outbreak suggests that gay, bisexual and other men who have sex with men make up a high proportion of the cases. This is transmitted through close contact, so anybody who's had close contact with somebody who had monkeypox is at risk. On May 20th, our department working with the New York City Department of Health and Mental Hygiene, provided a public update on the ongoing investigation of two suspected cases of monkeypox, both of which were identified in New York City residents. While one individual was ruled out, the other proved positive and had an illness consistent with monkeypox. The confirmation of monkeypox is done by the Centers for Disease Control. As of the end of last month, we have now a total of four confirmed ortho pox, monkeypox virus cases in the state. This is the designation that's now being used by the CDC. They combine testing positive for ortho pox with monkeypox. All of these were identified in New York City. They are identified, as I've said, through confirmatory testing for pox virus. So, it's important that we treat these as probable monkeypox cases and we are continuing to be vigilant as we watch this unfold. We have responded by alerting New York health care providers so that they have information that can help with the rapid case identification and presentation for testing should any of their patients present with symptoms. As you know, the number of cases has increased around the world, the global count mostly from Europe now stands at over 500. We have new data from England, which has seen a rapid increase in the number of cases. They now have 183 confirmed cases, most of them in the City of London. Based on the information that we have available, the current risk to the general public is low. But we are, of course urging the public to remain vigilant and ensuring that clinicians have information they need to rapidly identify and test patients who meet diagnostic consideration for monkeypox. We're working in partnership with federal and local public health authorities, and we will continue to keep the public and the health care community updated. On COVID-19, we do have some encouraging information. As you know, the last time I spoke with you, we were seeing the beginning of another wave that began in Central New York and spread across New York State and then to the entire state, including Downstate. For several weeks, we had a large number of counties in New York that were designated as high risk by the Centers for Disease Control over 50 counties of our 62 counties. We're now seeing a decline in cases across all regions, accompanied by a decline in hospitalizations in many part of the states. It appears that although case rates remain high and you'll hear a bit more about this from Dr. Bauer, that this current increase is now declining. We, as of Friday, going into the holiday weekend, we were seeing a drop in most measures, including the cases per 100,000, the seven day average and daily hospitalizations. We still continue to recommend to all New Yorkers in high risk counties

and anyone who is at increased risk of severe disease or of spreading it to someone in their family network who would be at increased risk of severe disease, that they wear masks in public indoor spaces regardless of vaccination status. COVID-19 is still here, but we continue to use the tools we have to ensure it's control. New Yorkers are, you know, about three quarters of New Yorkers, including the littlest children for whom a vaccine is not yet available, are fully vaccinated. We really need New Yorkers to continue receiving all of the recommended doses of the vaccine, wear masks, especially in areas of high transmission, get tested, stay home if they feel sick and seek advice on whether treatment would be appropriate to them. New York State has played a pioneering role through its Wadsworth lab and the identification of some of the new variants. These are the BA212 and the BA212.1. I don't know why we're keeping the name omicron and adding all these numbers, but these sub lineages of BA2 have expanded rapidly. Each new lineage seems to be more transmissible than the previous one and has a substantial growth advantage, crowding out the original variant and now the original BA2 variant. We have a lab that has been able to identify these variants, identify the mutations that appear to be related to transmissibility and to make these data available through the public reporting system. We now really are hardly seeing any of the original consequences among people who are infected and the CDC's Region Two, which includes New Jersey, Virgin Islands and Puerto Rico as well as New York, now is estimating that 100% of all samples are these sub lineages. Our lab is keeping an eye on other potentially emerging variants that have been identified elsewhere in the world. They are BA4 and 5, which we have not yet seen spreading in in New York State, but our lab we're lucky to have is keeping an eye on these. Turning to boosters, you are aware that on May 23rd, after the FDA authorized and the CDC's advisory committee recommended, we announce that children who age 5 to 11 should receive a COVID-19 vaccine boosters five months after completing their initial primary course. Children who are moderately to severely immunocompromised can receive their booster three months after completing their primary series, which would include three vaccinations. Vaccinations continue to be an extremely effective way that we have to protect from serious illness due to COVID-19. We are working rapidly to release new clinical guidance for the administration of the booster to children to all providers enrolled in the New York State vaccination program. We continue our work to reach out to inform parents and guardians of the expansion of booster eligibility. We are pushing notifications through our Excelsior Pass platform. This is also paired with the continued state investment in making COVID-19 testing available. We are continuing to provide over the counter tests. We've delivered more than 80 million over-the-counter COVID-19 tests to New Yorkers since December of last year, and we encourage people to use these tests when they're not feeling well or they've been potentially exposed as well as when traveling or before attending a large gathering. And of course, if you test positive, we urge contact with a health care provider to discuss eligibility for treatment. We have been reminding New Yorkers about treatment in the early days of the variant surge, we had a shortage of treatment. That is no longer the case. We want it to be very clear to New Yorkers that they should assess their eligibility for treatment and that this treatment is best taken when within five days of the onset of symptoms. So, when symptoms arise, people should not wait to get tested and they should not wait after testing positive and contacting a health care provider. These medications remain available at free of cost. We're continuing to work with providers to increase awareness and facilitate the early connection of New Yorkers who test positive. Continues to be the treatment of choice to appropriate patients with mild to moderate symptoms. We are seeing a decline in cases and therefore a decline of use at this time. We have been pleased to see that treatment did seem to be expanding and we want to ensure that people are aware that they should get tested and get access to treatment. I'm going to turn now to the cases of pediatric hepatitis. We know that in April, the CDC issued a nationwide alert to notify clinicians about a cluster of children with

hepatitis. They have seemed to be associated with that no virus infection. We've been alerting physicians to be on the lookout to identify these cases. We continue to not be clear on the origins of this pediatric hepatitis and the connection to adenovirus also remains unclear. Adenoviruses usually cause respiratory illnesses. We see outbreaks throughout the year, but we have found among the sick children with hepatitis the presence of Type 41. It may be a cause of hepatitis and this that's being observed clinically. The department is working with local and federal public health authorities and investigating cases of pediatric hepatitis. We now have nearly 250 persons under investigation. Some have led to quite severe outcomes, including the need for liver transplant. We know that influenza remains with us. We had an unusual pattern of influenza this season with a bimodal distribution of influenza cases, a late rise and seasonal flu and two weeks ago, we alerted New Yorkers that seasonal flu rates were unusually high for this time of year. We know that the precautionary measures that are followed with COVID-19 are also useful for influenza. Symptoms, stay home, consult your physician, get tested, get treatment, wear a mask in public indoor spaces and living in a high risk counties or at personal risk. We've issued an advisory to the New York State Public and private schools to remind administrators to contact their local health department if they see an increase in school absences. For the week of May 21st, the influenza activity level was categorized as geographically widespread, and this is the 27th consecutive week that we've seen widespread activity reported. The department has extended the surveillance season beyond May until influenza activity has decreased. While we've been managing COVID-19, monkeypox, influenza and pediatric hepatitis, we've also been faced with other events in our nation which we also consider relevant to public health. Obviously, some of these are events that have to be addressed very widely across government and across society. I'm referring to the acts of gun violence. Since I spoke with you last, the City of Buffalo experienced a heinous and unjust act that we have known too well when a white teen drove over 3 hours to the nearest Black neighborhood that he was able to identify and shot 13 people, 10 of whom who died all while livestreaming this event. I'm grateful to Governor Hochul for being unflinching in her characterization of this atrocity as an act of white supremacy. As a department, our thoughts are with the victims and their families, as they are with the victims in the State of Texas. June is Gun Violence Prevention Month, and we continue to view gun violence as a public health crisis and will work with our state, federal and local partners and our own newly established Office of Gun Violence Prevention to address the impacts of gun violence. We also are facing an enormous challenge with the anticipated reversal of Roe v Wade. We know that the Supreme Court is poised to roll back this landmark decision ending nearly half a century of federally and constitutionally protected abortion rights. If this happens, all pregnant people, particularly people of color and those who already have too little access to health care, will no longer be free to make the decisions that are best for them. However, in New York State, abortion access is the law, and here reproductive health care is enshrined in our state law as a medical freedom and a human right. When safe abortion access is stripped away, it doesn't stop abortions, but it does make abortions more deadly and dangerous. This impact will be particularly felt among low income communities, particularly among Black and Brown and Indigenous communities who are overrepresented among the poor in our state and our country. New York has enshrined these rights. We know that we need to think through what support we can offer to the rest of the country, should the ROE decision be overturned. Let me now say a little bit about what we've been doing inside the department. As things have slowed down a bit, we've been able to turn our attention to our own department. It is no secret that over the past few years, the department has lost many members of staff. It has a high vacancy rates that there are many full reasons, but burnout is among them, as well as retirement and whatever reasons people leave their jobs. We have been focusing on rebuilding the department not only through rehiring and through

recharging our staff who have made it through this long road towards the COVID recovery period, but trying to figure out how to work better, to communicate with our staff and improve our support for hard working people and dedicated people who have long served in this department. So, I hosted a town hall. Nearly half of the department employees, 2,700, turned out for this virtual town hall. I'm hopeful that this will be the beginning of many conversations, or at least exposure to conversations that we will have with members of the department. We have conducted a staff survey, which had a pretty good response rate, over two thirds of our staff. Actual numbers, 71% participated. We learned that people, by and large, are very proud to work at the department. 8 out of 10 said that they were proud to work for this department, but only 6 out of 10 said that they'd recommend the department as a great place to work. This is a challenge to us. We have a staff that is committed to the mission, and we need to make it a place where people really feel good about coming to work every day. And of course, another finding of this staff survey was that there was widespread belief that the department could do more to improve diversity and inclusion. So, this is then I'm now 6 months almost to the day into my role as Health Commissioner. As I was in the first days, I remain enormously impressed by the talent and commitment of the people who live here. We live here. It feels like they live here. I'm sure many of them feel that who work here. We are now on a road of looking at how to strengthen the department as we go forward. I of course, I have to finally mention that this is Pride Month, and I would be remiss if I didn't recognize the importance of the LGBTQ community and the Department's commitment to advancing health equity. We are grateful for the many partnerships and health care networks and community based providers that have allowed us to address urgent, emergent and long term community needs. With that rather long report, I look forward to keeping you apprised. As we continue to work on these many areas, I want to say just a few words about one of my colleagues who will be presenting to you for the last time today. I'm referring to Brett Frieddman, who stepped down as Medicaid Director. I want to thank Brett on a personal level for introducing me to this complex and important program for the people of the state and our department and for his service in leading the Medicaid program more generally. He has met the challenge of running one of the most robust Medicaid programs in the country and has advocated for critical funding during this year's budget cycle. He leaves with several key accomplishments, and we are grateful for that and grateful also for his his work and building a deep bench, which includes who is now acting Medicaid Director, and to whom we have been transferring Brett's responsibilities. Brett, we wish you well.

Dr. Bassett And with that, I'll turn it over to Dr. Bauer, who will provide additional updates and public health.

Dr. Bassett Dr. Bauer.

Jeff Kraut Just before we go there, just to take a pause. Is there any questions for the Commissioner on the wide ranging topics that she addressed? Anybody up in Albany?

Jeff Kraut Commissioner, I just want to thank you.

Jo Boufford Jeff, sorry.

Jeff Kraut Go ahead, Dr. Boufford.

Jo Boufford I don't know which hands to put up or the yellow guy or the other hand.

