

**NEW YORK STATE DEPARTMENT OF HEALTH**  
**PUBLIC HEALTH AND HEALTH PLANNING COUNCIL**  
**FULL COUNCIL MEETING**  
**February 6, 2025, 9:30 AM**  
**90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC**  
**TRANSCRIPT**

**Mr. Kraut** Well, let me just say, unfortunately, we do not have a quorum yet to call the meeting. We can't do official business and take votes. Can I start the reporting?

**Mr. Kraut** I can't ask the Commissioner to speak or anything.

**Mr. Kraut** How many do we have?

**Mr. Kraut** We're counting the Commissioner.

**Mr. Kraut** The Commissioner is on the camera.

**Mr. Kraut** We're just waiting for one more individual to walk into the room so we can begin. As soon as I see a face at the door, I will do so.

**Mr. Kraut** Is she in the bathroom?

**Mr. Kraut** Could you just make sure they're not loitering in the lobby?

**Mr. Kraut** Scott's also here.

**Mr. Kraut** You know that they're not on their phones or something.

**Mr. Robinson** Well, it's nine minutes to 10:00am. Everybody thinks they're still early.

**Mr. Kraut** Hi, Dr. Friedrich.

**Mr. Kraut** I'm going to start the meeting.

**Mr. Kraut** I'm Jeffrey Kraut, and I have the privilege to call to order the meeting of the annual meeting of the Public Health and Health Planning Council on February 6th, 2025. I'd like to welcome members, Commissioner McDonald, participants and observers, as well as the department staff. If you heard Dr. Yang talk about the rules that we follow following the Joint Commission on Public Ethics. We need everyone to sign in to the meetings. We're subject to the Open Meeting Law. You heard the suggestions on how to speak during the services, during the meeting. I'd like to encourage members and the public to join the department's listserv as well to get noticed on the Certificate of Needs. We regularly send out important council information and notices such as the agenda, dates and policy matters. We would ask people to

consult with that. There are printed instructions on the reference table how to join the list serve or contact Colleen Leonard for assistance. We're going to start and open today's meeting with the annual meeting. We're going to vote on the appointment of the council's chair, and then we're going to receive reports from Dr. McDonald, Ms. Deetz and Ms. Carnaby from the Office of Health Equity and Civil Rights, followed by a report from Dr. Rugge on health policy, Dr. Yang on regulation, Mr. Robinson on recommendations of the Establishment and Project Review Committee, or maybe it's Dr. Kalkut, whoever's doing it, and then we're going to move into Executive Session and get a report on the Committee of Health Personnel and into professional relationships. Now, I think before we call the Establishment Project Review Committee, I'm going to encourage the council members to take a look at the organization of the projects that we're going to call. We've batched Certificate of Need applications. If you take a look at how we're going to call and batch applications, if anybody wants to move one to a different category for whatever reason that you have, we will do so. Please let Ms. Leonard know and we will do that. Just before we do the annual meeting, I just want to point out, I hope you've taken the time to look at the material that was sent to you. We have a wonderful compendium of the activities of the council, the codes we review, the number of applications, the dollar value of those applications, the activities of each of our committees, the subjects and topics they covered. When you look back, you know, sometimes we get lost in the day-to-day business of the council. When you have an opportunity to look back and reflect, you see it's quite a bit of activity that we've done. We've made some very meaningful changes on issues regarding reproductive rights, access to mental health services. We just started a process on CON reform and the like. I think you'll find that quite impressive. The number of applications that came before us and into the committee and the growing amount of work that the department staff performs that we really don't see. It's a significant amount of productivity. As we've come out of COVID, you've seen, you know, a growth in it. There's a lot of, as we're going to hear today coming within the next year. I'd like to now move to the election of the council's Vice Chair.

**Mr. Kraut** I make a motion for Dr. Jo Boufford to serve as Vice Chair.

**Mr. Kraut** May I have a second?

**Mr. Kraut** A second, Dr. Kalkut.

**Mr. Kraut** All those in favor?

**All** Aye.

**Mr. Kraut** Opposed?

**Mr. Kraut** The motion carries.

**Mr. Kraut** We didn't take this vote because she's not here. She was unable to join us. You know, like you should have showed up. You could have. She has agreed to serve

in that capacity. The standing committee leadership roles, membership remains essentially the same. Mr. Robinson as chair and Dr. Kalkut as Vice Chair of Establishment and Project Review. Dr. Boufford as Chair and Dr. Torres as Vice Chair of the Public Health Committee. Dr. Rugge as Chair and Ms. Monroe as Vice Chair of the Health Planning Committee. Mr. Holt as Chair and Dr. Yang as Vice Chair of the Committee on Codes and Regulations and Legislation. Mr. Thomas will continue to Chair the Health Personnel and Interprofessional Relations Committee, as Dr. Boufford will also Chair the Ad Hoc Committee to lead the State Health Improvement Plan. I'd like to thank all the members of the council for their work and dedication in serving on the committee's work. We are really, as you'll hear a little later from Dr. Rugge. We're really forming the agenda that will guide the activities in this coming year. We're very looking forward to another productive year, keeping in mind our goals and service in maintaining improving the health of all New Yorkers. If you love change, you're going to love health care. If you love health care, you're going to love the coming to the Public Health and the Planning Council. I'm sure there is a lot of things we can't even anticipate that we're going to have to deal with in the coming year.

**Mr. Kraut** With that, I'd like to conclude the annual meeting and turn to today's meeting.

**Mr. Kraut** I'll start by having a motion to adopt the December 5th, 2024, Public Health and Health Planning Council Meeting minutes.

**Mr. Kraut** May I have a motion?

**Mr. Kraut** Dr. Berliner.

**Mr. Kraut** A second?

**Mr. Kraut** Mr. Robinson.

**Mr. Kraut** All those in favor?

**All** Aye.

**Mr. Kraut** Opposed?

**Mr. Kraut** The motion carries.

**Mr. Kraut** I'd now like to call on Dr. McDonald, who's going to update the council about the department's activities since our last meeting.

**Mr. Kraut** Dr. McDonald.

**Dr. McDonald** Thank you, Jeff.

**Dr. McDonald** Good morning, everybody. I'm joining you today from my office here in Corning Tower. I just had planned to be there in person, my friends, but there's a lot going on. Let me just tell you a little bit about what's going on right now. The first thing I wanted to acknowledge, though, is February's Black History Month. Obviously, that's very important to me and to the Department of Health. I think it's a time for everyone just take a moment and just reflect on the purpose of Black History Month, which is to look at the contributions of Black Americans in our country. I particularly want to just focus on one individual, if I could, please. There are many to pick from, but I chose Dr. David Satcher. It would just be important just to think about his contributions. He's still alive, but he was the Surgeon General from 1998 to 2002. He was also the only person who served not just the Surgeon General, but the Assistant Secretary for Health. I just think that's just really an important distinction. You know, one of the things about Dr. Satcher, his priority is something I really resonate with was his real priority was to eliminate health disparities. I just can't think of a more noble priority for someone who is Surgeon General or for someone who is leading health and human services. To me, that is just one of the noblest priorities to eliminate health disparities. Because really in a civilized culture, we shouldn't be having health disparities. He talked about that in 2010. He's had a really accomplished career, by the way. Dr. Satcher has earned over fifty honorary degrees. Still very active. He was someone who was part of the World Health Organization Commission on Social Determinants of Health as well. Really an accomplished career. If you're just looking for one source, you can learn about Notable Black Americans and their Contributions to Public Health the United States. The Trust for America's Health has a nice web page on this. It's just one little place to look. There's a lot of people who have made wonderful contributions. With that, as I start my comments that I just do want to be mindful of the federal transition. I do think it's just important to really just call this out a little bit. I just want to make sure you guys hear this from me time and time again. You know, as the State Health Commissioner, I'm focusing on the mission of the New York State Department of Health. I think it's really important that you know that. Our mission is to protect and promote the health and well-being for all built on a foundation of health equity. Our mission doesn't change. That's what I'm focusing on. You know, when you look at New York State, when I'm focusing on, the Governor's focusing on is just continuing to deliver for New Yorkers. It's evident to me there's just a lot coming on right now. Believe it or not, the federal transition is seventeen days old. Yet for a short period of time, it's certainly caused a fair amount of confusion and disruption. I can just promise you what I'm focusing on is my mission protecting New Yorkers. I know what the Governor is focusing on is challenging federal actions. We need to be. Quite frankly, if it threatens our people, our values, that's where you'll see that. I think one of the things you've noticed has been a record number of Executive Orders. I'm sure you've also invested in a fair number of temporary restraining orders and injunctions granted as well. You know, very thankful for the Attorney General we have in New York State, Letitia James, but also for all those throughout the United States who are working just to make sure there's checks and balances. You know, the disruptions that we're seeing, it doesn't look to me like an orderly transition of government. I think it's really important that we know that we're focusing on our mission here. A couple of other things that I want to talk about today. You know, I talk to you often about highly pathogenic avian influenza. It's an important

topic. The department remains vigilant on this. We talk daily to AG & Markets, Department of Environmental Conservation. One of the things you're seeing in New York definitely since I talked to you last time is we're seeing more detections in New York. Now, I just want to make sure you understand why that's the case. What we're seeing is an increase in the wild bird population with highly pathogenic avian influenza. Therefore, you're seeing spillover. Keep in mind, birds migrate. We're seeing spillover in New York state. One of the points I want to raise, though, is that it's called highly pathogenic avian influenza for a reason. Highly pathogenic means almost all the birds die and die really quickly. There isn't a vaccine for birds. There aren't drugs for birds. They die. When you think about what happens to the price of eggs. I think some people wonder, why are eggs so expensive? Well, eggs are expensive because eggs come from chickens and chickens are birds. When you get H5n1, where there's chickens, all the chickens have to be depopulated. That's a way of saying they're put to death. Quite frankly, that's why we're seeing egg prices as high as they are. I think just as importantly, though, I've really been happy to see how the local health departments have responded right now to what we're seeing in New York State. You know, Suffolk County, Putnam County Health Department, some other health departments have responded quite quickly doing the right thing. In other words, if there's human beings who are exposed to the birds, whether it's ducks or whatever, assessing the exposure, testing those who are appropriate and offering prophylaxis with Tamiflu if needed. Suffolk County in particular, just to name one, tested about twenty people. A couple of people had seasonal influenza. No one had H5n1. That's still the case in New York State. Right now, as of today, there's no reports in New York State of a human being acquiring H5n1, whether it's from poultry, a bird, a cow or any animal. That's still the case in New York right now. Having said that... You know, farms are practicing biosecurity, but if you're someone who's working with poultry or cows, really important for people not just to follow the biosecurity, but to wear the personal protective equipment. It should go without saying, but if you're dealing with a dead animal, you really shouldn't be dealing with a dead animal unless you're trained. You definitely need to be wearing personal protective equipment. H5n1 very contagious among birds. We still very low transmission. We aren't seeing human to human transmission. This is something we're very vigilant about. The New York State Department health is committed to this. We're doing a lot in this space. It's something of the other conversation with us over here. I do work with the federal government as well. As I mentioned the federal transition, I am seeing some normalcy return to some parts of the federal government. I was heartened to have a recent call with Health and Human Services. This was a call I saw that continued from the legacy administration where FDA, CDC, USDA and ASPR, Administration Secretary for Preparedness Response get together and talk to state health officers and representatives from Governor's offices about what's going on with H5n1 across the United States. These types of national calls are important. Everybody's on the same page of getting information. I was heartened that the administration has continued that. That makes me a little bit optimistic that we'll see some federal cooperation, at least with H5n1. I want to cover a couple other infectious disease rather quickly. You know, we're still in flu season, my friends. I think we're seeing flu in New York stabilized. Keep in mind, in New York, Influenza A comes first, Influenza B usually comes second. Usually, we get a slower bump of Influenza B, a