Jo Boufford Mary, thank you. I just want to say thank you very much for the wide ranging report. It's really good to hear about obviously, the infectious diseases which understandably attract very high levels of attention, but also the issues of gun violence that you raised and the the threat to Roe v Wade as well as LGBTQ support. I appreciate your adding those really important public health issues to your report. I do want to indicate that the Public Health committee of the council has hopes to really begin to be more active in support of the staff, especially, it has expressed interest. Before COVID was very involved and really taking a broad look at the issue of gun violence. New York State, as you noted, being very aggressive and assertive in its legal frameworks that have been developed, but also looking at how we could be using this platform, public platform or other mechanisms, working with the staff to address that important and tragic issue. Secondly, we have been very interested in maternal mortality going back five or six years. You mentioned family planning and access to family planning. One of the really two recommendations that a white paper for this council, which I think was very influential in setting up the Governor's Commission on Maternal Mortality and keeping that focus very much alive, was on the universal availability of family planning, as well as the importance of early identification of high risk pregnancy and availability of referral for women of high risk. hat thoTse two issues have not been as much of a focus of the gubernatorial commission over the last year or two. I think we would really like to revive the focus, as you mentioned, on the availability of family planning, abortion services and others in that context, as well as continuing the sort of visibility of that, using, again, the platform of the council. In the March 1st meeting, which I think allowed us to kind of set the agenda for what we hope the Public Health Committee and the Health Planning Committee will be able to take on in the coming weeks and months, understanding the changes that are afoot in the department. All the efforts that you're making to address, you know, what we all know have been real narrowness difficulties in bandwidth given COVID and all the other pressures. It's delighted to hear that. We really want to be supportive of staff bringing the issues that you all are committed to, to the public's attention through their work of the council, and look forward to ongoing collaboration and revitalisation of those collaborative efforts.

Jo Boufford So, thank you.

Dr. Bassett I really appreciate that comment.

Dr. Bassett Thank you.

Jeff Kraut Yeah, we certainly have kind of an appetite and a robust agenda that we'd love to get back to. I know we've been talking about it and frankly, been pretty patient given the challenges you have in staffing the department and frankly, addressing an the ongoing challenges every day in public health. We recognize that, but we'll be a dependable and I think a very useful partner in kind of helping to formulate some policy in the state. We really look forward to the upcoming year.

Jeff Kraut Any other questions before I ask Dr. Bauer to speak?

Jeff Kraut I just want to I neglected to mention to the council that the legislature has recently passed registration legislation, adding an additional seat to the council. I think it's primarily for women's health. And that's going to require us to change our quorum requirements from thirteen to fourteen. Currently our bylaws reference a quorum of thirteen members to constitute a quorum to conduct business, and therefore we're going to have to revise our bylaws. In order to do so, we're going to. In order to amend the bylaws, the council is going to be receiving the notice of the intent to amend those bylaws at a

meeting prior to the council voting on the amendment. So, essentially, I'm giving you notice now that we are going to amend the bylaws. You will receive revisions to you five days prior to the next full council meeting to review it. And then we will be coming back together to vote to amend those bylaws, raising our quorum requirements from thirteen to fourteen. So, just consider you. Everybody is on notice that we're going to do that.

Jeff Kraut Dr. Gutierrez, go ahead.

Dr. Gutierrez I'd like to bring up an issue, I think that is pertinent related to the presentation by the Commissioner, being that we are the council. I'm concerned the media coverage of monkeypox paints it as an African virus. I believe we should be careful to avoid that labelling. This particular virus is quite endemic. I think we need to mind our verbiage. That's it.

Dr. Bassett Thanks for that comment. I guess we should also point out that it's not correct to call it a monkeypox virus. This species that it's thought to be and host in is not the monkeys. It was just first found in monkeys back in the 1950's. So, you're right, but it is endemic in part in West and Central Africa. But currently, we really don't quite understand what's driving the current increase.

Jeff Kraut Thanks, Dr. Gutierrez.

Jeff Kraut Thank you, Dr. Bassett, for your remarks.

Jeff Kraut I now turn to Dr. Bauer to provide the remarks.

Dr. Bauer Thanks very much.

Dr. Bauer Good morning, everyone. I'll keep my remarks brief. As Dr. Bassett had mentioned, COVID is proving to be quite, quite resilient. And although cases and hospitalizations are declining, the rates that we're seeing now are still higher than they were one year ago and higher even than they were in March of this year. Nonetheless, we do recognize the COVID fatigue felt by the public, by our Health Department staff, and by governmental leaders at all levels. We continue to explore ways to make the COVID pandemic more manageable and for our public health workforce to contemplate a return to some semblance of regular order. We began such an effort back in the Fall. And, as you know, we were derailed by the surge. Right now, while we have more cases than we did in either of the past two years at this time, and we have a more infectious variant than we've had previously. And frankly, we have fewer mitigation measures in place than at other points in the pandemic. We still do have some wind in our sails, as it were. We have vaccines and boosters that still mostly protect against severe disease and hospitalizations and prior infections that also offer some protection. We have diagnostics, including a home test, to help us make decisions about gathering and traveling and when to stay home or seek treatment. We have therapeutics we're working hard to deploy to those in need who are eligible. We've lowered the likelihood that an infection leads to hospitalization or death. Right now, and I stress we don't know what's to come. COVID is not the killer that it was. So, in this context in OPH, we're planning for the future. We've been gathering perspectives and ideas from current and former Health Department staff and from our local health department colleagues to lift up the best practices from the COVID response that we should continue into the future and make sure that we have at the ready for future pandemics or other public health emergencies. We've been reviewing our executive orders and guidance documents to understand what's needed, when and how we can simplify

and streamline the information that we share and how we can strengthen and improve our internal processes. We're creating some approaches to understand the pandemic's trajectory now and into the future and identifying trends and signals that warn us to be ready to take action, to inform the public and to work to protect our health care capacity. As we wrap up our information gathering and synthesizing in June and July, we'll look forward to updating you on our public health approach to the pandemic going forward. Secondly, I'll share that CDC is expected to release a new funding opportunity on strengthening the public health workforce, public health infrastructure and our data systems with a focus on health equity. This is another effort to help rebuild public health and to address some of the challenges that frankly, existed before COVID, but were certainly stressed and exacerbated by the pandemic. We see this as an opportunity to reinforce our core public health capacity, especially our support to local health departments and our efforts to engage with communities. It's also an opportunity to continue and expand some of our data modernization efforts that were begun under the COVID ELC awards and to address many of our NON-COVID data systems, particularly in environmental health. This is one of the few CDC grants that is disease agnostic. It allows us to take a holistic approach to strengthening community health with a focus on cross-cutting efforts to build our public health capacity. We're looking forward to that work in the future. Finally, I'll just mention as a heads up for future discussion at the July and September meetings. The Department, through our Centre for Environmental Health is proposing to revise 10 NYCRR Part 5 Sub Part 51 to adopt maximum contaminant levels or MCL's for additional per and polyfluoroalkyl substances, also known as Pfas and add notification levels and monitoring requirements for 19 Pfas to meet the statutory requirements of Public Health Law Section 1112, which was enacted last year and of course, following the recommendations of our Drinking Water Quality Council.

Dr. Bauer I will leave it at that.

Dr. Bauer Thank you.

Jeff Kraut Thank you, Dr. Bauer.

Jeff Kraut Any questions or comments from the council?

Jeff Kraut I don't think anybody in Albany.

Jeff Kraut So, Dr. Bauer, I just want to thank you. With respect to your reference to making public health data more robust, the only thing I would also suggest is that in constructing those data platforms, that they be constructed in a way that they're open source, that all the data is downloadable. Much like the New York City data is. It be performed at a small area, almost at a census tract level in order to make it actionable. Data given to us at the county level or frankly, at the zip code level is not helpful to try to address and pinpoint issues of health equity. I think to the degree you also include water quality and other what we may not see as many in the health industry. We see a lot of medical and clinical diagnosis, but public health measures would additionally be of great value to the organizations that are really trying every day to deal with this. What we are is data starved in it, particularly at the state level. The data that we get is not timely. Frankly, we're making decisions today based on 2019 Spark's data, because we obviously have to disregard most of 2020. So, anything that we can do to get more of that data into the public domain, make sure we're providing data from health providers, it's bi directional, it comes back to them. Those are all important things. I would just you would find, I think, enormously strong support at the council level for that. And certainly we're going to need it

if we're going to be successful in the 1115 waiver, which we are not speaking about today, just we have a limited amount of time just warning everybody.

Jeff Kraut Thank you, Dr. Bauer.

Jeff Kraut Mr. Robinson, just has a comment.

Mr. Robinson Thank you very much.

Mr. Robinson I particularly want to underscore your comments regarding the public health workforce and perhaps actually push to go beyond that a little bit. I think that probably one of the critical crises in New York State with regard to health care is the workforce issue. When you look at the issue of even the risk to hospitals of being overburdened by COVID patients, probably more people being admitted with COVID than from COVID these days. I would argue that the government's initiative to fund health care workforce initiatives really needs to be reinforced by the Department of Health. I think both from the standpoint of long term care as well as hospital based programs. This is a crisis in New York at the moment, and I think our ability to care for and provide access appropriately is actually being very much challenged right now. I consider that to be a public health issue as significant as the other ones that you've mentioned. So, just wanted to make sure that that was on your radar screen. Recognize the state is trying to do something about it and appreciate the budget decisions that were made that start to make investments in that space.

Mr. Robinson Thank you.

Jeff Kraut Thank you very much.

Jo Boufford Thank you, Dr. Bauer, for the presentation. I just wanted to also reinforce the importance of the broader public health workforce. That was also one of the agenda items. We heard about the very exciting Public Health Fellowship program during our meeting on March 1st. I would really like to go beyond that and think with you about the broader workforce needs and the public health side. And then similarly, a few years ago before anyone, I think you and others were at the department, being around a long time that New York was one of the pilot states to take to do the self-assessment using the essential public health functions with a tool of CDC and Pan-American Health Organization that's been around for a while. I think it could be a really good vehicle. It's a self-assessment that includes local health departments and the Central Health Department on what are the so-called, you know, officially recognized by WHO and CDC, essential public health functions that all departments should be able to perform and could be a really important basis for applying for CDC funding for infrastructure, because it really allows you to identify you mentioned data specifically, but other areas that where help may be needed and to justify requests for additional staffing or additional sort of technical support in that in those areas. I just want to commend it to you. New York had used it very successfully. It's not a big, onerous process. It can be done reasonably quickly and I think might really inform a very, very terrific application, which we hope will be super successful for the federal funds.

Jeff Kraut Thanks, Dr. Boufford.

Jeff Kraut I'm now going to turn to Dr. Morley.

Dr. Morley Thank you very much. I want to thank the members of the committee for the perfect lead in to my report, Mr. Robinson and Dr. Boufford.

Dr. Morley The OPCHSM report, beginning with the Center for Health Care Policy Workforce Initiatives, is at the top of our list. Health care investment in fiscal year 2023 state budget that includes 1.2 billion for investment in frontline health care workers. 2.4 billion is directed to improving health care infrastructure, 3.9 billion in funding to provide aid to hospitals struggling financially from COVID-19 pandemic and 7.7 billion for four years to increase the home care worker minimum wages. These investments will combine to improve working conditions and grow the workforce by 20% over the next five years improving the health care industry considerably. The Nanny program, Nurses Across New York, which is similar to the current Danny or Doctors Across New York program. Nanny will provide loan repayments over a three year period to registered nurses and licensed practical nurses who choose to work in New York's high need health care facilities. 2.5 billion is available for loan repayments in year one. Over the course of the Summer, the department will work with stakeholder groups to develop the program further into identifying further criteria. The next is the public health related legislation, which Mr. Kraut has already covered. Just to remind folks that there is an additional member that will be joining us shortly. We hope. That's the person who will have expertise in women's health and facilities in the area of health equity and inclusion. The legislature has passed a bill public health law 2802B was amended requiring a health equity impact assessment be submitted as part of the Certificate of Need application to the Department. This law adds consideration of projects impact on medically underserved individuals as factors to consider when improving a CON application when considering whether to approve a project. It requires a health equity and inclusion assessment be prepared by an independent entity and include whether a project will improve access to services, health equity or reduce health care disparities with reference to members of medically underserved groups in the applicant service area. The requirement applies to Public Health Article 28 definition of quote hospital, end quote, which includes general hospitals, nursing homes, diagnostic and treatment centers, ambulatory surgery centers and birthing centers. The requirement applies to construction, establishment, changes in establishment, mergers, acquisitions, elimination or substantial reduction, expansion or additions of a hospital or health related service that requires review by the council or Commissioner. This would be full review CON's, administrative reviews and limited reviews. The law does not require an HEI assessment for a diagnostic and treatment center whose population is over 50% Medicaid or uninsured, unless it's a change in a controlling person. Requires posting of the application and assessment by the department on the DOH website, as well as a requirement for the applicant to post the application and assessment on its website within a week of acknowledgement of the application by the Department and requires the Commissioner to make regulations to take other actions, such as issuing guidance reasonably necessary to implement the law. The effective date will be June 21st, 2023, so one year from this month. The Center for Health Care Provider Services and Oversight, the Division of Adult Care Facilities and Assisted Living has developed a new administrator and new surveyor orientation, which is now close to production and will allow individuals new to the ACF platform to be consistently trained in best practices and regulatory expectations specific to the ACF industry. The division has further streamlined its licensure procedures to allow for expeditious onboarding of newly established facilities and new certifications. From the Division of Home and Community based settings, the division recently addressed the issue of local health department licensed home care services that went unregistered during COVID. 12 Local health departments were provided the opportunity to reregister without fines or in some cases where a fine was paid to request refunds. Personal care aide training program documents

are on the website and have recently been updated. From the Division of Hospitals, Transplant Counsel met on the 26th. There were presentations from the presidents and the Review of the National Academy of Sciences recent paper on Equity in Organ Transplantation. From the Bureau of EMS, Governor Hochul issued a proclamation recognizing EMS week on May 15. The proclamation recognized all the great people and work in their field and honored those who had fallen in the line of service. The World University Games will take place in Lake Placid. It's an 11 day international festival that will take place in January of 2023, involving over 1,800 athletes from 15 countries. Twice as many as those who took part in the venue hosted in the 1980 Winter Olympics. The Bureau of the EMS continues to work with the promoter to develop plans and procedures for the events that ensure participant health and safety and also support the local emergency services system. The surge operations center, part of BMS, fielded 98 calls for assistance through the first three weeks of May. That's down from 200 the month before, but still shows that assistance is being requested. From the Bureau of Narcotic Enforcement, they continue to work on the prescription drug monitoring program based on input from focus groups of New York State practitioners, including at adding visual indicators to flag for prescribers, the presence of overlapping opioid and benzodiazepine prescriptions and provider episodes, also known as doctor shopping. The PMP is now interoperable in 33 states the District of Columbia, Puerto Rico, the military health services and the VHA. The drug takeback program. They hope to announce very shortly the approval of two operators for the drug takeback program. We're anticipating its implementation in the coming months. The Opioid Stewardship Program has collected over 80 million in opioid stewardship revenue stemming from the calendar year 2017. Finally, OPCHSM is focused, as is the entire department, on rebuilding our state workforce. We have 76 open positions that we're recruiting and 16 positions, waiting for someone to begin. The people have been identified. We just want a starting date. The executive budget increased OPCHSM FTE's by 164 positions to implement the budget initiatives. Of particular note, we recently posted the position of the Director for the Center for Health Care, Planning, Licensure and Finance, and resumes are being collected. I'd like to thank in particular Shelly Glock, who's been performing her old duties while also filling in in the new duties of that acting role over the course of the last couple of years. She's done a terrific job, and I hope you join me in encouraging her to apply for that position.

Dr. Morley That's my report.

Dr. Morley Thank you very much.

Dr. Morley I'll be happy to take any questions.

Jeff Kraut Well, you've certainly gotten up to speed.

Jeff Kraut Thanks, Dr. Morley.

Jeff Kraut Questions for Dr. Morley?

Jeff Kraut Ann.

Ann Monroe I just would like to first of all thank all of you for your presentations. I have an observation and a request for you at the department. The observation is that we know that we will not advance public health and or service delivery without much better integration between the various delivery systems, whether that's mental health, substance abuse, or

the integration of public health and health care delivery. My concern is that as you report, we hear very good things coming out of each of the groups, but I would like next time to hear more about how you are integrating the things that are happening at the department, so that that can be a model for local departments of health and service delivery. I don't think we can be as successful as we want if we continue to focus on those things as separate. And I would just add with some history and I see Jennifer there. Over three years ago, John Rugge and I chaired a group to integrate mental health, substance abuse and physical health within some kind of limited license. It was in demand then. It's still in demand and nothing has happened. We have no way to really integrate those services within an organization which we know the waiver, which we're not going to talk about, but also regular delivery in public health can't be achieved with these silos. I just would like with the new fresh administration at the department level that in addition to the good work you're doing individually, that you have some joint projects that bring those two things together along with the various other parts of the service delivery system. So, that's an observation and a request to see more integration between the parts of the department that focus on very specific things. So, thank you for listening to me.

Jeff Kraut Nicely said, Ann.

Jeff Kraut Any other questions for Dr. Morley?

Dr. Kalkut Thanks, John, for the presentation. Is there a guidance for the CON assessment of equity inclusion that has already been issued or will be on how that should be structured?

Dr. Morley Fortunately, we still have a little over 12 months and we are working on that guidance. We will be issuing something. I would think there's a chance that there'll be some regulations, but they'll certainly be guidance.

Dr. Kalkut Thank you.

Jeff Kraut And within that guidance, we have to be clear about what applications. If we have an application to relocate to an office space or to build an elevator, there has to be some materiality of that as well.

Jeff Kraut Dr. Rugge, I think you had a question, if I'm not mistaken.

Dr. Rugge Well, really just a comment, and that is I'm here in Albany and able to do the count. There are sixteen senior health department staff with us. You may be outnumbering those of us on the council really appreciate the participation. And again, even in the face of COVID, just you have to recognize how many changes continue to happen in health care with movement toward value based payment. The need for integration as was brought up and also the very special challenges of the long term care that Jim Kline has been very articulate about, about bringing up so many issues so hard to do, especially with a shortage of workforce. Would only say again, as I've been saying offline, this council represents an available workforce to the department. We are eager for planning activities that help us to set priorities, and we will be glad to work with you to find next steps, because without state guidance and state oversight, we're unlikely to have the outcomes that we are hoping for. So, thank you, Dr. Bassett and Crew, very much for being here and joining us.

Jeff Kraut Thank you, Dr. Rugge.

Jeff Kraut Now, I'd like to now welcome and introduce Mr. Brett Friedman. You heard the Commissioner give her appreciation. And thanks for Brett, who is leaving state service. In fact, he was kind enough to arrange to be able to be here to give this presentation. I'm just going to give some context for his why he's here. When we took up a matter with an individual application, we heard a lot of perspectives about the PACE program. I think one of the things we didn't have the benefit of is understand the policy context and the importance of this program in the state's thinking of how it's going to take care, particularly with older populations and the coordination that we've all been just talking about. We asked Mr. Friedman to come here. He has a brief presentation. We're not voting on anything. It certainly is not the subject of any application. As you also I just wanted to mention, as you know, Mr. La Rue was unable to be here today. Today's the white mass that the diocese is undertaking, certainly had to be there. He wanted me to share with you that he is not opposed to a PACE program. He is not opposed to a for profit based program. He hopes that when we have the opportunity to get back together, when we are considering it, he's hopeful these comments that Mr. Friedman is about to make will give him better context for his perspective as well.

Jeff Kraut So, Mr. Friedman, I'll turn it over to you.

Brett Friedman Thank you, Mr. Kraut.

Brett Friedman And just to pick on something that Ms. Monroe said, that PACE is a great example of integrated licensure. I think all of the issues that I'll touch on in this presentation deal with both the challenges and promise of a program that spans multiple regulatory licensure silos. I think some of the complexity that the review committee was struggling with with that single application is a reflection of how to navigate integrated licensure on something like a PACE program. So, as Mr. Kraut mentioned, the purpose of my presentation today is to give an overview of PACE and to discuss the nuts and bolts of how PACE is currently regulated in New York in ways and options that New York could modify, expand, enhance its regulatory licensure process to promote PACE in New York. I have a very short slide presentation with pretty pictures, so I hope that will help everyone for visual learners figure this out.

Brett Friedman Is it working?

Brett Friedman Next slide, please.

Brett Friedman So, it's not me. I also want to say it's auspicious that my last day in state service is talking about PACE.

Brett Friedman There it is.

Brett Friedman So, briefly on the agenda, I'll give a background on PACE, what it is. I'll talk about the current regulatory framework for how New York establishes and authorizes PACE in the state. Very serendipitously or by happenstance, a bill was passed in both the Senate and the Assembly just at the end of last week on PACE. I'll talk about that bill and how it fits into this landscape. I'll discuss three structural options or alternatives for how New York could modify existing law or guidance to help expand PACE. I'm not going to provide a DOH recommendation, but these are the options that exist looking comparatively across states in terms of how New York could do it so that you can have a perspective on ways that it could pursue PACE if it wants to expand it. And then we'll talk about other

ways that DOH in particular, are looking to utilize our administrative flexibilities to expand PACE in New York.

Brett Friedman Next slide, please.

Brett Friedman One more.

Brett Friedman What is PACE? It's a unicorn of a program. People who really love and understand PACE have really good reason to do so. I sit here next to Mr. Thomas, who I believe operated a PACE, and I know Mr. La Rue also currently operates at PACE. There's a lot of experience here in terms of what the PACE model does, but what it is, think of it as an insurance program that spans provider services. It provides comprehensive medical and social services to elderly individuals, most of whom are duly eligible for Medicare and Medicaid. The PACE program is now over 50 years old. It's started with a single provider in California. They developed a model of care that was proven to help seniors age independently in the community, not in a nursing home by integrating every aspect of a person's care, medical care, prescription drugs, transportation, food, socialization, among other benefits. So, if they could control everything that person needs, it was proven effective at keeping that member out of a nursing home. It does so in a few very distinct ways. The hallmark of a PACE program is an interdisciplinary care team. We have care teams and other aspects of service delivery, especially in Medicaid, but PACE is unique. You have the physical therapist, a nurse, a recreational therapist, a dietitian, medical care providers, drivers, all meeting and discussing an individual's case and everything that member needs as part of their care plan to keep them in the community. As I mentioned earlier, it's a comprehensive benefit package. It allows the PACE program to be responsible for everything that member needs, medical or social. I like to think it was the first social care program. It really thought to address social determinants of health. It recognized those were important. It's critical that there be a PACE center. This is really where you and the CON establishment process comes into the picture. A member goes to a PACE center. It's a physical establishment. They receive socialization and medical care in that location and then there's capped financing. By definition, it's an insurance program. They receive a very large, because of what they control, capitated payment to manage all of the services that individual needs under the Medicare and Medicaid benefits. PACE is predominantly a medicare program, but states can elect to provide services to Medicaid members as an optional Medicaid benefit. It is authorized by state plan. It's not necessarily a waiver service. It's done pursuant to primarily. And then once a member joins PACE, PACE becomes the sole source of their benefits. They get everything from the PACE. That is their source of coverage. And critically, there's something that's called the amount that that would otherwise have been paid. So, in the PACE authorizing statute, which is federal, the federal government says we will pay the PACE program, but no more than the amount we otherwise would have paid if the member was receiving services in a nursing home. And that's critical because that's what ensures that PACE is cost neutral to the federal government and to the state.