lower bump, if you will. We are seeing this. Keep in mind, flu season lasts in New York usually for a couple more months here. This is one of those things where we're keeping a close eye on what's going on with influenza, but we're seeing some stabilization here. It's still widespread New York. It's still a threat. Virus seems to be declining. We're still seeing some in New York, but we're now in a steady decline. That's got some encouraging news. COVID may have peaked in New York a couple of weeks ago. It looks like COVID has peaked a couple of weeks ago. One thing is interesting about COVID, you know, we're in our fifth year of COVID. It might be settling into a seasonal pattern. I think one of the things that's interesting, though, when you look at hospitalizations, we had a much higher peak of hospitalizations in August than we did here in January, which is interesting. There could be a lot of reasons for that. Again, one of those things where I think five years into this, it's certainly not what it was before. That's good. Another topic I want to touch base with you is just where we are with a consumer directed personal assistance program, also known as the CDPAP program. Mentioned this last time, but since we talked last time we are seeing the transition going smoothly. There's been at least 25,000 members who have transitioned over. We've seen at least 21,000 workers transitioned over the transition to going as it was expected. The way the transition was designed by the vendor PPL is slow transition, then get into a higher transition that's going. It's going as designed. Keep in mind, we're very committed to the 250,000 New Yorkers who rely on this for this program to continue. Since I saw you last, we did make a public service announcement to really just address the misinformation about the transition. There's been just an enormous amount of misinformation about this. It showed up in everyone's mailboxes. It's on TV. You can't escape the misinformation on this. You know, I really just think this is just important that we, the department just felt we really needed to just set the record straight, as it were. You know, the bottom line is we're moving the program over. We're protecting the program. As you look at the federal future, I think it's really important that we have sound stewardship of health care dollars. It's really important that the program be maintained and protected. That's what we're committed to doing here in New York State. I do want to talk a little bit about the upcoming budget. Just for those who are interested, the Department of Health's budget hearing is Tuesday morning at 9:30am. If you're in the Albany area, you want to stop by. It's open to the public. It's in the legislative office building. Anybody can attend. You don't need special permission, but it is available online as well. Anybody can watch it online. I certainly welcome people to attend. I do think there's some nice budget initiatives, though, that I just want to give you a few examples. I think when you look at the whole budget in its aggregate, there's a couple of messages you pick up. One is there's real emphasis on affordability. Affordability is so important, right? You know, we all have limited financial resources, at least I think we do. It's just great to see us trying to get New York to be more affordable. The other theme I see in this budget was there last year and the year before too is there's real emphasis on health and wellness. Not every proposal in health department budget, but when you look at all these proposals in aggregate, you can usually see a connection to it's probably improving someone's health and wellness, more specifically, helping improve people's social determinants of health. Here are just a few examples. One initiative is distraction free schools. You know, more and more we see people using phones in school. More and more studies show how common this is. There's a myth. I

think people think they're multitasking. By the way, you really aren't multitasking. When you're multitasking, you're really what's called switch tasking. In other words, the way our brains are wired we don't usually think about two things at once. You think about one thing, then you switch to another thing. I think we could all agree it just doesn't benefit kids learning to be distracted. There's really, to me, a momentum to move from distraction to interaction in schools, right? Get kids interacting with each other, learning our social skills, being polite to each other and getting off the phones during school. I think it's a wonderful proposal. Nineteen other states have done something in this space. They're states have all different political persuasions. It's nice to see there's some agreement on this. A lot of these states did it in 2024. I think you're seeing now what the country saying is really and really what you see in this proposal is \$13 half million dollars for schools to develop a storage solution. Every school must come up with a local solution. The schools still have the autonomy they need. If a student needs to contact their parent during the day, they can still do that. We're just trying to create some normalcy in classrooms where kids are on their phones. It's funny. I was talking to my sister-in-law who's a teacher. She was like, "Oh my gosh, this is long overdue". Teachers shouldn't have to fight for kids' attention from phones in school. By the way, parents, you shouldn't have to fight for that either. You know what I mean? Make a rule at the dinner table, if you don't mind. We're eating for ten minutes. Can we please put the phones away. I think it's a great proposal. There's another proposal I'm really excited about, which is universal free school meals in New York. In other words, you don't have to demonstrate an income problem to get breakfast at school or lunch at school to be afforded nutritious food. This is going to save families who are affected by this \$1,600 a student. It's going to help at least 300,000 New York students. A nice proposal for a lot of regions so kids can access nutritious food in school, save families money, save families, time in the morning. A lot of kids want to eat when they get to school. I think it's a nice thing. \$1,600 a year for families that's real money. One of the proposals we have that's in the Health Department budget that I'm excited about is building on the success of the Safety Net Transformation Program that started last year. There's a nice \$1 billion capital investment in this year's budget. That's a billion with a B. I'm really happy to see that. The Safety Net Transformation Program was designed to help hospitals form partnerships, but really to find ways to transform so we can improve access to care, but also financial stability here. These partnerships have so far been very helpful. We were really impressed with how many applications we got. It was thrilling to me to see that there's another investment going in this year. There were some great awards that have already been given. A couple the Governor announced. I was happy to see we gave \$188 million in funding to Jamaica Hospital. They're partnering with Memorial Sloan Kettering to establish a comprehensive care center in Queens. I love this particular investment for a lot of reasons. One is world class cancer care. Improving quality of care, improving access to care. The partnership helps both partners. This is a nice example of just how we can use our tax dollars to really improve health and wellness. Another investment I want to just draw your attention to is St Barnabas Hospital in the Bronx. \$142 million to help construct a new Emergency Department. They've got a wonderful partnership with City Block. They're going to have to do some incremental changes to help reduce their Emergency Department wait times. Help also people with complex mental health disease get the treatment they need

in the appropriate setting, but also, quite frankly, expand their Emergency Department. You know, St Barnabas during the pandemic, the way they expanded their Emergency Department from forty-six beds to ninety-two beds. They just simply divided the existing spaces with curtains. It was a really pragmatic solution. You can imagine how cramped it is for them. I think this is just a wonderful example of another sound investment. Really glad to see that. Couple of other investments I want to draw to your attention. There's a nice emphasis this year on nutrition. One of the things I'm happy to see is we're seeing a nice investment in the Hunger Prevention Nutrition Assistance Program, another \$23.5 million, bringing the same investment over to \$57 million. You know, the Hunger Prevention Nutrition Assistance Program provides hundreds of thousands of meals throughout the year. Really just a very successful program. There's an additional \$5 million for the Nourish New York Program, bringing our investment there to \$55 million a year, which I'm excited to see. There's also a \$9.5 million increase in our WIC program, bringing our state investment up to \$26 million. The federal government does give us a fair amount of money for WIC, but it's been flat over the recent years. I do hope as the federal Government puts their budget together this year, I hope they remember that when you don't increase funding for WIC over the years that creates a problem across the whole United States or of people going hungry. I think we all know that no one benefits when people are hungry. Certainly, a country like ours should be able to feed everybody. It's exciting to see our budget initiatives there. Other things I'm excited about is workforce you know is a problem for us. I think you've heard me talk about workforce quite a bit. I'm very pleased to see that we're still pushing for a certified medication aide to give medicines and nursing homes. I think that's important. I've been to a lot of places in the last year. I hear this all the time. We'd like to join the other thirty-eight states that are doing this. I think the time is now for us to really do this so that we can have nurses be nurses and really help just other people deliver routine medications with appropriate training of course doing that. Another proposal I'm glad to see there's some legislative interest. We've been working with the State Education Department. We've really enjoyed our partnership with the State Education Department on medical assistance giving vaccine. I recently got the Chair of the Health Committee, Amy Paul, and met with our team and is interested in this proposal. I'm optimistic that she might be able to help us get this through this year. I think it's a wonderful proposal. I want to end a little bit where I started, though, with the federal transition folks. I know it's top of mind for folks. When you look at the media, it's really all over the place. I think it's just important to remember we're the Health Department. We're going to focus on our mission. We're going to protect and promote the health and well-being for all built on a foundation of health equity. We're not going anywhere. We plan on really sorting this out through there. Having said that, just so you know. I have a team of people that meet every day who go through all the federal Executive Orders and all of the injunctions and all the restraining orders and just really assess the impact. New York State Department, we're looking at how it affects grant funding and everything else. We're very closely monitoring the federal transition. I just I know that we are vigilant about this as well. Let me stop there for just a few minutes and see what questions you guys have for me this morning.

**Mr. Kraut** Thank you very much, Commissioner.



**Mr. Kraut** Anybody have questions for the Commissioner?

**Mr. Kraut** Dr. Berliner.

**Dr. Berliner** Thank you, Commissioner.

**Dr. Berliner** Just kind of an off the wall question. Is the department or the state going to be offering guidance to either individual hospitals or systems about how to deal with kind of immigrant issues?

**Dr. McDonald** It's certainly not an off the wall question. I'm glad you're asking it. What I'm seeing right now is hospitals are offering guidance. I'm looking at whether we need to do that as well. I think one of the things we're struggling with is... You know, health care providers we are not wired up to be in the middle of this. What we're wired up to do is take care of people. You know, when we see people in our practices or hospitals where we are we don't check their immigration status because it doesn't really relate to the health care need there. I think what's happened because of what's going on, the federal government has created a very uncomfortable space for health care workers. What we've been advising as hospitals to have a liaison who deals with this and make sure health care workers know what to do. In other words, a health care worker, you can ask someone for identification to make sure they are a law enforcement person. You can ask to make sure there's a warrant. Really, I think hospitals need to liaison so this can be handled. I certainly hope law enforcement knows you just simply can't take an ill person out of a hospital regardless of who you are. If people are in a hospital, they're generally sick and need health care. I think it's very unfortunate that this federal government chose to head in this direction. I think it's unfortunate with the direction they're heading with many things right now. There's a way to do things that are orderly that have a fair amount of just compassion to it as well. They're going in spaces right now that traditionally the federal government hasn't gone in. To me, this intrusion is quite unwelcome. The department is looking at what kind of guidance we can build. We've seen some hospital systems right now that will be proactive on this, but we would be saying the same thing they've been saying. I think that it's important for us to all be on the same page on this. Thanks for asking.