Brett Friedman Next slide, please.

Brett Friedman Oh, you're there.

Brett Friedman Perfect.

Brett Friedman What are the benefits of PACE? As I mentioned earlier, PACE is a proven model. It's shown and we highlight some of the data sources. It's proven to reduce hospital admissions. It provides better preventative care for PACE members as compared to a fee for service program. It provides high rate of community integration of residents. It's effective at keeping members in the community. Again, these aren't compared to MLTC. New York is a little bit unique, because we have such a robust, managed long term care program. But in states where the primary alternative is fee for service, it's very effective at keeping members in the community and the caregiver satisfaction is extraordinarily high. These data and this support has resulted in many states wanting to both elect PACE, but also increase PACE enrollment. Notwithstanding the benefits of PACE, it has been a very hard program to scale. There are a number of reasons for it. Mainly it's a very expensive program to start. You have to have the PACE center. You have to either employer contract for the interdisciplinary care team, you have to be competent and managing substantial insurance risk. You have to be or contract for direct provision of services, including medical and home care. A PACE model is. It's not for the faint of heart. As a result, there's about 55,000 members nationwide who are at PACE. If you scale that, we have about 270,000 people in New York alone who are on. PACE comparatively is a very small program, but it's one where there is great promise to try and increase. Again, this is full risk, full capitation, full integration of social care in health care, and very effective at keeping high needs members into the community.

Brett Friedman And so if you go to the next slide, what is the status of PACE in New York? New York is 1 of 31 states that have elected to expand the program to their Medicaid benefit for dual eligibles. We were one of the first states to do so beginning in the late 1980's as part of a federal demonstration program. And that program has since been permanently codified in federal statute and in the manual. We, because we don't have a separate PACE authorizing statute, we have treated PACE as a form of managed long term care. If you're a fan of the DOH Medicaid enrollment reports, PACE is a line on the enrollment reports. We did a snapshot here. This was as of December 2021. Of our 5.7 million Medicaid members in managed care, 5,800 were in PACE. It is a small program. About 400 million a year. These numbers actually have increased actually pretty dramatically in the last couple of months, right. About 6,400 currently. If you think about it, for the scale of the entirety of the Medicaid program, we've got 7.4 million members in Medicaid right now. That number may drop a little bit with the unwind. Of those 7.4, we have 5.7 in some form of managed care. 284,000 in managed long term care. 5,800 at PACE. PACE is a critical area of growth. Historically, we have nine non-for-profit plans currently operating in New York there throughout the state. We have two Downstate, we have seven in rest of state, and they're all not for profit entities. I'll talk about why. And then just one plug for work that OHIP has been doing in my time as Medicaid director is we put out a comprehensive roadmap for integrated care for dual eligibles. And in that roadmap and please look at the came out just the other month of all of our initiatives designed to increase integrated care for dual eligibles. Expanding PACE enrollment is a critical initiative. Finding ways to increase PACE enrollment is something that we desperately want to do.

Brett Friedman You can go two slides.

Brett Friedman So, what's the current regulatory framework for PACE in New York? This is really why we have only not for profit PACE. If you think about it, PACE is a federal program, but we have to superimpose that federal program on our state licensure rules, which would did not make for an easy fit. If you look at the benefits and services offered by PACE, it implicates three separate articles of the public health law. Article 40 for licensure

is required, because PACE organizations receive capitated payment and they receive a risk. So, because they bear insurance risk, they have to be licensed as a managed care organization. Because the center is delivering medical care in a clinic environment, we have required that the PACE Center be licensed as an Article 28 Diagnostic and Treatment Center. In addition, because the PACE organization has to deliver and arrange for in-home personal care nursing services, they also have to have an Article 36 license. And so this goes to Ms.. Monroe's point about integrated licensure, right? A PACE is a program that requires integrated licensure. There's a complexity here because under federal rules, which are codified in the manual in Section 50 of Chapter 9, it says that a new operator cannot contract out the center services until it has demonstrated fiscal soundness and competence. This predates my arrival, I think it probably dates back to the 1980's where we have the that requirement to say, if you are seeking new a new PACE application, the Article 28 license and the Article 44 license need to be held by the same legal entity. I tried to sketch it out. On the right side of the slide is what a for profit PACE organization could look like in New York. Starting with the bottom left, that is the operating. That is the PACE organization. It needs to hold integrated Article 44 and Article 28 licenses. Because we regulate on the insurance side. This is what OHIP issues. We regulate the PACE as an Article 4403FMLTC under the qualifying applicant criteria, it needs to be a subsidiary of a nursing home, an Article 28 operator, an existing HMO or other qualifying applicant, which means it needs to be a sub. So, the qualified parent entity, it's a set of a qualifying parent under 4403F. You have to have natural person owners, because those natural person cannot be more than two levels away from the Article 28. So, if you are a for profit national plan, you're not going to have natural person owners two levels in an ownership structure away from the operating entity. You're going to have 50 or 60 or 70. I mean, if you've ever seen a corporate org chart for any for profit managed care organization, it's a hydra. And so that has effectively precluded for profit PACE in New York. But for profit PACE is permissible.

Brett Friedman If you go to the next slide, that's the reason why all nine existing organizations are not for profit entities, because it aligned with historical federal requirements. Beginning in 2009 and fully authorized in 2015, CMS permitted for profit. It was historically a not for profit model federally. It allowed for for profit PACE. I'm a reform corporate attorney. We did a lot of private equity deals in PACE. It was a hot button issue seven or eight years ago, and CMS explicitly stated that they would expect for profit organizations to exist, but to retain all key administrative functions. But as I mentioned, because of our Article 28 44 integrated licensure requirements, based on our interpretation of CMS rules, structurally a for profit PACE couldn't ever get over the hurdle. It's not to say they didn't try or they tried to advance unique interpretations, but I think some of the confusion that came out in the review committee meeting was testing the waters around what structure may work. But the Pace Center, the DNTC under our existing interpretations, needs to be in the same legal entity as the 44 and that can't have more than two levels until natural person ownership in order to pass PACE licensure muster.

Brett Friedman If we can go to the next slide.

Brett Friedman What does the recent legislation do?

Brett Friedman One more, please.

Brett Friedman Passed both houses on May 24th, 2022, and it would create a separate article of the public health law to establish a unified PACE licensure process that is otherwise in compliance with Articles 44, 28 and 36 of the public health law. The

predominant change is that, as opposed to us treating PACE as a form of MLTC, it would allow us to treat it as something different. It pretty much delegates how that would look to the promulgation of regulations enacted by the department that would likely come through as part of the codes review that we heard earlier today. It gives the department authority to think about licensing PACE differently. It doesn't address how to promote for profit PACE. It doesn't address directly those challenges with integrated entity licensure on its face. It just creates, again, authorization. If the bill were to be signed by the Governor to reconsider how the department treats PACE organizations, bring them out of Article 44 in particular, so that we can think about how to prudently develop and support the expansion of PACE in New York. Regulations like that, as you know, we'll take time and we'll have to think about how they align with our requirements under Part 98 of the New York Codes and Rules and Regulations, how they relate to Part 405 and other aspects 10NYCRR. There's a lot there. It's going to be a fairly substantial and owner's regulatory development process. It does reflect the fact that PACE is unique and that we've been struggling to superimpose state licensure on a very innovative and unique federal model. So, apart from the statute, what are structural options for expanding PACE? There's a reflection here that in order to expand PACE, you need to do more to overcome the hurdles for for profit PACE operation in New York. Because PACE is expensive and because it's hard for PACE to scale, it's very difficult for a not for profit organization to raise sufficient capital to meet reserve requirements to do a statewide or a more expansive PACE model. These options overcome that integrated licensure requirement to allow for PACE to expand. Option one is what we call representative governance. The best analogy for this group would be how we currently issue CON's to dialysis clinics and around what would be the normal natural person ownership requirement. This would require a change in Article 28 of the public health law. The current PACE statute as voted on and approved by both houses, doesn't provide for this. We would have to go back to the statute. We'd have to amend and allow specifically for representative governance in connection with a application, so we could keep that integrated entity requirement without the natural persons prohibition or without natural persons restriction. There's pros to this, which is it's a process with which is familiar and that you know how to approve. It preserves the requirement that the same entity hold both licenses, which reflects what CMS has basically stated in this case manual. The cons are it requires a new statutory enactment, which is not been in the current bill. It creates a further expansion of representative governance, which is a change. It's a change from the way that us and DOH typically do it. So, that's option one.

Brett Friedman Option two. If you go to the next slide. Is to adopt a contracted diagnostic and treatment center model. So, as I mentioned, we've traditionally required a PACE entity to hold both licenses, and that's based on a very long standing interpretation of CMS rules by the state. We could go and seek guidance from CMS, as other states have done, to see whether the PACE Center and the DNTC license needs to really be held in the same legal entity, or whether we can permit a new PACE operator from contracting from a limited subset of medical services performed by the DNTC that resides outside of the license PACE entity. We already do that for Article 36 services. I think only six of the nine PACE organizations have an integrated Article 36 license. The other three do not. It's a way to separate out that licensure. You would approve a separately incorporated and established DNTC and then OHIP under its authority to approve contracts with regulated managed care entities, would approve what's likely a provider services agreement between the DNTC and the PACE entity. We would include integration requirements or coordination requirements within that agreement in order to ensure that the PACE model is effectively delivered. The pros about is it preserves the center, as is the DNTC license in accordance with Article 28. It doesn't require any new statutory or regulatory promulgation. We would

simply seek CMS guidance and develop a new contract template. It avoids further expansion of representative governance depending on what you wants to do there. It retains a department approval right of the contract between the PACE Organization and the DNTC to ensure the PACE model of care is delivered appropriately. The cons are we'd have to go back to CMS and make sure it works for them. We've spoken with the National PACE Alliance, and they're hopeful that CMS would approve something like this, as they've done in other states. We would have to ensure that splitting out from voluntary integration doesn't have a programmatic impact. But we think, again, we could probably control that by contract, and it would require further analysis of you to review and approve the DNTC component to ensure that DNTC is capable of delivering services in connection with a PACE model of care. So, that's a little bit different, but it's something that we think is capable of being done. The third option, and just from a full transparency standpoint, I don't particularly like, but it's an option. We're putting on the paper here is to allow the PACE center as opposed to contracting with a third party DNTC, to contract with a physician practice to deliver the medical services in connection with the PACE model. If you think of Article 44 in a contract number 28 instead of 28, it would be a physician practice. We put it on the list because other states, notably California and Colorado, which are probably the other two states with the largest PACE presence, do allow for physician practices to deliver PACE medical services in connection with the PACE model of care. It's simple. It would allow for a PACE organization to have the greatest potential access to medical services. I think it would limit the purview of DOH to surveil and authorize the medical services in connection with the PACE model. In addition, I called into question whether it could really be called a PACE center, because as this group knows well, says you cannot use the term center if you're not authorized DNTC. I think there would be a complexity there that's something that's not an DNTC is using the term center. We'd have to think about whether it implicates other regulations. In terms of those options, any of them would help navigate the challenges with expansion of the PACE model. Of the three, two is probably the simplest. We're just going to put that out there. Apart from this, I'll call it access to capital problem. We are working in other ways to promote and expand PACE.

Brett Friedman And so if you go to the last slide, slide 17, we're doing a lot of different things. The first is pending CMS approval. We've submitted something called an appendix P to the model contract, which would allow PACE organizations to engage in direct enrollment of members of potentially eligible PACE members without perspective review by what's called the Conflict Free Evaluation and Enrollment Center. All MLTC's dating back to I think 2014 or 2015 have to go through which deems a member eligible before that member could be enrolled and receive services from a MLTC. PACE has historically complied, because we treat it as an MLTC, but because PACE is really unique, we would and consistent with CMS permission carve out PACE enrollment from it. That would allow PACE to go in to a nursing home to a hospital upon discharge and more rapidly enroll a member to help improve PACE access and growth. We have excluded PACE from the recently implemented independent assessor process. Those of you who have who closely follow the long term care space, as you know, part M of Chapter 56 of the laws of 2021, which was the budgetary enactment two years ago. The quote unquote MRT2 budget required DOH implement an independent assessor to all of the community health assessments, sometimes called the UAS to which board assesses eligibility, helps determine risk score and then informs the service authorisation. All community health assessments now have to go through the independent assessor, but because of the federal requirements and federal preemption case, organisations are able to retain the authority to do the assessments and reassessments that MLTC's cannot. We are implementing that in connection with the carve out of PACE. In addition, we have carved out from the MLTC benefit non-emergency medical transportation. Historically, was

managed by the 26 or so MLTC's. We brought that back into fee for service. So, the entire Medicaid benefit could be managed by a single statewide transportation broker. PACE is the only managed care product that is able to retain risk for the benefit because it's instrumental to the PACE model. We have exempted PACE from any rate range reductions that have applied to other managed care plans and we are working to increase the quote unquote amount that that would have otherwise been paid calculation. That's an actual calculation done by the state's independent actuaries. We've been working with our actuaries to make sure that our calculation is appropriately done, especially Downstate, where it's been substantially lower than PACE program cost, so that it doesn't become a financial gaiter to PACE expansion just from a rate standpoint. With everything, you know, we have a tremendous number of PACE reforms that are designed to expand PACE, given its uniqueness, given its proven excellence in keeping members in the community and being cost effective. We need to tackle this integrated entity licensure requirement, which, unless change by virtue of statute or guidance, is going to be an effective preclusion to third party sources of capital in the PACE program going forward.

Brett Friedman Thank you, Mr. Friedman.

Jeff Kraut That was enormously cogent and helpful policy framework for us to understand what we were discussing last time, which I don't you know, I wish we would have reversed the order.

Jeff Kraut Let me open the floor for questions.

Jeff Kraut Dr. Berliner and then I'll go to Dr. Boufford.

Dr. Berliner Thank you very much for the presentation.

Dr. Berliner So, as I understand what you said, I mean, the only advantage to having for profit based programs is access to capital. Is that fair?

Brett Friedman I wouldn't say it's the only advantage. I mean, the primary advantage. I think it's the issue that has limited PACE expansion, because PACE is very expensive. But there are many national for profit organizations that want to come in to New York that could do a very good job.

Dr. Berliner Right, but, you know, another way to approach this, rather than New York State having to kind of been to allow access to our services, is to find another way to provide access to capital. You know, for pay for potential programs. We do it for hospitals. We do it for other kinds of organizations in the state.

Brett Friedman It's an interesting point. There is a critical difference. I'll give you a very good example. So, under Section 98 17 of the American Rescue Plan Act, there was 10% enhanced FMAP for HCBS. PACE is qualifying home equity based services that was entitled to enhance death map. It generated an additional 40 million that we said okay pro-rata we're going to put back into PACE and CMS said you can't, because you're already at your amount that would have otherwise been paid. We can't load any more money into rates than we already do. We've been working with CMS quite difficultly, trying to find ways through just pay PACE plans money, capital grants, other things. CMS has said to date that it is an effective bar on that funding. I would have loved to give 40 million or even 80 million if we could find a way to match it right back to PACE for expansion. It's been more difficult than it should be, frankly.

Jeff Kraut Dr. Boufford.

Jo Boufford Yeah, thanks very much for this and thank you for all your great work over the time you've been with us. We're going to miss you. I want to just because you have experience in the investment sector, I kind of want to double down on Howard's question, because I think it really is that important. Maybe let's try to solve the problem in more than one way question. One of the things that's, you know, for example, HUD runs these new development agencies which provide capital to community health centers to expand. You know, as a federal program, provides loan guarantees, etc., funding to give capital for expansion of facilities. I appreciate what you're telling us about CMS not being willing to go there. But on the other hand, you know, in my look at and I think I've been to like tens and scores of seminars in the last three or four years on social investing in private equity. They're looking for opportunities where there is a third party funding stream, and usually that comes from government. I'm thinking with the nine that you have in hand, let's forget about licensing new ones and all these other things while we're waiting for the revolution, which, you know, may have to happen to get these regulations changed. Are there not ways for, say, some of the currently authorized programs who have the license, have dealt with the tough stuff in some ways to get access to capital through some mechanism that would be set up to encourage private investment and or through some other kind of facilities if they have to have a center, a physical center, which obviously is an expense of expanding the scale of the existing providers would be inhibited. I want to push it, because I think there's a lot going on nationally about social investing, leveraging private capital and the missing element in getting a lot of these things done is third party funding streams, which PACE has.

Brett Friedman It's an excellent point. I don't want to imply that for profit investment is the only way to expand PACE. There's social impact bonds, third party subventions. I spent a career for not for profit. I mean, I think there is never one approach. There needs to be a toolbox of efforts. People who are aware of some of my policy initiatives when I was Medicaid Director was I don't want to see more plans than we need in the state. Nine PACE organizations in New York State is a lot of PACE organizations. They're relatively small. It would be great to scale the PACE organizations that we have. Even if the state does nothing, I would expect there to be for profit PACE. I expect some organization will find a way to live within the existing rules because, you know, there is such a demand. And PACE in particular, just thinking about the thesis of investors in the health care space. Investors love a full risk model. PACE is the full list of full risk. You are taking a high cost, high needs population and you are managing everything. I think there's an opportunity here to, you know, at this inflection point with the houses passing the bill, with, you know, various applications coming before the review committees to think critically about how it works currently and whether we as a state want to change it going forward. I love to watch how these things develop from the sidelines. It's not a single solution for sure. I agree with you entirely on that.

Jeff Kraut Ms. Monroe and then Mr. Thomas.

Ann Monroe Thank you.

Ann Monroe As you know, I've been a fan of PACE for a long time and hope that it's available when I'm ready to use it. This is very interesting to me just to educate the committee. When I was President of the Health Foundation for Western and Central New York, we funded the first rural PACE in New York through a revolving loan. And that has

worked really well, because until they built up the balance sheet to repay that loan, they were able to use that capital. I have to believe there are other ways that we could tap philanthropy to do some kind of revolving loan program to allow programs to expand and develop. I don't want to lose this. I'm not opposed to for profit PACE either. But I do think we have a certain standard of quality that we have to maintain and we have to make sure happens. The legislation is a good step, but I agree with my colleagues that there have to be other creative ways to get capital to these programs.

Brett Friedman One point there on the revolving loan. What we typically see in not for profit managed care organizations looking to raise capital. A loan is difficult only because a loan typically doesn't count toward statutory equity requirements unless it's something called the 1307 Surplus Reserve Note, which is such a subordinated form of loan capital that from an insurance law perspective, it's as good as cash. A typical, you know, unless it's coming from a foundation or a real philanthropic advisor or some other non-for-profit looking to expand. 1307 Notes are a hard business, I'll just say, but it's a possible solution. It just needs to be. I just want to make it clear it needs to be a very specific type of loan in order to meet the statutory capital requirements for an insurance entity.

Jeff Kraut Mr. Thomas.

Ann Monroe I'm sure that's true. You lost me at one of those numbers. I think the point is that investor capital in New York is a big jump for what has traditionally been non profit. I'm not opposed to it, but I think it should be one of several options. If we can enrich just specifically Rochester and Syracuse have one PACE with over 600 people enrolled in each. Western New York, Buffalo has three PACE programs with less than 200 in each of them. That's not good. We should look to a different organizational structure. I don't want us to default to investor capital as the only way to expand PACE.

Jeff Kraut Let's not forget the majority of many of the ambulatory applications we've approved here are all investor for profit entities. So, the majority, almost all the ambulatory surgery centers, most of the diagnostic and treatment centers that we've seen, the dialysis centers we've seen, all the nursing homes we see. So, the issue here is and you know, I think you kind of said it at the beginning. The objective here is let's create a pathway. If these are good programs to have a unified licensure, which will refer now is the Monroe Doctrine to have a unified licensure to give comprehensive services. These are means to an end. And so the question is, can we get the expansion of the services? We used to run a PACE many years ago in mental health. Everyone loved the quality of the care, the services you done. I think there'll be reasonable protections to deal with the quality issues, which because we're not going to allow ones, particularly if they're out of the box to be weak ones or that are going to undermine it. Just recognizing, we sometimes lose sight of the fact that almost all of our physicians, the major physician groups that are being acquired, are all equity backed. The urgent care expansion. They're all private investor backed. So, this is another option. I agree. We should be supporting the not for profit in a different way, but we also shouldn't do that at the exclusion of trying to expand the service for like 2009 to 2015. We thought we knew better. This is the only way you could do it. There's different options. We need to be flexible.

Jeff Kraut Mr. Thomas.

Jeff Kraut And I'm mindful of the time, everybody.

Mr. Thomas Thank you.

Mr. Thomas Just a couple of comments and it's terrific, really. I have lived this quite a while and we still do. Just to give you as the council a little perspective, I ran our program personally, actually the first operations I ran for four years, ending in 2010/2011. We've tripled our enrollment since I left, so that's probably a good sign that I should have left. The fact is, we've been able to grow. Now, it's a unique structure for us, because we're in fully integrated delivery system. We have hospitals, DNTC Center, got through Article 36. We have transportation. We don't see the same barriers really. We're continuing to grow. We expanded to a rural county to the West a couple of years ago. I think and that may be unique to us, because we are a fully integrated system with capital. Two comments one on our newer B model, which I tend to share if we're going to do anything. When would we allow a sub cap to a DNTC center and that would get into the insurance side of this. I would say that, Jeff, I agree with you that the vast majority of things that we do in the space is in for profit. Totally agree. This is an interesting animal because of the insurance component of it. There's a lot of money here and a lot of money passing through here. I think that's why I appreciated your conversation, because I think the integration in Albany between the Medicaid and health insurance program and the Article 28 work, which we do here, is very important, because I think what you'll find is there's becomes a huge profit potential inside of that risk, and that creates strange dis alignment or alignment. I think, you know, I think we all know the most profitable and successful health insurance company in the world is in Minneapolis, and they're on to PACE to make 50 billion this year. That's an extreme example of of risk in for profit space. I caution, of course, we don't have shareholders and, you know, extent. And, by the way we're not making huge profit on our risk. We are paid properly thanks to the statutes in the state. My last comment would be, this program is fantastic. If you've ever been in a center, it's really remarkable what goes on there: the socialization, the health care, all of it. It's really fabulous.