**Dr. Berliner** Thank you.

**Mr. Kraut** Mr. Robinson.

**Mr. Robinson** Two issues just to ask you to comment on, so I won't put a preamble around them. Could you comment at all on the status of the 1115 waiver and where that is? And also, the Attorney General's announcement with regard to transgender patients.

**Dr. McDonald** I expect the federal government to honor the contracts they signed with us. Just to be really blunt about that. I expect them to honor the word they have with us. The 1115 Amendment it's also called the New York Health Equity Reform 1115

Amendment is slated to go until March 31st, 2027. I expect that to be honored. There's no change right now in that. I don't see any change going on there. I expect that that agreement will stay in place. Regarding the Attorney General, I'm glad she's speaking to where she is speaking. I think right now it's important for hospitals and all of us to get on the same page with this, because what's happening with this Executive Order that I just think was very poorly thought out and mean spirited. Quite frankly, just grounded in medical science or even reason. It's really disproportionately affecting people in New York. There are thousands of people, tens of thousands of people in New York who this is affecting. I think it's inappropriate for any executive to target individuals' health care. It is their health care. I think what's important for health care providers to know is as health care providers, we can't abandon our patients. That's a professional obligation. We just simply can't abandon an individual no matter what is going on out there. I think this is where health care providers are really getting caught in between the federal Executive Order and what's going on at the state level, because there are state laws are just basically say you have to keep doing this. You can't discriminate. What we're hoping for is a court to step in. There's been litigation that's been put forward. There was a preliminary injunction that was asked for. It was a forty-four-page complaint. I looked at it Tuesday night. I find their case to be compelling. You know, I think they're able to find injured parties across the United States from this because I think it was a very poorly thought-out Executive Order. I think they're in lines what we're waiting for is a court to step in. This is why it's so important to have an Attorney General who's got the courage to move forward and a Governor who's very committed to challenging these things that, quite frankly, are just inappropriate. I think all of us look for a government with checks and balances. There's a way to do these things through a legislative process where at least the public can speak to these things and representatives can offer a voice to this thing. It's just concerning to many of us how unilateral this is occurring and how abruptly it's occurring. I think one of the things that this area that you're seeing a lot of Executive Orders, but you're also seeing a lot of temporary restraining orders and injunctions going on as well.

**Mr. Kraut** Dr. Kalkut and I'll go Mr. La Rue, and then Dr. Eisenstein.

**Dr. Kalkut** Thank you, Dr. McDonald, for the report.

**Dr. Kalkut** I have a question also about immigration issues. Have there been federal agents seeking illegal immigrants in health care facilities in the state? Have we had any incidents thus far?

**Dr. McDonald** I haven't seen it yet. It hasn't been reported to me yet. It hasn't gotten wind to me yet, which doesn't mean it's not occurring. It just means it hasn't been reported to me yet.

**Dr. Kalkut** Thank you.

**Mr. Kraut** Mr. La Rue.

**Mr. La Rue** Good morning, Commissioner. Scott La Rue, member of the council. These are more a couple of comments than they really are a question. First of all, I'd like to thank the executive branch for the proposals they put forward around scope of practice, med tax and also the recognition for the necessity of an increase in the Medicaid rate that was included in the budget proposal absolutely needed. I just continue to remind the team that the state legislature passed a staffing mandate for nursing homes, which continues to be unfunded. It's causing severe problems for nursing homes across the entire state. The Medicaid increase that's being proposed is insufficient to cover the requirements of that staffing mandate. I also wanted to mention I do appreciate the commercial that you referenced than that you did, because the number of people that we serve have come forward having seen the commercial, followed up with questions and provided them some comfort in terms of the continuity of their care and what's happening as it relates to the process. Thank you.

**Mr. Kraut** Dr. Eisenstein.

**Dr. Eisenstein** Good morning. Dr. Larry Eisenstein, council member.

**Dr. Eisenstein** Thank you, Dr. McDonald.

**Dr. Eisenstein** Going back to the Medicaid 1115 waiver. We're all hopeful certainly that the three-year window that was promised is kept. We're almost a third of the way through that now. I was just going to ask you if you had a perspective or can give some statewide perspective on the progress being that we are so far along. It seems like in most cases we're still in the very early establishing processes and protocols and the time is going quickly. I just wondered if you had any perspective on that.

**Dr. McDonald** It's actually going well. I think one of the things I want to put forward when I talk about the 1115 waiver, just so people know what that is, is these are when you're doing a waiver, you should ask yourself what am I being waived from, by the way? Because if it's a waiver, what am I being way from, right? Center for Medicaid and Medicare Services after over a year of really intense detailed negotiation with us, came to an agreement that they would allow us to do these demonstration projects and therefore we'd be waived from traditional rules of CMS so we could get money from the federal government with a state contribution to spend it differently. The demonstration projects, though, are designed to actually show return on investment. It's in the Federal Government's best interest for our demonstration projects to be successful. Now, we have established the social care networks, in other words, that the team at the Office of Health Insurance Programs, Amir Busari, Amanda Northrup, Salena Hodges, great work, great people doing great work. We've partnered with these nine social networks throughout New York State. We have \$3.4 billion committed to them. The social care networks are active doing what we said they would do, right? Helping improves individual social determinants of health. That's a great thing. We have partnered, though. Workforce was a big part of our investment. In other words, we have a \$694 million commitment to improving workforce in New York State. We all know we need more health care workers, right? We had these three workforce innovation

organizations throughout the state. When what they're doing is helping people, one, be interested in health care, also helping them get through health care training and get connected to health care jobs and really sorting out what are the issues you need to do to do that. There's also a sizable commitment to do global budgeting. There's a lot going on in the 1115 Amendment. It's a very significant investment that New York has put forward. It's \$7.5 billion in aggregate. The federal government gave us \$6 billion. We put up \$1.5 billion. We have a lot invested in this. It's really important that continue. By the way, there's other things that are important to continue as well. I expect the federal government to honor their word on everything. I signed a contract with them with specific terms and conditions about the Affordable Care Act. Our Affordable Care Act is supposed to run to the December 31st of 2029. I expect them to honor the contract we signed that just another example of like when you make an agreement your yes should be a yes. That's what I'm expecting.

**Mr. Kraut** Any other questions for the Commissioner?

**Mr. Kraut** Well, Commissioner, thank you so much. We appreciate it. Every passing day, I think you're a little busy up there based on what comes out of Washington. Keep up the good fight.

**Dr. McDonald** I have a great team, Jeff. We can handle it. We're doing fine.

**Mr. Kraut** There you go.

**Dr. McDonald** Thank you so much, everybody.

**Mr. Kraut** Well, thank you so much, Commissioner. Thank you again.

**Mr. Kraut** I'm now going to ask Ms. Valerie Deetz to give a report on the activities of the Office of Aging and Long-Term Care.

**Ms. Deetz** Good snowy morning, everybody. I'm Val Deetz. I'm the Deputy Director for the Office of Aging and Long-Term Care. Thanks for having me. The Commissioner is always a tough act to follow, but I'm going to do my best. Just a couple of quick updates. I know everyone has a copy of the report that was submitted Statewide Health Care Transformation Program, the statewide grants. We are responsible within the Office of Aging and Long-Term Care to administer the \$50 million in awards for residential and community-based alternatives to the traditional model of care. Those are applications are under active review. Of course, I'd be remiss if I didn't say that we received many more qualifying submissions with requests totaling far more than what is available. We do look forward to moving those awards forward here in 2025. Next, I want to talk a little bit about the capable program, which is community aging in place, advancing better living for elders. The Office of Aging and Long-Term Care will be funding twenty qualified organizations to implement this state funded initiatives and their communities. This grant opportunity was actually... Is an evidence-based intervention for low-income elders. It was developed by the Johns Hopkins University School of

Nursing. The goal of this is to provide care in the home and allow individuals, the elderly, individuals, to remain in their home. They will receive care from teams of an RN, an occupational therapist and a handyman to help with keeping them safe in their communities and helping them to meet goals that they, with their teams, create to support their independence. We look forward to releasing that RFP in the next several weeks. We did go out with a solicitation of interest just so we could kind of gauge what folks were thinking about. We let that solicitation of interest out in November of 2024. We were so happy to see that we had about forty-four respondents said that they would be interested in applying for that grant funding. As we move forward with that grant funding, we will certainly apprise the council of where we are. Next, I just want to touch a little bit about the Master Plan for Aging, and I know that council has been involved from the very beginnings of the New York State Master Plan for Aging. We do expect that the final report will be issued later this month. That report hopefully will provide a framework for approaching aging with proposals for infrastructural, immediate and long-term actions that can be taken to achieve the vision of the actual master plan. We also anticipate that there will be ongoing processes in which input from the public, including the over 400 stakeholders that were involved in the initial process, it will give them an opportunity to continue to monitor and our implementation of the master plan. I want to publicly thank the individuals and the organizations that devoted numerous hours to this effort, enabling us to have a strong support for this initiative and what we believe to be some very comprehensive and sound proposals for the future and aging. Next, I want to talk a little bit about our Center for Residential Surveillance. This team, led by Heidi Hayes, has been doing an enormous amount of education and training for both nursing home and adult care and assisted living providers. As we move forward through state fiscal year 2026, we will continue those training efforts. We have hosted all of our trainings on our learning management system. As leadership and other physicians' turnover in the residential facilities, new members of their teams will have an opportunity to call down that information, review, and hopefully make some meaningful changes within that organization. We took it a step further. We started to evaluate our education and training. What we have identified is based on some targeted training that's been done by the surveillance groups what we've noticed is a decrease in the number of citations in specific areas. For example, advanced directives. We did train on that a few months back. We took and looked at the next order worth of data. There were no citations. There were no incidents. There were no complaints with respect to advance directives. I call that success. I say, hats off and thank you to our surveillance teams for doing that under the direction of Heidi Hays. Lastly, we are involved in numerous cross-sector quality and education work groups. We have engaged our actual industry partners in that. We collaborate with them to provide consistency and mission focused quality care. We are working on our assisted living facility work which was enacted into budget. The following metrics were enacted into budget late last year. We are looking at food service, overdose prevention, case management, life safety and resident safety issues as well. We're really, really looking forward to working and reporting on our quality initiatives in long term care over the next several months I also was asked Jeff, you had asked me to just briefly touch upon the nursing home CON review process. I do want to bring that up. First, I want to give a big thank you to my team for the outstanding work that they do on CON applications and licensure activities on a daily basis. Our

teams perform those application reviews for nursing homes, for a home care, for hospice, for adult care facilities and for assisted living facilities from across the state. The objectives of the Certificate of Need process are to promote delivery of high-quality health care and ensure that services are aligned with community need. That's first and foremost. We embrace that every day. Every cycle for PHHPC, our Center for Licensure Index reviews of all of those projects that I just referenced, whether they be nursing homes, whether they be homecare agencies, whether they be assisted living providers. They're very thorough and very thoughtful in their reviews to be presented as a recommendation to the PHHPC members. It's imperative for our staff to have a complete application and all of the required information necessary to enable the review units to issue a sound recommendation. Our process includes, but is not limited to the character, competence, financial and legal reviews of these applications that come before us and also the additional step of involving and engage our state Long Term Care Ombudsman Program to opine on quality issues that they may or may not have regarding specific onsite visits that they've made at the facilities. Over the last several months, the department has been presented with some very complicated applications which require the department's in-depth review. Based on governance structures and in general complex organizational presentations this is taking longer. Often, the intensive review leads to additional requests for information from the applicants. It involves collaborating across agency with our partners in different offices. When we review these applications and extends, unfortunately, it has extended the review time necessary to ensure that the proposed operator maintains operational control and that finances are in place to support ongoing nursing home operations. It's important to remember that the intent is to issue licenses to applicants committed to providing high quality care. It's not about the number of applications that are being issued and moving forward. It's imperative that the department continues its thorough review of the information on the application. We have a complete understanding of the governance and operational authority and ensure that ample finances are available to sustain the operations of nursing homes for which so many frail elders call home. Currently, we have about forty-six nursing homes full review projects that are under review of which approximately half have request out to the applicant for additional information. As part of our quality assurance program, the department is initiated outreach to the applicants that to date have failed to provide a response. If we do not receive response, we will consider those applications closed. We are looking at tightening up our processes, making sure that quality controls are in place and will continue to correspond as appropriate with the applicants for nursing home applications. We are hopeful that over the next few cycles excuse me, that you will see more applications on the Public Health and Health Planning Council agenda. I think that's it. Thank you.

**Mr. Kraut** Thank you so much.

**Mr. Kraut** Are there any questions?

**Mr. Kraut** Yes, Dr. Torres.

**Dr. Torres** Good morning. Could you clarify the name? You mentioned the first core grant. Was that the Capable Program? Am I correct?

**Ms. Deetz** Yes, Dr. Torres. Community aging in place, advancing better living for elders.

**Dr. Torres** Thank you so much.

**Mr. Kraut** Any other questions?

**Mr. Kraut** Mr. La Rue.

**Mr. La Rue** Good morning. Scott La Rue, member of the council. I just didn't hear the number that you said. Was it forty-six?

**Mr. Kraut** Well, forty-six were pending and about half of those are missing information.

**Ms. Deetz** Correct. Yes, a little less than half are missing information and need additional clarifying information. Forty-six is our number.

**Mr. La Rue** Thank you very much.

**Mr. Kraut** You know, with respect to those. First of all, I appreciate the information, and I know Mr. Holt who posed also the question last time. Hopefully, maybe he'll be viewing, or he'll review it. I think you've thoroughly answered the questions that were posed. Obviously, we don't want applications coming here that are not fully complete, particularly on character and competence. The star ratings are frozen. I think they're still frozen. Who knows what's posted or not posted any more. We rely on that to look at the past record of potential applicants. I would just hope the group that is doing that character and competence review are diving deep into here to be able to ask the questions when it comes in front of us because that's a particular focus. I just have a question. In a previous conversation, we discussed the revision of the need methodologies for CHAAs and particularly hospices. Could you give us an update when we will see those changes come to the council?

**Ms. Deetz** I don't know if I can give you a date certain there, Jeff, but I can tell you that our staff from the new Center for Hospice and Palliative Care are working diligently on perfecting that hospice need methodology. Hopefully, we'll see something over the next couple of cycles.

**Mr. Kraut** This has been a problem. I mean, end of life issues, the restriction on hospice care. It's really being a challenge. We're getting... At least I'm getting questions from the industry about where this is at. I just don't understand why it would take a couple of cycles to revise a need methodology that we've been discussing for over a year. I would suggest that we'd like to see that come back to us the next cycle. If it can't, a reason why it can't come back to us. As we said at the educational retreat, we're going to take a more active role in setting some of the agenda of the issues that come before us. That's

one of them as well. I would just ask that if it's not coming to us at the next cycle to give us an explanation of what it's taking and what are the issues that prevent it from doing so.

**Ms. Deetz** Thank you.

**Mr. Kraut** Ms. Mazzucco.

**Ms. Mazzucco** Hi. First of all, on the topic of hospice, I just want to give a shout out for the proposed additional hospice funding in the state's proposed budget that's needed by the existing hospice in order to provide education. Because we remain one of or the lowest states in the country in the utilization of hospice. It is definitely an education issue. I was wondering if at a future meeting, if we might be able to receive data about closure plans pending by type of provider, sorted by region of the state as well as perhaps maybe a one or two year look back at what some of those trends have been in terms of closures.

**Mr. Kraut** Specific to long term care or just all that all license---

**Ms. Mazzucco** Certified home health agencies, hospices, skilled nursing facilities.

**Mr. Kraut** Okay.

**Ms. Deetz** Thank you, Michelle. Well, I'll take that back and pull some information together.

**Ms. Mazzucco** Thank you, Val.

**Mr. Kraut** Dr. Rugge and then Mr. La Rue.

**Dr. Rugge** John Rugge, member of the council. Thanks for this presentation. It is quite the continuum of care being offered for the aging population. One of those new initiatives is the renewed development of PACE programs. I wonder how is a policy that's being regarded or supported? I have a question after that too.

**Ms. Deetz** I didn't hear.

**Mr. Kraut** Do you want us to repeat it?

**Ms. Deetz** Dr. Rugge, I think you're asking me about the new case regulations under 29 EE.

**Dr. Rugge** Yes, and how you may or may not be supporting the development of those PACE programs as one part of the continuum of care being now offered.



**Ms. Deetz** I think maybe in our next report we will definitely articulate on that. I will let you know that the assessment of public comment is just under its final stages of review. The team is working across the agency. This is just not a novice of aging and long-term care. There's also the managed care component to this. We're working very closely with our partners in the Office of Health Insurance Programs. Really move forward on this program and hopefully be able to expand PACE organizations in New York State. We recently just approved a PACE, first one in ten years. We're very happy about that. We'll continue. I'm glad that you're interested in that, and I'd be happy to report on that in future meetings.

**Dr. Rugge** Just one more question. Given the complexity of opportunities, is there any compendium or guidebook available to consumers in choosing for themselves or for family members what would be best for them?

**Ms. Deetz** In choosing services for a family member?

**Dr. Rugge** Yeah, choosing where to go for the right services and the right level of service when now so many opportunities are being developed.

**Ms. Deetz** I'm not aware of any newer additions of any compendiums. There was one that was released in 2021, a caregiver guide that we distributed over 400 copies of that compendium.

**Dr. Rugge** I would only---

**Ms. Deetz** That's something that we can take back and consider.

**Dr. Rugge** I would just suggest that might be helpful in this day and age with emphasis on age.

**Dr. Rugge** Thank you.

**Ms. Deetz** Thank you.

**Mr. La Rue** Good morning again. I just want to jump back to hospice for a second. I don't know whether it's the case or not, but it's possible this whole hospice CON review is somewhat being delayed because of the debate around allowing for profit hospice into the state or not, which, of course I think would be a mistake given the history that for profit hospice has across this country. If that is the case, and again, I don't know that it is, perhaps that particular issue could be kicked down the road and we could move forward under the current nonprofit rules but modified the CONs. I certainly know there are a number of hospice providers existing that are looking for opportunities to expand. As the health care environment has evolved with palliative care and expanded services, both as it relates to palliative care and end of life care, I don't think there's ever been a greater need for an expansion of our hospice services here in the state. Those are just my comments. Thank you.

**Ms. Deetz** Thanks, Scott.

**Mr. Kraut** Go ahead.

**Ms. Deetz** No, that's okay.

**Ms. Deetz** I just want to address what Scott just said. One of our big accomplishments over the past year was standing up the Center for Hospice and Palliative Care. The team is out. They are visiting different hospice agencies and residences across the state. One of the long-term, longer-term objectives which we'll continue throughout this year and into future years is providing education and training on end-of-life care. And I say end of life care, because not everyone will like the hospice benefit, and some will want to move to palliative care. Thanks, Scott. I appreciate that.

**Mr. Kraut** I guess that's why the focus is on that need methodology for the existing providers. They are poised to enter new areas to continue that would automatically create more people providing education when as was just mentioned, we have among the lowest utilization of hospice, end of life, the people that are in the last two months of life spending in the ICU. This just seems that we are falling behind. We have the opportunity to maybe change the direction of that trend. We can't do so if we're not permitting the current level of providers to essentially innovate and expand into different market areas of the moratorium that we have on this justifies good health policy. It relates to the Commissioner's statement about affordability. So much of the cost of have the \$5 trillion we spend is in the last two years of life. It just would seem that there would be some sort of urgency to move this forward. That's all I would say.

**Ms. Deetz** Thank you.

**Ms. Mazzucco** Just following your statement and Dr. Rugge's just throwing an idea out along those same lines regarding PACE. That if there was a more fast-tracked process for existing PACE plans to open new centers on a fast-track basis, that might be a way to bring that model to more patients and families. It gets at the same affordability issue that you mentioned because the co-pay burden that people are paying for. All of these fragmented services are addressed in the PACE model.

**Mr. Kraut** Well, this is all under the umbrella of what we started the Codes Committee about, and we'll talk a little later is about reforming the health code. That there's these many, many opportunities. We're picking a few here. There is a theme here. I think the Commissioner has committed to identifying those areas. Any suggestions that members have and or the public has, we want to encourage them so they can be considered, and we can get them in a more organized framework to pursue and create a holistic agenda on this matter.

**Mr. Robinson** I think there is another theme that at least some members of the council are expressing, which is a general concern about the issue of moving more of health

care in New York to the for-profit sector. I think at least some of us want to express some concern about that. It's certainly because hospice is at the forefront at the moment in terms of what we're looking at that's where the focus is. I think there's a broader based issue around for-profit health care in the state and our ability to preserve our not-for-profit model which distinguishes New York and benefits New Yorkers.

**Mr. Kraut** Mr. La Rue.

**Mr. La Rue** I'm sorry. I just feel compelled to make one more comment. I don't think it's ever in the best interest of the people we serve when an organization's primary objective is improving the wealth of their shareholders versus a nonprofit whose mission is to serve the community and the people of New York and reinvest in those services.