Brett Friedman There's tremendous potential to co-locate a PACE center within senior supportive housing.

Mr. Thomas Ours is adjacent to low income housing.

Jeff Kraut Let me just put a context on this. So, you know, you've heard now, I think, the importance and the value of the PACE programs. You've heard different models that may or may not be considered when it comes to the Public Health and Health Planning Council. We are not in the process of approving a PACE program. That is a licensure issue under OHIP. We are in the process of approving is the diagnostic and treatment center model. You saw two models, one representative governance, one a diagnostic and treatment center. Mr. Friedman, I think, expressed a preference for that second one. And then there's a third, which is outside of licensure, which is a contracted physician group which would not come here. The only thing I think I would ask you. Well, I'm not going to ask you, but your successor is that before a application come before us, that the Office of Health Insurance Program, the Office of Hospitals, Health Systems and Primary Care be on the same page as to the model that they would approve to advance to us. It's not our decision to make, but, you know, I'm sure we'll have a preference which model you choose. I think within the diagnostic and treatment center model that is owned by the entity, we certainly have familiarity with that. It's not foreign to us. We've approved it. I think that would be helpful. I just want to close Brett, everybody should know Brett really arranged his last day here. It is literally his last day and he arranged to do that to be able to speak to us as a state official to coincide with this council meeting. I thank you and I thank your family for for extending your state service. And, you know, on behalf of the Public Health Council, on behalf of New York, as you heard the Commissioner say it, the Medicaid program, which

everybody should understand, we insure over 7.3 million people on Medicaid. That's almost 37% of the entire population of the state. This is the single largest, most important program. When we're dealing with issues of health equity and access and coordinated care, there is no better program and no more expensive program than in New York State. The fact of the matter is, that was a conscious decision we made as a state to insure everybody. And we're even expanding it further with additional regulation for undocumented individuals of a certain age to qualify. So, Brett, we owe you so much. We thank you so much for coming here today and we wish you well. And who knows, maybe you'll sit at the other side of the table one day or at this side of the table one day, preferably. He has a bar for a little while, but we'd love to see you back here one day.

Jeff Kraut Thank you very much.

Jeff Kraut You have a replacement, I believe.

Mr. Friedman Yes. I mean, this is I think, to Mr. Kraut's point, right. This is going to live under various pieces of the department. It's my successor, Mr. Carcieri is now fully briefed on these issues. PACE organizations are approved within our Division of Health Plan, contracting oversight. And then OPCHSM will retain its authority over the process. I think Mr. Kraut's point on there being alignment between OPCHSM in applications that go through the process and the model under which they're being licensed is really the immediate next step. But this is, you know, despite this being my swan song, I think there's a lot of people within the department who are aware of the issue and ready to take up the mantle when I leave.

Mr. Friedman Thank you.

Jeff Kraut I'm now going to turn over to Mr. Holt to give the report on Codes, Regulations and Legislation Committee.

Tom Holt Thank you, Mr. Kraft.

Tom Holt Good afternoon. At today's meeting, the Committee on Codes, Regulations and Legislation, the Committee reviewed and voted to recommend adoption of the following emergency regulation proposals for approval to the full council. First, we have COVID-19 vaccinations of nursing home and adult care facility residents and personnel. Mr. Furnish and Mr. Karmel from the Department are present should there be any questions from the members.

Tom Holt Are there any questions?

Tom Holt Dr. Gutierrez.

Tom Holt Question, Dr. Gutierrez?

Tom Holt No.

Jeff Kraut Got pulled away for a sidebar.

Jeff Kraut I have a motion. I have a second by Dr. Berliner.

Jeff Kraut Any discussion?

Jeff Kraut All those in favor, aye.

All Aye.

Jeff Kraut Opposed?

Jeff Kraut No abstentions.

Jeff Kraut No opposition.

Jeff Kraut The motion carries.

Tom Holt Hospital and nursing home personnel, protective equipment, PPE requirements. And again, Mr. Furnish, Mr. Karmel and the Department are present should there be any questions of the members. I make a motion to accept this regulation.

Jeff Kraut I have a motion. I have a second by Dr. Berliner.

Jeff Kraut Any questions?

Jeff Kraut Hearing none, all those in favor?

All Aye.

Jeff Kraut Opposed?

Jeff Kraut Abstentions?

Jeff Kraut The motion carries.

Tom Holt Next, we have the investigation of communicable disease, isolation and quarantine. And again, the department is present should there be any questions of the members. I move the acceptance of the regulation.

Jeff Kraut I have a motion. I have a second by Dr. Berliner.

Jeff Kraut Any questions from the council?

Jeff Kraut Hearing none, all those in favor?

All Aye.

Jeff Kraut Opposed?

Jeff Kraut Abstention?

Jeff Kraut The motion carries.

Tom Holt Next, we have face coverings for COVID-19 prevention. The department are present should there be any questions of the members. I so move this regulation.

Jeff Kraut I have a motion. I have a second by Dr. Berliner.

Jeff Kraut Any questions for the department?

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

Jeff Kraut All those in favor?

All Aye.

Jeff Kraut Opposed?

Jeff Kraut Abstentions?

Jeff Kraut None indicated.

Jeff Kraut The motion carries.

Tom Holt Next, we have surge and flex health coordination system. And again, Mr. Furnish and Mr. Karmel of the department are present should there be any questions. I move the acceptance of this regulation.

Jeff Kraut I have a motion. I have a second by Dr. Berliner.

Jeff Kraut Any questions?

Jeff Kraut All those in favor?

Jo Boufford Jeff, I'm sorry.

Jeff Kraut Yes.

Jo Boufford I have a comment, if I may. I just want to since we're in the theme of dot connecting today, I just want to raise again the issue that the council has asked several times to have either a parallel or some integrated approach to COVID, our future pandemic responses that would include connecting the hospital systems with the primary care system with the local health department. I was pleased to hear Dr. Bauer talking about working with local health departments, but I think now that Dr. Morley's in place, really revisiting the connection between local health departments in primary care especially, and then connecting them into a more integrated preparation for and hopefully response to any future pandemic challenges.

Jo Boufford Thanks.

Jeff Kraut Thanks, Jo.

Jeff Kraut Any other comments?

Jeff Kraut Any questions?

Jeff Kraut Hearing no, call for a vote.

Jeff Kraut All those in favor, aye.

All Aye.

Jeff Kraut Opposed?

Jeff Kraut Abstentions?

Jeff Kraut Hearing none, the motion carries.

Tom Holt Thank you.

Tom Holt And lastly, today's meeting of the Committee on Codes, Regulations and Legislation, the committee reviewed and voted to recommend adoption of the following regulation proposal for approval to the full Council. And that is prevention of COVID-19 transmission by covered entities. The Department are present should there be any questions. I move the acceptance of this regulation.

Jeff Kraut I have a motion. I have a second by Dr. Berliner.

Jeff Kraut Any questions for the department?

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

Jeff Kraut All those in favor, aye.

All Aye.

Jeff Kraut Opposed?

Jeff Kraut Abstentions?

Jeff Kraut None indicated.

Jeff Kraut The motion carries.

Tom Holt Thank you, Mr. Kraut.

Tom Holt This completes the agenda of the Codes, Regulations and Legislation.

Jeff Kraut We're going to turn to Mr. Robinson in a minute, but I need a time out. Go ahead. Use your mic and just bring it close to you.

Dr. Berliner Does the schedule have to be approved?

Dr. Berliner We approved it. We're on a completely different schedule than we used to be in New York verses Albany, right?

Jeff Kraut Yes.

Dr. Berliner We've given up the Saratoga dates.

Jeff Kraut Yes. We removed. This is the issue. I should have made mention of it. We usually scheduled six meetings a year and I asked to schedule five. The reason I asked to schedule five is because inevitably, during the course of the year, we're asked to meet on an emergency basis. I would just assume, try to to space out the meetings a little more, knowing that it's quite likely and I'm trying to preserve a little more of the Summer where we frankly have trouble getting a quorum. I just thought we'd try to do it, but mark my word, I'm not naive. We will have more than five meetings next year. Call me crazy, but it's possible if at least more than five cycles. And frankly, if the department, and I told this to the department just so everybody knows that if they get backed up with a large number of applications and need to move them along because our cycles are the limiting factor, then I think we would call a special meeting to deal with the backlog, so the process keeps moving and we're not the obstacle necessarily. We'll do that.

Jeff Kraut No, I don't want to take a break.

Jeff Kraut We have sixteen people on the meetings right now. We lost Dr. Yang, I think, right? She's here. We have sixteen. We need fourteen to pass.

Jeff Kraut Do we want to take on the two applications?

Jeff Kraut You have an application, which I have to be excused on, but we had two no votes. The question is we need to discuss it to see if we can get that passed. I think you go and do that.

Jeff Kraut Go with the agenda.

Jeff Kraut Just move the agenda.

Jeff Kraut We need everybody to stay in the room for the voting. I just don't want anybody leaving.

Peter Robinson Okay.

Peter Robinson So, as Mr. Kraut mentioned earlier, we're going to be batching applications where appropriate.

Peter Robinson Is there anybody on the council that wants to pull a particular application out of a batch and handle separately, other than those where we have an recusal, which we'd have to do anyway.

Peter Robinson Here we go.

Peter Robinson Application 2 1 2 1 7 4 C, Westchester Medical Center in Westchester County to construct a five story inpatient bed tower on the main campus to house 96 beds, 41 ICU and 55 met surge and with shelf space on the fifth floor with no change in total certified beds. The department and the committee recommend approval with conditions and contingencies. Application 2 2 1 0 6 5 C, Elizabeth Seton Children's Center in Westchester County to certify a 96 bed residential health care facility for a young adult demonstration program to be constructed at 315 North Street in White Plains. Here, the department recommends approval with conditions and contingencies, as does the committee. I move those two applications.

Jeff Kraut I have a motion. I have a second, Dr. Torres.

Jeff Kraut Any questions on these applications?

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

Jeff Kraut All those in favor, aye.

All Aye.

Jeff Kraut Opposed?

Jeff Kraut Abstention?

Jeff Kraut The motion carries.

Peter Robinson Noting this next application involves a recusal by Dr. Kalkut, noting that Dr. Lim has expressed an interest and a decision to abstain on this application. This is application 2 1 1 0 9 4 C. I will note that Dr. Kalkut has left the room. 2 1 1 0 9 4 C, New York Presbyterian Hospital, New York Weill Cornell Center in New York County. This is to certify adult heart transplant services and acquire requisite equipment. The department and the committee recommend approval with conditions and a contingency. I so move.

Jeff Kraut I have a motion. I have a second, Dr. Berliner.

Jeff Kraut Any comments or questions from the council?

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

Jeff Kraut All those in favor, aye.

All Aye.

Jeff Kraut Opposed?

Jeff Kraut Abstentions?

Jeff Kraut None indicated.

Jeff Kraut The motion carries.

Peter Robinson Thank you.

Peter Robinson Dr. Kalkut remains in conflict with this next application and continues to be recused. Again, Dr. Lim expressed an interest and is abstaining. Application 2 1 2 2 1 2 C, NYU Langone Orthopedic Center in New York County Certified Ambulatory Surgery, a multi-specialty center and perform renovations to an 18 OR ambulatory surgery facility in the extension clinic located at 333 East 38th Street in New York. The department recommends approval with conditions and contingencies, as does the committee. I so move.