**Mr. Kraut** Well, when those regs come to us, you'll have the ability to express that point of view if it's not codified in there. I think there's a general consensus in many areas. There may be different points of view in other areas where we need capital investment and we're not willing or unable to make that investment. It'll be situationally specific. I'm going to now introduce Ms. Akanbi to give us an update on the Health Equity Impact Assessments. I just want to say as an introduction here, thank you for coming. This is coming out of a discussion that we've had as we've considered different projects with the HEIA requirements questioning why they are included, and the office conducted, as you know, a kind of a listening tour of applicants and the independent assessors. We've asked them to come and kind of give us first impressions. I just want to modify expectations here. You know, I'm not sure if they're up to recommendations here, but they just want to share what current thinking and some feedback. You'd have the opportunity to add your voice and perspective to this.

**Ms. Akanbi** Thank you.

**Ms. Akanbi** Good morning. My name is Toni Akanbi. I'm the Director of the Health Equity Impact Assessment Unit within the Office of Health Equity and Human Rights. I'm joined today on Zoom by Mary McCormick, who is the Executive Operations Manager within the office. We're both happy to be here. This morning I'll be providing a brief update on the first year of implementation and how that went for the Health Equity Impact Assessment, commonly known as the HEIA. I'll be sharing a review of programmatic data and successes. We'll share the results of our engagements with our independent entities and health care facilities. I'll also touch on the guidance distributed last year to our stakeholders related to protected health information and the HEIA. Since the law went into effect, the HEIA Unit has been very busy reviewing and analyzing HEIA's, meeting with stakeholders and developing guidance. We will soon be releasing our first annual progress report. This report will provide a comprehensive overview of the first year of the year requirement and will include data, findings, trends and recommendations.

**Ms. Akanbi** Next slide, please.

**Ms. Akanbi** Since the start of the program, the HEIA Unit has accomplished several activities, many of which are listed on the slide. Notably, the unit has been working hard to engage with a variety of stakeholders and has conducted five webinars, two listening sessions and several other presentations. My team has also established a dedicated email mailbox for questions and an email listserv for announcements or updates for guidance documents. I'll finally add that we have reached out to our local health departments last Spring to create a main contact list for the year. This was done to help streamline communications between them and independent entities and also to encourage more engagement with public health experts at the local level.

**Ms. Akanbi** Next slide, please.

**Ms. Akanbi** Let's take a look at a summary of important data points. The reporting period for this data is from June 22nd, 2023, through September 30th, 2024. Starting on the left side of the slide, this chart breaks down the number of HEIAs that were reviewed by the department by facility type. A total of thirty-eight HEIAs were reviewed by the department within the reporting period, nine of which were for full reviews, fifteen were administrative reviews, and fourteen were limited. Moving to the right side of the slide, a majority of submitted HEIAs or for expansion of beds or services and change in location projects. Less than a quarter of projects were for the elimination of services or reduction of beds, services or hours. At the bottom of the slide, you can see the average cost for an HEIA by review type. As expected, for reviews come out on top at \$38,950 and administrative and limited reviews cost a bit less.

**Ms. Akanbi** Next slide, please.

**Ms. Akanbi** This slide shows the distribution of thirty-eight projects across the state of New York. As you can see, slightly more than half of the projects were located downstate, including in New York City, Westchester and Rockland counties in Long Island. Eighteen of the projects were located Upstate, and several of those projects were based in rural communities.

**Ms. Akanbi** Next slide, please.

**Ms. Akanbi** Within the reporting period, we worked with sixteen different independent entities who mostly were individual consultants or consultant groups. As a refresher, an objective independent entity must be hired by the applicant to complete the HEIA using an evidence based five step approach. This entity is tasked with determining demographic information within the service area and identifying unintended health equity impacts on medically underserved groups. Importantly, they must meaningfully engage with the community and receive feedback about proposed facility projects. During the reporting period, the average amount of time it took for independent entities to start and finish an entity is illustrated on the right part of the slide. They report that much of this time is spent waiting for stakeholder feedback as part of the meaningful engagement requirement. What we've seen is that as an independent entity conducts more HEIAs and becomes more familiar with the process, this completion time has

been going down. When it comes to the approval of these independent entities, applicants are required to submit a conflict-of-interest form alongside the other HEIA documents. This conflict-of-interest form must be completed in full and signed by the independent entity. Independent entities must possess a baseline level of expertise and have no conflict of interest as outlined in the form. So far we've been able to accept independent entities based on these factors.

**Ms. Akanbi** I'm going to briefly mention what is required for the HEIA and we'll talk about our internal review process. The HEIA has different sections with the first section capturing project information and a summary of HEIA findings. The second section is the assessment itself, which includes scoping of demographic information, health equity impacts, a section to meaningfully engage with the community and develop mitigation and monitoring plans. The last part of the HEIA, the health care facility is required to attest to having reviewed the HEIA and must then share the HEIA documents publicly on their website. In terms of the internal review process, my team will review and evaluate an HEIA based on the validity, strength and value of the information presented. Similar to the other review units within the department, the team reviews submitted assessments concurrently with other parts of the CON application. In these early days, we've seen the need to simplify the communication process. You know that back and forth with the applicants and the independent entities in order for them to clearly understand what needs to be revised in an HEIA. So much like the other review units, we use a request for additional information form letter to communicate. We also do phone and video calls if further support is needed. Once all of the request for additional information letter are addressed, my team finishes the review of the HEIA and submits a final recommendation. During the reporting period for those thirty-eight HEIAs all thirty-eight were approved. To better ensure confidentiality of protected health information in the HEIAs, the team did release two updates last year in our Frequently Asked Questions Guidance Document. In June, we developed an identifier system for the meaningful engagement process. This system requires that the independent entities use identifiers and place of names when interviewing community members unless the contributing stakeholder explicitly requests that their name be disclosed. They also are responsible for informing the stakeholders that any direct quotes or statements may be posted publicly as part of the HEIA and that their names may be requested by the department. In December, we shared further guidance that any of the field notes or records created and maintained by the independent entity are subject to a FOIL request when these records are received by the department. All of this information was shared through our listserv and posted on our website.

**Ms. Akanbi** Excuse me.

**Ms. Akanbi** Let's shift gears and discuss some of the feedback that we've been hearing from our key partners. The unit has been a very intentional in creating opportunities to listen and better understand challenges and insights related to the HEIA process. So, for example, the team convened independent entities in July for two listening sessions. They also disseminated a voluntary survey for the Article 28 facilities in August. We also have been documenting feedback that's been shared during individual meetings with

these same partners. So far, health care facilities have reported challenges in finding independent entities, particularly ones that are reasonably priced. With regards to accountability and mitigation, independent entities have seen that some facilities are not meaningfully considering community concerns and would like to see accountability measures added to the requirement to ensure that mitigation strategies are implemented. We also do recognize that some applicants see these mitigation strategies as financially unfeasible at times.

**Ms. Akanbi** Next slide.

**Ms. Akanbi** Insights into the meaningful engagement component really center around the challenges with building relationships and gaining trust in the community. There is a general lack of understanding when it comes to the types of services offered by local health care facilities and the lack of awareness of current or upcoming facility projects. Most successful engagements occur when the health care facility can facilitate soft introductions with existing partners such as with local community organizations or advisory councils. While there is some concern for feedback fatigue among stakeholders that are repeatedly engaged, overall, the community has really appreciated the outreach conducted to get their feedback on facility projects. Finally, feedback on the overall process. For some of the health care facilities they would like to see changes to the requirements, specifically to reduce the number of expansion or change in location projects that have to do in HEIA. They would also like to take away the requirement to collect stakeholder feedback for smaller projects. Most of these health care facilities are looking for additional training and resources to better understand what to expect before, during and after an HEIA is conducted. And then on the other side, for many of the independent entities, they would like to regularly meet with the department and each other to share ideas and best practices. I just wanted to share a couple of success stories that we've seen in this first year and a half. I think these illustrate how the tool could be used for facility projects. The first one is just in Downstate New York. We saw one case where stakeholders were interviewed for the meaningful engagement component. They had significant feedback about a hospital expansion project. In response to findings from the HEIA and this community engagement, the health care facility decided to develop a mitigation plan to address their concerns about accessing building entrances, parking traffic, etc. The plan that they implemented included constructing a replacement parking lot with larger capacity. They made sure that the entrances were accessible. They basically addressed all of their concerns about parking and traffic. Another example, a facility in a large city proposed to close their rehabilitation unit and convert all sixteen of their beds to medical surgical beds. The independent entity engaged with over 400 stakeholders, with only 4% expressing support for the project. Their primary concern centered around reduced access to services, diminished quality of care, potential transportation challenges as well as perceived adverse health outcomes. Due to the strong opposition from the community, the independent entity worked with the facility to revise the project. Instead of eliminating all sixteen rehab beds, they decided to only convert eleven to med bed search beds, maintaining five beds, five rehab beds and their rehabilitation gym. These are just two examples of many to show how the tool has the potential to provide that on

the ground insight into what are some of the challenges communities are facing. Health care facilities have this opportunity to listen to concerns shared in the HEIA and consider making informed changes to their project plans. With that, thank you so much for this opportunity to provide this update to the committee. We do welcome any questions.

**Mr. Kraut** As you get your questions, we have members of the council that are watching that because of the weather weren't able. They're texting in questions. I'm going to start with those and then I'll go around the table. This is coming from Ms. Monroe. Just to clarify, for information as part of the HEIA, what's the expectation in collecting stakeholder input; public meetings, surveys, one on one? There are three questions. Let me ask them and go ahead. I don't want to just throw them all out at the same time.

**Ms. Akanbi** In terms of meaningful engagement, the expectation is that the independent entity will meet with a variety of stakeholders, and this meaningful engagement has to be commensurate to the size, scope and complexity of the CON project.

**Mr. Kraut** There's no one size fits all. It's dependent on the parameters. She acknowledges the successes. Depending on where you're sitting, you see a success. She said there's obviously been problems. What are the major problems that you believe have to be addressed with the HEIA process?

**Ms. Akanbi** I think that's a great question. I mean, one of the issues that comes to mind is just getting used to the HEIA. You know, this program has been around for a year and a half and independent entities. I mean, I think we have maybe one or two independent entities who've done more than like five or more HEIAs. The rest have done one, two, three HEIAs. What we've seen is that as they do more and more, they get better at it. I think part of the like one of the major challenges right now is just kind of this run up period of getting used to conducting these.

**Mr. Kraut** Her last question for the moment is... These are good questions. She noted that you mentioned the length of time it takes for it to be completed. It's somewhere in the little north of seventy days. Does that affect the department's review cycle and timing? You don't even look at the application until the HEIA has been completed and submitted. There are no interim conversations. How does the delay? Is it adding seventy-five more days to preparing applications? How quickly do you guys review it once you get it?

**Ms. Akanbi** I'm not sure if I have the data to answer that first part of the question. That might be a question for the Certificate of Need team. The independent entity doesn't have to start doing the HEIA after the Certificate of Need is done. They can actually start it while the Certificate of Need is being completed. As far as I know, there hasn't been too much change in time. Again, I would defer to the Certificate of Need team for that.

**Mr. Kraut** Got it.

**Ms. Glock** Hi. Thank you for the question. Because the CON... The requirement is that the CON is submitted with the Health Equity Impact Assessment. They come in together at submission. The CON is not considered complete without the submission of the Health Equity Impact Assessment. Because the Office of Health Equity and Human Rights begins to review that concurrently while the other reviews are going on, we have not seen any noticeable delay in the processing time with the CON waiting for those Health Equity Impact Assessment Reviews. I think that the Office of Health Equity, Human Rights has done a fantastic job at reviewing those timely.

**Mr. Kraut** Thank you.

**Mr. Kraut** I'm going to go to Dr. Kalkut and Dr. Eisenstein, then Dr. Berliner.

**Dr. Kalkut** Thank you very much for the report.

**Dr. Kalkut** I'm Gary Kalkut, member of the council. I also appreciate what the effort you've gone through to get feedback. I'm going to provide a little feedback also. The first thing I wanted to ask about, and you had it in one of the slides about how do you build trust in the community? One of the things that we found was early on our independent assessor was in the interaction with stakeholders saying your name would not be released. If you provide some statement now there's a way that---

**Mr. Kraut** Your mic is not on.

**Mr. Kraut** Thank you.

**Dr. Kalkut** A verbatim statement if we can be shared, the name could be shared if they consent to that. Apparently what was clarified, I think it was clarified in the FAQs that the state, DOH can request the names of people who were associated with identifiers. I guess my question is, why is that necessary? It's not part of the law. It inhibits true feedback to provide names because these are patients of all sorts. Why would they do that? I think part of the problem with feedback and perhaps repetitive inquiries to groups that are willing to provide this and take the risk of having their names identified, but I think it chills the interaction. I think it doesn't get truly objective information. I'm just not sure why that's necessary. There's another part to this which you've addressed, which is about FOIL requests. Could you answer the first one first. Why collect names?

**Ms. Akanbi** Just to provide some context, independent entities need to maintain a record of names as part of the identifier system used for community engagement. These identifiers must be used in place of names unless a contributing stakeholder wants their name to be shared publicly. We implemented that identifier system back in June basically as a response to the feedback from our independent entities that publicly posting names wasn't a great way to maintain confidentiality and also encourage stakeholders to provide feedback. That identifier system, again, went into place back in



June. Similar to the other sections of the HEIA, the department does reserve the right to request further documentation to clarify details presented in the submission. It could be this list of names. It could be we need to see this document or that document in order to better clarify the details in the HEIA. That's why the list of names is included, because it's part of the identifier system itself. I think it's important for the committee to know that. So far we haven't actually requested a list of stakeholder names from any submitted HEIA.

**Mr. Kraut** It doesn't make sense. We're going to look at what the state is doing to protect the names and identities of people dealing with reproductive health issues. Let's say we have an HEIA on reproductive health. You're actually undermining what the state is doing. People are very concerned now. Notwithstanding the confidentiality that you keep, we know from all the cybersecurity risks here, you can't guarantee that. Either you trust the independent entity to do the work they're doing, or you don't trust it. This is a major, major issue that is coming up in almost every discussion about people. The issue, Dr. Kalkut said. You've never asked for it. Why not? I mean, that means you're not trusting the independent entity. If you're not trusting the independent entity. There's a different issue here. I mean, this is really an issue that has to be addressed.

**Ms. Akanbi** Thanks, Jeff.

**Dr. Kalkut** I had another question.

**Ms. Akanbi** We don't have a reply but thank you.

**Dr. Kalkut** You know, we've had to stop telling the stakeholders that we cannot protect, can't assure them that their names will not be shared, particularly, as you point out, in the FAQs. Anything in the possession of the department can be foiled. You address someone who the issue of foiling and said you would do your best to redact names in there. That was from, I think, one of the either listening tour or a phone call with members of the department. There apparently is no written policy on that about how you can protect the names of stakeholders who are subject if you request to a FOIL that would make their names public.

**Mr. Kraut** I think they've heard the issue.

**Dr. Kalkut** Is there a policy?

**Mr. Kraut** Is there a policy? I think what we're asking to do is to take our feedback under consideration here, because I know we're not going to particularly answer it right here in the room.

**Dr. Eisenstein** Larry Eisenstein, council member.

**Dr. Eisenstein** I wanted to ask about on Page 3 of your presentation, the cost. Are those numbers just the cost that was given to the independent entity on average?

**Ms. Akanbi** Yes, that's the average cost of contracting with an independent entity.

**Dr. Eisenstein** I'd like to add that it's significantly more expensive to do this than just what we paid to the independent entity. Those costs get lost. As a Health Equity Practitioner, so to speak, practicing health equity, which we're not going to get into a whole discussion of definitions, but it's expensive and underfunded and we're trying to serve the most vulnerable and the costs to do this to show that we're successfully doing that makes it even more difficult financially to achieve that work. Having been part of them, I know what we've paid our independent entities, and I know all the other costs that go into it. Even something like as simple as if somebody is having a public forum, they might need to rent the space. That's not accounted for. I think somewhere this becomes a significant unfunded mandate as we try and serve the most vulnerable. Maybe a thought is maybe the money that providers spend proving that they're doing the work can be returned to them in some form of grant to serve the most vulnerable or a model like that. I think the costs, the manpower is understated here. I'm not opposed conceptually, but it's a lot. The requirement is a lot. At a time when more than half the hospitals in the state are losing money and half the providers are losing money. To try and do the right thing and be charged a lot of money to show that you're trying to do the right thing, I think maybe there's a better way to have that money spent.

**Mr. Kraut** Mr. La Rue and then Dr. Berliner and then Mr. Thomas.

**Mr. La Rue** Good morning. Scott La Rue. The previous speaker just mentioned some of the comments I want to make. I don't remember the name of the council member that was here that's no longer on that used to every single time bring up the discussion of cost. He's not here anymore.

**Mr. Kraut** Dr. Bennett.

**Mr. La Rue** I hope that doesn't project my future with the council.

**All** (Laughing)

**Mr. La Rue** Because here I go again.

**All** (Laughing)

**Mr. La Rue** I don't think a regulation has ever come to the Public Health Council where in that section they talk about the proposed costs of the regulation. I think every single time it says de minimis or nonexistent. I don't know whether we're talking about the cybersecurity, compliance or the Health Equity Assessment. All of these things over the last ten years have added significantly to the cost of operating our programs. It is not the minimums when your rates are so inadequate and now you're asking a nonprofit to go out and spend money that's not reimbursed or paid for. It's just adding to the problem. I am not commenting on the worthiness of the effort. It seems we have a

pattern in New York of passing legislation and passing regulations that sounds good and has good purpose and intent, but it is never funded, and it just compounds the problems that we're facing every single day in trying to maintain the services we're providing to the people we serve.

**Mr. Kraut** Understand. I think in order to seek redress, it's somewhere out of this room. It requires organized efforts to engage with the legislative process to address it. One of the ways that I've heard suggested that the full cost of conducting the HEIA is to deduct against the CON fees that is required. That you get a credit for incorporating the costs against that is another way to come at it, and that's another way at least to try to recover. It's not in the purview, I think, of the department necessarily or maybe in the purview of the department, but I suspect it's legislative and not regulatory. Your point is well taken, and it needs organization outside of outside of here.

**Mr. Kraut** Dr. Berliner.

**Dr. Berliner** Thank you for the presentation.

**Dr. Berliner** I have a couple of questions, though. How does someone become an independent entity? I don't mean like get a divorce or something like that, but for the purposes of this discussion.

**All** (Laughing)

**Mr. Kraut** That's funny.

**Ms. Akanbi** Someone becomes an independent entity on their own accord. We have baseline requirements in our regulation, so they have to have stakeholder and community engagement expertise and experience, health equity and anti-racism expertise and experience. Before they contract with the health care facility, they have to fill out that conflict of interest form.

**Dr. Berliner** Are they vetted by your department, or they just taken by the say, I'm an independent entity and go to that provider and say choose me?

**Ms. Akanbi** I mean, I think it'd be helpful to hear some context first. When the law was implemented, the parameters of independent entity were broadly stated. Broadly stated but provided enough specificity to ensure that the independent entities possessed that baseline level of expertise and had no conflict of interest as required by law. Again, they have to have that baseline level that I mentioned before. As part of the process, health care facilities have to submit that conflict of interest form alongside the other HEIA documentation, and that form has to be reviewed by the applicant and the independent entity for a signature. That's basically the context of how this process started for the independent entities.

**Dr. Berliner** If I'm a provider and I want to do a project and I have to go through this process, if I call you up, do you provide me with a list of potential people to do this? Do I have to find someone myself? Do the two things happen at the same time? You don't provide a pre vetting of whether I could provide this service?

**Ms. Akanbi** That's a great question. This was something that was shared with the committee back in 2023. The department decided not to provide a pre-approved list of independent entities at that time because it was a brand-new law. The department didn't want to unintentionally take away certain entities that could potentially do this job. They left it again, broadly stated yet with these baseline qualifications.

**Dr. Berliner** I'm pursuing this for a reason that we'll get to in a few minutes. I watched Legally Blonde last night. Supposing I wanted to be an independent entity. I think I'm qualified. Five/ten, dark piercing eyes, swift, catlike movements, gold flecks dance in my eyes, filthy rich, devilishly handsome and built like an Adonis only better. Plus, I've been a medical school Professor and Department Chair. I've written many books and articles on health equity and things like that. What you're saying is that I don't get independently vetted as long as Scott is willing to accept my incredibly low fee. I say this to everyone out there. Not expensive. That's okay with you. This is what you call networking. I mean, at some point, you don't come back and say to Scott, "No, he doesn't qualify." Do you just say, "Yeah, if it's okay with you, it's okay with me."

**Johanne E. Morne** Hi, everyone. This is Johanne E. Morne, if I could respond. Thank you for allowing me to jump in. I am the Executive Deputy Commissioner here at the department. I appreciate the candid description that you've provided. What I will say in response to the question, though, is, as my colleague has indicated, there are specific criteria as to who can be that the independent reviewer or contractor. If a contractor is selected by a hospital facility, they meet the criteria and they're able to rightfully so indicate no conflict of interest, then the facility has the opportunity to work with that vendor. It was an intentional decision when the Health Equity Impact Assessment legislation was first put through, that the state would not take on the review or the selection of candidates. Certainly, as we continue to move forward in the advancement of the Health Equity Impact Assessment and continue to learn, perhaps there's a space for conversation for future, but that was an intentional decision that was made at the time in an effort to allow facilities to have broad opportunity to work with facilities that they had identified and seemed in the best interest of the process.

**Dr. Berliner** Thank you for that answer. But as you're probably aware, where I'm driving is I'm a member of PHHPC. Do I have an innate conflict of interest?

**Mr. Kraut** I would say you do.

**Dr. Berliner** I would be recused from any discussion or vote on a project that I was involved in, assuming I declared it.