Jeff Kraut I have a motion. I have a second by Dr. Berliner.

Jeff Kraut Are there any questions on this applications?

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

Jeff Kraut All those in favor, aye.

All Aye.

Jeff Kraut Opposed?

Jeff Kraut Abstentions?

Jeff Kraut None indicated.

Jeff Kraut Motion carries.

Peter Robinson Have Dr. Kalkut return.

Peter Robinson Noting Mr. Thomas is leaving the room, having declared a conflict and is recusing himself. This is application 2 2 1 0 5 4 C, Canton, Potsdam Hospital in St Laurence County. Certify 15 additional med surge beds, construct a four tower addition to include 60 single bedded rooms, an expansion of the emergency department and shelf space and renovate the existing emergency department. Department recommends approval with conditions and contingencies, as does the committee. I so move.

Jeff Kraut I have a motion. I have a second, Dr. Berliner.

Jeff Kraut Any comments?

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

Jeff Kraut All those in favor, aye.

Jeff Kraut Opposed?

Jeff Kraut Abstentions?

Jeff Kraut None indicated.

Jeff Kraut Could you please check? We're being told that the webcast volume is out.

Jeff Kraut Okay, it's still on.

Jeff Kraut Thank you.

Peter Robinson We're going to continue with the batching of applications. 2 1 2 2 5 8 B, Regal Park Counseling, LLC, doing businesses Regal Park Diagnostic and Treatment Center in Queens County. Establish and construct the Diagnostic and Treatment Center at 6336 99th Street in Regal Park, co-located with mental health and substance abuse disorder services. The department here recommends approval with conditions and

contingencies, as does the committee. Application 2 0 2 1 0 6 E, Montgomery Operating Company, LLC doing business as Montgomery Nursing and Rehabilitation Center in Orange County. This is transferring a total of 99% ownership interest from withdrawing members and one existing member to six new members. The department is recommending approval with a contingency, as does the committee. Application 2 0 2 2 6 9 E, Ross OpCo LLC doing business as Ross Center for Nursing and Rehabilitation in Suffolk County. Establishing Ross OpCo LLC as the new operator of Ross Center for Nursing and Rehabilitation, which is an existing 120 bed nursing facility located at 39 Suffolk Avenue in Brentwood. The department recommends approval with a condition and contingencies, as did the committee. Application 1 9 2 0 2 6 E, East Side OpCo LLC doing business East Side Nursing and Rehab in Wyoming County. This is to establish East Side OpCo LLC as the new operator of the 80 bed residential health care facility located at 62 Prospect Street currently operated as East Side Nursing Home. The department is recommending approval with a condition and contingencies, as did the committee. A Certificate for Amendment of the Certificate of Incorporation for Saint Barnabas Nursing Home Inc, which requests consent for filing a name change and change purposes. The Department and the Committee recommend approval. I'm going to make a motion for those applications.

Jeff Kraut I have a motion. I have a second by Dr. Berliner.

Jeff Kraut Is there any comments or questions on any one of these applications hearing?

Jeff Kraut Hearing no, I'll call for a vote.

Jeff Kraut All those in favor, aye.

All Aye.

Jeff Kraut Opposed?

Jeff Kraut Abstentions?

Jeff Kraut None indicated.

Jeff Kraut The motion carries.

Peter Robinson Thank you.

Peter Robinson These two applications involve Mr. La Rue's either interest in the first one or recusal in the second. He's not present, but I just want to note those for the record.

Peter Robinson Application 2 1 1 1 3 9 E, Village Acquisition One LLC Doing business as Lower West Side Rehabilitation and Nursing Center in New York County to establish Village Acquisition One LLC as the new operator of Village Care Rehabilitation Nursing Center, a 105 bed residential health care facility located at 214 West Houston Street in New York. The department and the committee recommend approval with a condition and contingencies and a Certificate of Dissolution for residents. This is where Mr. La Rue has indicated a conflict and recusal request consent for filing to dissolve residents. The department is recommending approval, as does the committee. I move those two applications.

Jeff Kraut I have a motion. I have a second by Dr. Berliner.

Jeff Kraut Any comments or questions on these applications?

Jeff Kraut Hearing none, call for a vote.

Jeff Kraut All those in favor, aye.

All Aye.

Jeff Kraut Opposed?

Jeff Kraut Abstentions?

Jeff Kraut Not indicated.

Jeff Kraut Motion carries.

Peter Robinson Thank you.

Peter Robinson Dr. Boufford, you're going to chair these next two applications, please.

Jo Boufford Yeah. My only problem is I can't see much of what's going on. You have to help me.

Peter Robinson I'll take care of it.

Peter Robinson Thank you.

Peter Robinson These two applications both involve a conflict in recusal by Mr. Kraut. The applications are 2 0 1 2 2 E, True North Three DC LLC doing business as Grand Boulevard Dialysis in Suffolk County. This is to establish True North Three DC LLC as the new operator of the 20 station Chronic Renal Dialysis Center, located at 860 Grand Boulevard in Deer Park that is currently operated as an extension clinic of Bronx Dialysis Center. The department recommends approval with contingencies. The committee recommended approval with conditions and contingencies with two members opposing. Application 2 1 1 2 4 4 E, True North Six DC LLC doing business as Peconic Bay Dialysis in Suffolk County. Again, a conflict and refusal by Mr. Kraut to establish True North Six LLC doing business as Peconic Bay Dialysis as the new operator of Peconic Bay Dialysis, a 13 station chronic renal dialysis facility at 700 Old North Old Country Road, Suite Four Riverhead currently operated by Knickerbocker Dialysis Inc. The department is recommending approval with conditions and contingencies, and the committee is also recommending approval with conditions and contingencies, but with two members opposing. I am going to make that motion.

Peter Robinson May I have a second?

Peter Robinson Thank you, Dr. Berliner.

Peter Robinson I'm going to call the question.

Peter Robinson All in favor?

Jo Boufford Just one second. Sorry, Peter, but I guess I would have. I think it might be reasonable to hear from Dr. Gutierrez and Dr. Berliner about their concerns for the rest of the council.

Peter Robinson Okay.

Jo Boufford If they wish to. If they don't wish to, it's fine.

Jo Boufford You can go ahead.

Dr. Gutierrez I have been concerned with this situation with the dialysis centers that are run by companies that have been questioned in the past about their business practices. I brought that issue up at committee level and evidently my concern is not shared by the people that voted otherwise. I think that the documentation is abundant that in spite of the paper that was presented and we discussed at committee level showing their practices regarding medication, staffing and were questionable, there had been no answers by any of the companies that I would have appreciated to see an attempted rebutting that the paper. I remain opposed to that and that is what my position was at committee level and remains to this day.

Jo Boufford Dr. Berliner.

Dr. Berliner I share Dr. Gutierrez's concerns. Also, the rationale for these applications as for some in the past have been. This dilutes the for profit ownership. I don't see dilution as really addressing any of the concerns that Dr. Gutierrez has has raised about the inimical effects on dialysis patients and staff. So, that's the reason for my opposition.

Jo Boufford This is, it strikes me that I think this is an issue that's been raised before in general terms. Were your concerns specific to this operator just for this application, or generically concerns about the issues that have been brought up before by the council?

Dr. Gutierrez I will answer that first, if I may. You are correct, but it appears that either those of us who have read the article do not feel it powerful enough or the bulk of the legal issues that have been involved that DaVita and Fresenius and the US Renal Care, because it's not just DaVita. The three of them have failed to answer in my estimate. I'm used to seeing open debate to things in medicine. If a big article comes out saying, this is not good practice, this is not good medicine or this is not good treatment. The people that are defending those come out with a rebuttal. You have a healthy discussion between the parties. I have failed to see that. There seems to be an inertia that moves people to just continue approving. I don't like that.

Peter Robinson Mr. Thomas has a comment.

Mr. Thomas Thank you, Mr. Robinson.

Mr. Thomas Just a quick response. In the committee conversation, we did speak extensively and Dr. Gutierrez shared his views. What was also clear, we heard from the Northwell partners at the table, and they were very compelling about what they would bring to these. This is a existing licensed operation owned by DaVita. With a integrated delivery system that has other JV's with them, all of which, by the way, I think seven out of seven are five star. I think at least from my perspective, this is an enhancement of an existing

program through the insertion and the integration and partnership of Northwell and those folks.

Jo Boufford Thanks.

Jo Boufford Are there any other comments?

Peter Robinson If I may? More broadly speaking, at the committee meeting, we did also make a suggestion to the department that we bring this broader issue to the planning committee of the council, so that we rather than resting our actions on individual applications, we review our broader policies with regard to for profit dialysis and how we ought to be relating to that. I think everybody was very cognizant of Dr. Gutierrez's issues. I did think that the applicants did respond well, at least in terms of their own case for the applications they brought forward. I felt reassured that we were moving in a positive direction with regard to these applications, considering where they're currently structured now. I think that probably was the sentiment that resulted in a favorable vote from the committee. I just bring that out as well. With that now, I guess we're ready to vote on the two applications.

Jo Boufford If there aren't any other comments or questions. I appreciate Peter, having, Mr. Robinson having the planning committee, having that put on the agenda. The planning committee, Dr. Rugge is looking attentive. I know it's come up before, so perhaps we can do that. In absence of being able to see, can we have a vote all in favor of the two applications.

All Aye.

Jo Boufford Any opposed?

Jo Boufford Dr. Gutierrez. I assume Dr. Berliner remains opposed.

Jo Boufford Is that correct, Peter? Sorry, I just can't see the other people.

Peter Robinson As a result of Mr. Kraut's recusal and the two votes opposing, we only have thirteen positive votes. We need fourteen in order to approve the application. The application is not able to move forward.

Jo Boufford I thought we had one vote. I'm sorry.

Jo Boufford We don't?

Jo Boufford Okay.

Peter Robinson We need fourteen affirmative votes to move the application forward. We have thirteen in favor, two opposed and one recusal.

Dr. Rugge Excuse me. I'd like to abstain.

Dr. Rugge I would like to abstain, please.

Dr. Rugge I would like to abstain.

Jo Boufford I didn't ask for abstention.

Peter Robinson I would say that clearly we do not have a sufficient number.

Jo Boufford Okay.

Peter Robinson Did we not catch your vote accurately?

Jo Boufford Yeah, I did not. I failed to get to the finish. I didn't ask for abstentions. He's now said he's abstaining. We have two negatives, two nos, one abstention and the rest are pro, so it's twelve. Twelve in favor, two negatives and one abstention.

Peter Robinson And I think the issue here is I don't want to sort of turn to a motion for disapproval of the application, because I think that's going to actually send it in the wrong direction. My feeling is that if we brought it back to the full council at the next cycle where we had a larger attendance, we might end up with a different outcome. My recommendation is that we move this application to the next cycle.

Jo Boufford Is that a formal recommendation, Peter? I'm just asking for guidance from legal counsel as to whether that choice.

Marthe Ngwashi Thank you. I'm an attorney at the Department of Health. I'm just asking if you could all speak into the microphone when you are talking so that your discussion can be heard clearly by everyone and then you can make the determination about what next steps you desire to make, and then a formal motion can be made thereafter.

Peter Robinson I'm not sure. It's not disapproved, because we did not carry sufficient votes to approve it.