**Mr. Kraut** You'd be because of the ethical guidelines for PHHPC. You can't appear or do any work on behalf of any client in front of us.

**Dr. Berliner** If a hospital council has a subunit that does this kind of work, why don't they have an automatic conflict of interest as I would have?

**Johanne E. Morne** If there's a specific case in which there is an issue or a concern, certainly we would be open to that to hearing about that. However, based on the criteria and the review process that we have in place, I'm not aware of any particular cases at this time.

**Johanne E. Morne** I would ask if you had anything to add.

**Ms. Ngwashi** Sure.

**Ms. Ngwashi** Thank you.

**Ms. Ngwashi** My name is Marthe Ngwashi. I'm counsel at the Department of Health and counsel to the Public Health and Health Planning Council. I think we do understand what you're saying as it relates to conflicts of interest. I think that we'll take the information that you have said back, and we will look at that in relation to the regulations surrounding the independent entities. But just so that you know, when the Health Equity Impact Assessment reports come in, they do look at who did it, but it is under the applicant's obligation and it's their due diligence where they have to make an assessment and determine that this is an appropriate independent entity that is providing information for us on behalf of them for the CON project. That being said, we can take all the information that you are bringing up as it relates to what the department does to make its own assessment, but right now that's not happening. We can look at that in the context of regulations as it relates to the independent entities.

**Dr. Berliner** I mean, thank you for that. There are... You know, in especially for a new process which is just started, and which is trying to establish a foothold, I mean, a certain degree of public optics. When a hospital project uses a subunit of a hospital council, it just looks so wrong. I would wonder and I do wonder. I'm a public member of the council. How could this possibly be approved? I'm not saying anything about the applicant. I'm not saying anything about the organization that's doing this. I'm not saying anything about the individual people who are doing this. They may be great. Everything may be great. It just looks wrong. I mean, that's the part that's really been bothering me for the last couple. Again, I want to thank the advocates who brought this at least to my attention. I just read independent, and I was satisfied. I never went back to look at who the independent entity was. Had I done that, I would have just been... Are you kidding me? What I would recommend is if the unit would actually kind of look at this with a sense of this doesn't quite sound so kosher to me. Maybe we should ask the applicant to find someone else. I mean, find a way for that particular group of people to not have that direct conflict of interest by working for an organization that does have a conflict of interest.

**Ms. Ngwashi** We'll absolutely take that information under consideration. I would also like to add that as a counsel, you also have a role to play as it relates to Health Equity Impact Assessment reports and also the fourth of the Certificate of Need application. When you see information in there, you have an opportunity either at the committee meeting or here at full council to further discuss some of those things and make a determination.

**Dr. Berliner** That's correct and that's something that we try to do. The reality is it is not fair to the applicant. You know, at the time when the application is being discussed to say, "Wait a minute. We're not happy with the independent entity that you chose." I mean, it has nothing to do with the application assuming everything else is fine. It's just the wrong time to do it. What I'm suggesting is that the department has to take a greater role in looking at this stuff before it comes to us, because it's inappropriate for us to do it at that time.

**Ms. Ngwashi** The other thing that I want to make sure we are clear about here is the department acts within its authority, which is prescribed by law and regulation. We cannot do something that is going to exceed what ability we already have. Understood everything that you said, and we'll take it into consideration. As I mentioned, we'll look at it in the context of regulations.

**Mr. Kraut** We'll have more conversation on this.

**Mr. Kraut** Mr. Thomas, then Dr. Kalkut.

**Mr. Kraut** I'm sorry. Mr. Thomas, then Mr. Lawrence, then Dr. Kalkut.

**Mr. Thomas** Good morning. Hugh Thomas, member of the council. Just a sort of a follow-on Ann Monroe's comment at the beginning, my colleagues. To me, this whole conversation talks about one slide on your document, which was successes. You did thirty-eight. You've chosen to present three successes. I would encourage you; this is more of a comment than a question. I would encourage you to really think long and hard about the outcomes from this process because this conversation, because of cost, because of conflicts is going to be driven by data. I appreciate the three Ann suggested where the problems are. You've talked about some of those this morning. The successes are just as important because in the end what may be extraordinarily well-meaning legislation is not having the intended effect. This is new. You're fourteen months in. I get it. I would encourage you to focus on that specifically and be willing to defend the successes to this group and to a larger audience.

**Mr. Kraut** Thank you.

**Mr. Lawrence** Mr. Thomas, you stole much of what I was going to say. I think it's really important. Harvey Lawrence, member of the council. I think it's important to have measures of success. I would say for me, one of the most important would be the

potential impact on reducing health disparities. Really having the data to show and indicate how this process is helping to reduce health disparities, not only improve health equity. With regard to costs, having been at a FQHC any unfunded mandate is an incredible burden. I was looking at the \$38,000 costs and saying to myself, is that average? Is that on a project of \$1 million project or is it on \$150 million project? The scale makes a difference. Because in fact, if it's on \$150 million project and that's probably maybe close to rounding error on that project when you look at all of the costs. It depends on the entity, the size of the entity. There are some entities that could absorb \$38,000 and write it off as just a rounding error. There are others that are suffering. I think it's important to have a progressive system in which those that can afford to pay more, maybe contribute more, and maybe that contribution could be allowed to offset others that are burdened by that \$38,000, that average cost of \$38,000 for this process. I think we all appreciate the value involved here in terms of health equity and improving the health outcomes of New Yorkers across all across the entire state, especially those that are most vulnerable. I think in terms of the cost, it's important that we look at it. I was also reflecting that when you undertake a development project or an expansion, there are some things that are embedded. I mean, we can complain about the environmental impact statements having to complete those, but that's a given. You factor that into your budget when you're about to take on a project. Maybe this is something that I think was mentioned that maybe additional grants could be made available for those that would struggle with this process. I think it's an important process for the state, and I echo Mr. Thomas's point that it's so important that we must have data that supports that is making a difference. If it's not, then we need to be able to tweak it.

**Mr. Kraut** Dr. Kalkut.

**Dr. Kalkut** One more question. I noted in your slide show that 21% of the HEIAs were related to a relocation. I think there are relocations that my organization has had HEIAs done for. Three of them were a move of 300ft or 178ft. The address was different, but it was across the street. The public transportation is the same. There was no reduction in services. In fact, there was enhancement of services. Certainly, the feedback from stakeholders was very positive because it was consolidating things. I'd asked you to consider when it comes to relocations, if there's a meaningful distance change. Again, you can probably reduce your costs if things have a low chance of actually demonstrating a problem with or disparity in worsening. The successes may go up in terms of how you spend your time. Again, a consideration for now. I really think we all are very grateful for you to come here and present answer questions as you have and do something that, as just said, we all support. We just want a year in see if we can make it more. I was going to say more better, but I won't.

**Mr. Kraut** Issues that come up from time to time.

**Mr. Kraut** I just have the last question from Ms. Monroe. Is there any discussion of applying the HEIA requirements to hospice and to Article 36, Article 40, you know, other because it's covered by hospitals, nursing homes, DNTCs.

**Ms. Akanbi** I'm not familiar with that. I haven't heard anything about that as of this point.

**Mr. Kraut** With that, on behalf of the council, thank you so much. You did great job. We really appreciated the work that went into the slides and the prep for this. Just did wonderful. Thank you. This is just another stop on the listening tour. We thank you and thank the staff for the work they've done. It could have been rolled out with a lot more problems. I think we're just thankful for how smooth it's gone, and all the work you guys have done. Thank you so much for coming to it.

**Mr. Kraut** I am now going to turn to Dr. Rugge, who will give a report on the Committee on Health Planning.

**Dr. Rugge** Thank you very much.

**Dr. Rugge** Can people hear me? My voice gets a little foggy.

**Dr. Rugge** I'll try. I don't want to shout, though.

**Dr. Rugge** I hope everyone here in the room, certainly everyone at the table recalls that our last council meeting there was approval of a new and revised charge for the Planning Committee of the Public Health and Health Planning Council, and that was based on a very spirited, enthusiastic meeting of the committee members and committee session, both to redefine what our responsibilities are and also to lay some groundwork for how to do a fresh start. Where do we go from here? Based on PHHPC's authority as conveyed by the legislature some time ago, there was certainly a very special and well-defined role for PHHPC. As I see it, the Planning Committee and the council as a whole has a special opportunity to focus on projects and serve as a valuable resource to the officials in the Health Department. How to bring this together and go forward is what we've been trying to do to, especially at a time when the health delivery system is changing constantly. We don't think there's going to be an expiration date for planning. This is going to continue on and on. To do this requires a very ongoing continuous, includes a relationship with members and leaders of the Department of Health. We're not simply a separate advisory committee writing a paper in the journal. We are here to work together to find new opportunities for change and new possibilities for again, renewing and revising our regulations. Based on this new charge and that early committee meeting, where, again, there was so much enthusiasm and interest, there have been several prep sessions with myself, Ann Monroe, Vice Chair, Dr. Heslin, First Deputy Commissioner Jackie Sheltry thinking about how do we prepare, how do we organize a discussion so the next committee meeting is really productive in terms of setting our direction, knowing where we're going to go and being both helpful and maybe sometimes a little annoying, but that's okay. What we identified in those prep sessions was really two needs for our next meeting. One is to identify, certainly this is more the department than the committee identifying a couple of regulations in need of update and renewal and change. A second project for the committee would be to talk through and then select one or another policy topic which



seems to have a special need or opportunity for focus and revise changes eventually probably leading to possible new regulations. Starting with an in-depth understanding of what we can do to improve one part or another part of the delivery system, knowing that there is plenty of opportunities there and we can only start someplace. That would be a decision of the committee. I'm having with Dr. Heslin and the other staff taking care, of course, to go back to their colleagues and all the offices and divisions with the Health Department. There is clearly a need for deep and systematic review and approval and approach and collaboration. As it turned out, that has taken longer than we expected as a committee. We expected to meet yesterday and not having matured enough or developed an offer of the collaboration we need are looking at our meeting to postpone that to sometime before our next council meeting. That's where we stand. Questions are very welcome as are concerns.

**Mr. Kraut** Dr. Berliner just asked if there's a date.

**Dr. Rugge** A tentative date of April 9th, the day before the next council meeting. If progress is made and we think might even need two committee meetings. This is not a final decision, but it's a preliminary idea.

**Mr. Kraut** The next committee day is... Well, the Planning Committee day is not the same day.

**Dr. Rugge** We have a separate meeting because it takes hours to work through all this.

**Mr. Kraut** Thank you very much, Dr. Rugge.

**Mr. Kraut** I'm now going to turn to Dr. Yang, who will give a report on the Codes, Regulation and Legislation Committee.

**Dr. Yang** Yes, there were two regulations that were presented to the committee this morning that are being forwarded to the council. One is an amendment of section 405.45 regarding trauma centers and nurse review, a component of that. Mr. Greenberg, I think was the lead for the department explaining that up in Albany. The second one, the second regulation for discussion was an amendment to 710.1 approval of medical facility construction. Ms. was the lead for that.