Dr. Berliner Right, but I mean, what's the point of voting if a negative vote means it just goes on to another meeting where there might be a different number of pro votes? I mean, it just seems like it's mediating the point of the vote completely.

Jo Boufford Can I ask a question about lacking a quorum, because of their refusal.

Peter Robinson We have a quorum. There are fourteen people that need to be present for a quorum in order for us to act, but we also need fourteen affirmative votes to move an application forward. So, anything off that fourteen doesn't allow us to advance an application.

Dr. Kalkut What would be the next step?

Jo Boufford That's what I'm trying to do.

Dr. Kalkut We don't push it into the next cycle. Certainly one of the steps is this dialysis will continue to operate with DaVita as the sole owner. We're voting against a shared governance or operating for it. I think that's what gets most of the approval votes for this project. Just so we all recognize and everyone I'm sure does. It just remains an operation exclusively for DaVita. That's the outcome if we don't move forward in another way.

Marthe Ngwashi At this juncture, the applications require a formal act by the committee, right? But that formal act by the council would be whatever your motion that was presented

for. Your motion was presented for an approval for these projects. In order for that motion to serve as a formal and final act by statutory purposes, we would have needed to have fourteen affirmative votes for that motion.

Dr. Kalkut Right.

Marthe Ngwashi Right now, because we do not have the fourteen affirmative votes or approval on that motion, the application isn't just going to disappear. The application still needs a formal action by the council, so that's why I was saying the council should now have a conversation and determine the next steps for the project applications that are presented, because right now they're just sitting in limbo, right?

Jo Boufford Well, they're sitting in limbo unless there's a vote that says, you know, I think that's the question are we able then to indicate to have a vote on what the next step might be? That's the question.

Marthe Ngwashi Absolutely, yes. You have a discussion about what your next steps are going to be. Are you going to make another motion? What is that motion going to be? Have a discussion.

Peter Robinson I'm going to make a motion then that this application be deferred for reconsideration at the next full council meeting.

Jo Boufford Second for that.

Jo Boufford Second from Dr. Kalkut.

Jo Boufford Any discussion of that by the council?

Jo Boufford Before we have a vote, questions? I think we discussed it before we got to it, so we know what the implications are.

Jeff Kraut Dr. Boufford, there's a question in the room.

Jo Boufford We can't hear.

Ann Monroe Am I correct that because we only have fourteen people here today and one of them has recused, we don't have enough votes to take it forward.

Peter Robinson We do not have the votes to move this application forward as an approved application.

Ann Monroe Right, so we don't have a choice except to defer it, because even if we all voted for it, there's only thirteen of us.

Peter Robinson You can vote, for example, to turn down the application. We could have everybody voting to sort of say, no.

Marthe Ngwashi You are permitted to have a discussion about what your next step is going to be, right? Because you need to achieve the fourteen votes either way, either in the affirmative approval for the project applications or in the negative. You're disapproving the project application. I think that based on the conversation, it's unlikely that you will get

fourteen votes disapproving the applications. However, I don't know. If someone wants to bring that motion forward for disapproval, you are welcome to do that. However, I believe that Chairman Robinson wanted to defer these to the next full council, so that perhaps there will be additional members there. Otherwise, the applications will continue to just sit in abeyance or in limbo until we have fourteen votes one way or another to make a final action by the council.

Jo Boufford And the vote that's on the floor, the motion on the floor as defer to the next cycle for a vote, correct?

Jo Boufford Dr. Gutierrez.

Dr. Gutierrez I think that procedurally the motion may need to be withdrawn and then proceed with another motion. You cannot just ignore the motion that was made.

Jo Boufford The initial motion for approval, which was seconded and there wasn't a sufficient vote for that.

Peter Robinson We voted on that motion, so the fact is that let's just say the approval was not. We did not carry the approval of it. That was the outcome of that. Now, we're in a position where we can take on a new motion.

Jo Boufford For next steps.

Peter Robinson For next steps. .

Jo Boufford That's what legal counsel is saying in the motion for next step is deferral to the next cycle.

Jo Boufford Seconded by Mr. Kalkut.

Dr. Kalkut The issue with a new motion for deferral and perhaps I'm projecting where I shouldn't be is if the vote remains the same, then that will also not be approved. Where it just hangs in abeyance, as you said. How do we get ourselves out of that? I'm not saying what the votes will be, but that seems like a likelihood, because the current motion would disapprove. If there is one to put it into the next cycle with the idea that there will be a larger group of council members to vote on that and we would not be as constrained we are by attendance now three and a half hours into the meeting that could result in a different outcome.

Jo Boufford The other issue for this vote may be that since some of the concerns have been expressed about general concerns on for profit dialysis and expectations, Mr. Robinson suggested that the planning committee take that up as a general factor, whether our colleagues would be willing to support deferral for a larger number of council members on this vote. Otherwise you are correct, we'll still have a stalemate. So, that would be one argument.

Jo Boufford Are there any other comments for this?

Marthe Ngwashi I'd just like to make one more comment. I think that what I hope has come across from this is the importance of your dialogue, right? It's important to have a discussion, so that you can make a determination about the recommendations and the

motions that you're going to put forward. That said, I welcome whatever motion you're going to put forward now.

Jo Boufford I would argue, I guess one of the reasons. I think we've had a discussion in the sense that I asked specifically for the two colleagues that voted no on both of the proposals to be explicit about their concerns. And then we had other discussion about concerns on the positive side. I think Mr. Thomas actually came back and indicated from his point of view he felt there had been a constructive discussion about the reasons for the positive votes on the resolution. The fact that we ended up with the same vote in the council as was in the committee, I think is the fact. It's just a fact. Now, the suggestion that we have another vote, another vote to defer to the next cycle has been discussed in the context that we don't have a quorum. And also the offering suggestion and Dr. Rugge may want to say something, but the suggestion that some of the concerns are generic to for profit dialysis and failure of those entities to respond to concerns that have been longstanding, not necessarily specific to this application and that that might mitigate the negative votes for that notion, might get the negative votes for the next resolution, which would be to defer to the next cycle.

Jo Boufford I don't know, John, you want to say anything?

Dr. Rugge I would just suggest that I think a broader consideration of the role of for profit centres is in the order, so that we can effectively address this particular application and would prefer to defer the vote until that broader discussion of taking place.

Peter Robinson Dr. Torres has a comment.

Dr. Torres Would it be appropriate, correct me if I'm wrong and guide me to make a motion to remove this application from the batch and defer it so that we can engage in additional discussion about it? Can we just remove it?

Jo Boufford We wouldn't be acting on it by deferring to the next batch. I think that's the same unless there's some legal nicety there.

Peter Robinson Yeah, there's two applications, by the way. I just want to be clear.

Jo Boufford Yeah.

Peter Robinson Dr. Gutierrez had a comment.

Dr. Gutierrez I think we've got to be careful here. I think you have a motion which was received a second. You're counting the votes. And because the motion is not going to pass, you're going to bring it back? It doesn't look good.

Jo Boufford That's right. I think we have a motion on the floor. It is seconded. We're still having discussion about that motion at this point.

Dr. Gutierrez I think the person that made the motion should be prepared to say I withdraw the motion. And that is in a way it needs to be approved. And if everybody says, yeah, let's withdraw it and do something. You cannot leave the motion on the floor and ignore it.

Jo Boufford I'm not.

Jo Boufford Excuse me. I'm not leaving it on the floor.

Peter Robinson Are you asking the motion that I just made, Dr. Gutierrez?

Dr. Gutierrez This is not the first time this has happened while I work.

Peter Robinson Was it my motion that you want me to withdraw?

Dr. Gutierrez I think that that's procedurally what needs to happen.

Jo Boufford Excuse me. I guess I don't agree. Just because Dr. Torres suggested it that might be a way forward. That's part of our conversation. We still have a motion, a seconded motion on the floor, which we haven't voted on. I mean, I don't know. It seems to me that this is a discussion we're having about that before we get to withdrawal. I don't know. Unless Peter, you want to withdraw it. I don't see that that gets us anywhere.

Peter Robinson I mean, my preference would be to actually defer this. I think that would also give time for the planning committee to get into this issue as well, so that we can take a look at our policies. Hopefully, that could be done in an expedited way and that we would have time such that by the time the next cycle shows up, we would have had a planning committee review and set of recommendations that might have an effect on the outcome. So, that's the reason for my motion for deferral.

Jo Boufford Dr. Rugge.

Dr. Rugge I'm no attorney, but it seems to me that there's no need for a motion. We've had a failure to approve, but no motion to disapprove. And therefore, by leaving it as it is, it will be up to the leadership of the committee and the council to bring it back at the appropriate time.

Jo Boufford Advice of counsel, I think she said the opposite.

Marthe Ngwashi Right, right. Absolutely. Yeah. It's more appropriate, if we have a motion on these two projects one way or another.

Jo Boufford Excuse me, I thought we had a vote where we had the number of Dr. Rugge abstained. Dr. Gutierrez and Dr. Berliner continue to say no. And then we had the balance of votes, I guess it was twelve to approve. So, that transaction has happened. And then the issue was, is that we also are authorized to talk about it next step since we didn't have a quorum.

Peter Robinson Should we just maybe make a clarification and vote on the deferral and then see where we stand after that and then we can kind of move forward. So, there is a motion and a second on the floor for deferral of this application. And then, you know, as a not a sidebar, but as a comment, it was noted that this would also give time for the planning committee to conduct a review of the policy regarding for profit dialysis units so that when the application was recycled, we have that as context for our consideration.

Jo Boufford That's where I thought we were.

Peter Robinson We haven't called that vote yet?

Jo Boufford I understand that, but we were still... I was trying to get clarity from our legal counsel. We needed to have a discussion. I think we've had the discussion on that motion. If it's in order, we should move ahead with it. The motion and second for deferral is in order. We could move ahead on that, correct?

Jo Boufford All in favor?

All Aye.

Jo Boufford All opposed?

Jo Boufford Dr. Berliner is opposed. Continues to be opposed.

Peter Robinson Dr. Berliner is in favor of deferral.

Jo Boufford I would say that then I believe that case would be that the deferral is approved.

Peter Robinson That motion would carry.

Jo Boufford All right.

Jo Boufford Dr. Rugge voted yes. So, everyone voted yes, but Dr. Gutierrez.

Peter Robinson We have Mr. Kraut still in recusal.

Colleen This is Colleen. I'm also confirming that the vote had passed.

Peter Robinson The vote has passed.

Jo Boufford Vote for a deferral is passed.

Jo Boufford Thank you.

Peter Robinson Thank you all, colleagues. This is a very, very difficult issue. I appreciate the collegiality with which we managed it. So, thank you, everybody, for that.

Jo Boufford We could call Dr. Kraut back in to finish the meeting, complete the meeting.

Jo Boufford Mr. Kraut, sorry.

Ann Monroe Mr. Robinson.

Ann Monroe What is the status of the Niagara Ambulatory Surgery Center that we postponed at our meeting?

Peter Robinson We would have to ask the department that. I don't know.

Ann Monroe So, it's not coming up?

Shelly Glock Hi. This is Shelly Glock from the department. That application will be brought forward at the July EPRC meeting.

Shelly Glock Thank you.

Jeff Kraut The public portion of the Public Health Council and Planning Council is meeting now adjourned.

Jeff Kraut The next regularly scheduled committee day is going to be held on July 14th. The full council will reconvene on July 28th.

Jeff Kraut We are now adjourned.

Peter Robinson Thank you very much.