**Mr. Kraut** For those of you who weren't here for the presentation of these reports, they're both for information. They're going to come back to the council. The second is the CON kind of a construction. It's a repeal and replace that comes out of our conversations that occurred last May at the educational retreat. We had reviewed a lot of elements of that. You'll have an opportunity. It'll be put out for public comment, we'll get some reaction, and it'll come back to us at our next meeting of the Codes Committee for adoption both items. If there's any questions, we do have a staff to answer anything if you've read those documents before.

**Mr. Kraut** Thank you, Dr. Yang.

**Mr. Kraut** I'm going to turn now to Dr. Kalkut to give us a report on the actions of Establishment and Project Review.

**Dr. Kalkut** Montefiore Nyack in Rockland County to certify therapeutic radiology to operate two linear accelerators and perform renovations in a medical office building on the hospital campus. Both the department and the committee approved with conditions and contingency. I so move.

**Mr. Kraut** I have a motion.

**Mr. Kraut** May I have a second?

**Mr. Kraut** Dr. Berliner.

**Mr. Kraut** Any questions?

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

**Mr. Kraut** All those in favor?

**All** Aye.

**Mr. Kraut** Opposed?

**Mr. Kraut** The motion carries.

**Mr. Robinson** 242176C, NYU Langone Hospitals in Westchester County. Noting a conflict and recusal by Dr. Kalkut, who's left the room. This is certifying a new multi-specialty ambulatory surgery hospital extension clinic at 4 Westchester Park Drive in West Harrison. Department and committee recommend approval with conditions and contingencies. I so move.

**Mr. Kraut** I have a motion.

**Mr. Kraut** Can I have a second?

**Mr. Kraut** Dr. Berliner.

**Mr. Kraut** Are any questions on this application?

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

**Mr. Kraut** All those in favor?

**Mr. Kraut** Opposed?

**Mr. Kraut** Abstention?

**Mr. Kraut** The motion carries.

**Mr. Kraut** Have Dr. Kalkut return to the room.

**Mr. Kraut** I'm going to leave the room for the next application.

**Mr. Kraut** Mr. Robinson will take over the responsibilities of the Chair.

**Dr. Kalkut** 242247C, South Shore University Hospital in Suffolk County. There's a conflict in recusal by Mr. Kraut who is out of the room. This project amends and supersedes previously approved CON 201151 to construct a new six story building in patient building with sixteen net new medical surgical beds by adding thirty ICU beds. The building will also house six ORs, two endoscopy rooms and forty-one post-acute care unit bays. The department approves with conditions as contingencies and the committee approved with conditions and contingencies with one member abstaining. I so move.

**Mr. Robinson** Thank you.

**Mr. Robinson** I have a motion.

**Mr. Robinson** A second by Dr. Berliner.

**Mr. Robinson** Any questions on this application?

**Mr. Robinson** Hearing none, call the question?

**Mr. Robinson** All in favor?

**Mr. Robinson** Any opposed?

**Mr. Robinson** Motion carries.

**Mr. Robinson** Have Mr. Kraut return.

**Dr. Kalkut** The next category will be several seconds batched. Let me start with the 231189E, St Michael's Home Inc doing business at St Michael's Home Care. There's an exhibit with a list of geographic service areas. This is to establish a new licensed homecare agency at 1220 Front Street in Uniondale. Both the department and committee recommend approval with a condition. 241073E, First Class Care LLC doing business as Homestead LHCSA. Again, a geographic service area in the exhibit. Establish First Class Care LLC as a new license homecare agency at 8245 Grenfell Street in Kew Gardens. The department and the committee recommend approval with a

condition. 241149E, Westchester PACE Program, LLC. Again, geographic surveying areas laid out in the exhibit. This is to establish a new license homecare agency at 1 Wartburg Place in Mount Vernon. The department and committee approved with a condition. I so move.

**Mr. Kraut** I have a motion for those applications.

**Mr. Kraut** I have a second by Dr. Berliner.

**Mr. Kraut** Any questions?

**Mr. Kraut** Mr. La Rue.

**Mr. La Rue** Yes, I apologize. I wasn't at the committee meeting. I just wanted to ask in terms of process on the PACE application. Did this entity already receive full approval to operate a PACE program, and now we're approving the LHCSA? Are we approving the LHCSA, and they've not yet received full approval on the patent application?

**Mr. Kraut** That question was asked at the Project Review Committee. There's a condition here that it's conditional upon the approval of OHIP. We're proceeding first to approve it, and then it still has to go through a secondary approval with OHIP.

**Mr. La Rue** Thank you.

**Mr. Kraut** Any other questions?

**Mr. Kraut** All those in favor?

**All** Aye.

**Mr. Kraut** Opposed?

**Mr. Kraut** Let's do this. We're going to amend the motion. I'm going to just ask for a vote on the first two. You made the motion. Do you agree to amend the motion to limit this to the first two applications? Just for clarity, it will be St Michael's Home. We will vote on 241073E First Class Care doing business as Homestead LHCSA.

**Mr. Kraut** May I have a second for the amendment?

**Mr. Kraut** Dr. Berliner.

**Mr. Kraut** Are there any questions on those two applications?

**Mr. Kraut** Hearing none, call for a vote.

**Mr. Kraut** All those in favor?

**All Aye.**

**Mr. Kraut** Opposed?

**Mr. Kraut** Motion carries.

**Dr. Kalkut** 241149 E Westchester PACE Program LLC establish a new license homecare agency and 1 Place in Mount Vernon. Approval with condition was recommended. I so move.

**Mr. Kraut** We have a motion.

**Mr. Kraut** May I have a second?

**Mr. Kraut** Dr. Berliner.

**Mr. Kraut** Are there any other questions on this application?

**Mr. Kraut** Seeing none, I'll call for a vote.

**Mr. Kraut** All those in favor?

**All Aye.**

**Mr. Kraut** All those opposed?

**Mr. Kraut** It's a yes to approve.

**Mr. Kraut** All those who indicated yes already raised their hand. Dr. Torres is opposed, voting no on this application.

**Mr. Kraut** The motion carries.

**Dr. Kalkut** Oyster Bay Manor Home Care Inc doing business as Oyster Bay Manor Homecare. Geographic Service area is available in the exhibits. This is the transfer 25% ownership interest from one shareholder to the remaining shareholder. The department committee recommend approval with a condition. 241136E, Vista on Fifth. Corporation doing business as Vista on Fifth. Geographic service area available. This is to transfer 100% ownership interest to a new member corporation. The department and committee recommend approval with the condition. I so move.

**Mr. Kraut** I have a motion on these two applications.

**Mr. Kraut** I have a second, Dr. Berliner.

**Mr. Kraut** Are there any questions on these applications?

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

**Mr. Kraut** All those in favor?

**All Aye.**

**Mr. Kraut** Opposed?

**Mr. Kraut** Motion carries.

**Dr. Kalkut** 232078E, Brooklyn, Queens Nursing Home in Kings County. This is the transfer of 50% ownership from one existing shareholder to one new shareholder. The department and committee recommend approval with a condition. I so move.

**Mr. Kraut** I have a motion on this application.

**Mr. Kraut** May I have a second?

**Mr. Kraut** Dr. Berliner.

**Mr. Kraut** Any questions on this application?

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

**Mr. Kraut** All those in favor?

**All Aye.**

**Mr. Kraut** Opposed?

**Mr. Kraut** The motion carries.

**Dr. Kalkut** 242152E, Central New York Eye Center in Dutchess County to transfer 100% ownership of Central New York Eye Center at 22 Green Street in Poughkeepsie. Department and committee approved with conditions and recommend with conditions and contingencies. 242159E, Capital Region Ambulatory Surgery Center in Albany County. This is the transfer 89.48% from eight withdrawing members and two existing members to seventeen new members. The department recommends approval with conditions and contingency with an expiration of the operating certificate three years from the date of issuance. The committee recommends the same, three-year operating certificate from the expiration of the operating certificate three years from the date of its issuance is recommended. 242161B, East End Surgery Center LLC in Suffolk County. This is to establish construct a single specialty amatory surgery center for Gastroenterology by converting an existing private practice at 287 Wading River Road.

Department recommends approval with condition and contingencies with it an expiration of the operating certificate five years from the date of its issuance. The committee recommends the same. 2242189B, Southern Tier Surgery Center LLC in Broome County. This is to establish construct a dual single specialty ambulatory surgery, diagnostic and treatment center for Orthopedics and Pain Management at 601 Harry L Drive Johnson City. This amends and supersedes project number 222227B. The department and committee recommend approval with conditions and contingencies. I so move.

**Mr. Kraut** I have a motion to move these applications.

**Mr. Kraut** Second, Dr. Watkins.

**Mr. Kraut** Are there any questions on these applications?

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

**Mr. Kraut** All those in favor?

**Mr. Kraut** Aye.

**Mr. Kraut** Opposed?

**Mr. Kraut** Motion carries.

**Dr. Kalkut** 242037B, ABC Little Clinic 115 in New York County. This is to establish to construct a diagnostic and treatment center at 158 East 115 Street in New York. The department and committee recommend approval with conditions and contingencies. I so move.

**Mr. Kraut** I have a motion.

**Mr. Kraut** May I have a second?

**Mr. Kraut** Dr. Berliner.

**Mr. Kraut** All those in favor?

**All** Aye.

**Mr. Kraut** Opposed?

**Mr. Kraut** The motion carries.

**Dr. Kalkut** The last matter is a certificate of dissolution, Living Resources, Certified Home Health Agencies. The department and committee recommend approval for the dissolution. I so move.

**Mr. Kraut** I have a motion.

**Mr. Kraut** Second, Mr. Thomas.

**Mr. Kraut** Any questions on the dissolution application?

**Mr. Kraut** All those in favor?

**All** Aye.

**Mr. Kraut** Opposed?

**Mr. Kraut** Motion carries.

**Dr. Kalkut** That concludes the report of the Establishment of Project Review Committee.

**Mr. Kraut** Thank you very much, Dr. Kalkut and committee members. I would say by any measure, this has been a pretty productive and substantive meeting. I want to thank the department and all the presenters for the work that went into preparing for the meeting and the conversation. It felt really good today. We touched on a lot of important issues. I appreciate the effort that went into that and the participation and the preparation of the council members as well. The next regularly scheduled committee day is going to be on March 27th. They'll be a separate committee day for the Planning Committee. The full council will be convening on April 10th. Both these meetings will be held in Albany location. That will all be confirmed in emails as well.

**Mr. Kraut** May I have a motion to adjourn the Public Health and Health Planning Council meeting?

**Mr. Kraut** We are going to go into Executive Session to consider a health personnel matter. Please don't leave. Well, we could take a bio break, but please don't leave. I'll ask the public to leave. I'll have the web services turned off. We have one more matter to consider. Thank you.