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TRANSCRIPT

Mr. Kraut We're going to start the meeting if everybody would, as they say on stage, places everybody.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt Good morning. My name is Tom Holt and I'm the Chair of the Committee on Codes, Regulations and Legislation. I call today's meeting to order. Just as a reminder for the members of the council present today, the committee consists of this morning of myself, Mr. Kraut, Dr. Yang and Dr. Soffel for the purposes of motions and votes today. Members of the public, and we do have a number of speakers who have signed up to speak on some of our regulations this morning, I would remind you that you need to limit your comments to three minutes or less. I will be the timekeeper. You'll get a warning at the one-minute remaining. Presenters are limited to one per organization. We would ask that you be prepared to deliver your comments promptly after your name is called and your name will be called in the order in which you signed up. Move close to the front when you deliver your remarks.

Mr. Holt There are three regulations on the agenda for today. The first for emergency adoption is the hospital and nursing home PPE requirements.

Mr. Holt Can I have a motion and a recommendation of adoption of this emergency regulation to the full Public Health and Health Planning Council.

Mr. Kraut So moved.

Mr. Holt A second.

Dr. Yang Second.

Mr. Holt Thank you.

Mr. Holt Mr. Jason Riegert and Jonathan Karmel of the Department are available and will provide us with information on this proposal.

Mr. Riegert Can you hear me okay?

Mr. Holt Yes.

Mr. Riegert Thank you.

Mr. Riegert Good morning. My name is Jason Riegert. I'm an associate counsel with the Department of Health. The emergency before you is being presented for emergency adoption, as you said. Overall, the regulation remains unchanged from the last time that it was presented and approved by the council on January 26th of this year. Just to briefly summarize, the emergency regulation requires both hospitals and nursing homes to

maintain a sixty-day supply of PPE. The regulation also authorizes the Commissioner of Health to increase the stockpile requirement up to ninety days in the event of a declared state or local public health emergency. The emergency regulations continue to require four different types of PPE, that is, gloves counted as a single unit, gowns, surgical masks and N95 respirators. The regulations allow PPE to be stored offsite, including by third party vendors under contract provided the offsite storage is located within the state and accessible within twenty-four hours. Additionally, there must be an onsite PPE supply of at least ten days in those instances. The regulations also strongly encourage facilities to rotate their PPE stockpile just to help reduce waste. Finally, as a reminder, the regulations do include a provision stating that the Commissioner shall amend the regulations should an alternate methodology that is appropriate for the state and that adequately ensures the safety of staff and patients be developed. We're asking the Codes Committee today to approve this emergency regulation as it will enable the department to continue requiring that general hospitals and nursing homes maintain a sixty-day supply of PPE to help ensure that sufficient PPE is available in the event of resurgence of COVID-19 or other communicable disease outbreaks. Just of note, this is really for information, but the department plans to file a notice of revised rulemaking, which will be subject to a forty-five-day public comment period. It's really just for information for the committee.

Mr. Riegert That's all.

Mr. Riegert Thank you.

Mr. Holt Thank you, Jason.

Mr. Holt I want to acknowledge that we did receive a couple of letters from associations and individuals who are interested in this, and those were distributed to the members of the committee in the council prior to.

Mr. Holt I did not have anybody from the public sign up for this specific regulation, but would just asked once if there was anybody from the public who wishes to address this.

Mr. Holt Any questions for members of the council or committee?

Mr. Kraut I would just acknowledge in light of the letters we received, and you heard Mr. Riegert to say this, that the department is looking for an updated or, if you will, an evidence-based methodology that would permit them to alter these regulations. I think the provider community, the vendor community, it behooves them to maybe engage in some sort of study that could be validated to see what the appropriate level is given not only... It's not so much the threat level being lower, but it's getting ready for the unknown threats that may come down the line. I think that's one of the reasons why we're continuing to maintain readiness for PPE at the levels that have been suggested. You heard the department is open if there's an alternative. I don't think the department's responsibility is to actually do that research. It has to come from someone outside of the department to be valid.

Mr. Kraut That's all I was going to say.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt Any other comments or questions from members of the committee?

Mr. Holt Hearing none, I call the question.

Mr. Holt All in favor?

Mr. Holt Opposed?

Mr. Holt Motion carries.

Mr. Holt This regulation will go to the full council for its adoption.

Mr. Holt Next for emergency adoption and for information. We have the investigation of communicable disease. This regulation is being presented for both emergency adoption and for information as a proposed regulation. The proposed regulation will be presented to this committee and the full Public Health and Health Planning Council for adoption at a later date and does not require a vote at this time.

Mr. Holt Can I have a motion for recommendation of adoption of the emergency regulation to the full Public Health and Health Planning Council?

Mr. Holt Mr. Kraut, Dr. Yang, thank you.

Mr. Holt Jason Riegert and Emily Lutterloh from the department are available and will provide us with information on this proposal.

Mr. Riegert Good morning. My name is Jason Riegert. I'm here today to ask the committee members to vote on the adoption of the emergency regulation concerning the investigation of communicable diseases, as well as to present the regulation for information so that the department can take steps toward making this permanent, which would include a sixty-day public comment period. Just to briefly summarize this regulation amends Section 2.6 of the State Sanitary Code related to communicable diseases to update and clarify existing local health department authority for investigating communicable diseases specifically an update Section 2.6 to include setting forth specific actions that local health departments must take to investigate a case, suspected case, outbreak or unusual disease. Clarifying the authority of the Commissioner of Health to lead disease investigation activities under certain circumstances, such as where multiple jurisdictions within the state are affected and codifying the requirement that local health departments and reports to the Department of Health during such a disease outbreak. The emergency regulation also amends Section 405.3 of Title 10 to require hospitals to report syndromic and disease surveillance data during an outbreak of a highly contagious communicable disease and to allow the Commissioner to direct hospitals to accept patients during such an outbreak. In addition, the emergency regulation also adds Section 58/1.4 to Title 10 to clarify clinical laboratory reporting requirements for communicable diseases. Finally, there is an update to the term monkeypox to mpox in the two places that the virus is referenced within the State Sanitary Code. Again, this regulation was last approved by the council on December 8th. No changes have been made to the expressed terms of the regulation since it was last adopted by the council. We're asking the Codes committee today to approve the emergency adoption and then as well, this will also be now subject to a sixty-day public comment period, so we can take steps towards making this regulation permanent. I would just note that the standard for an emergency regulation such as this is that the agency here at DOH finds that the immediate adoption of the rule is necessary for the preservation of public health, safety or general welfare, and that waiting

for the rule to be subject to that sixty day public comment period and the extended rule making process would be contrary to the public interest.

Mr. Riegert With that, I'm happy to answer any questions that you may have.

Mr. Holt Thank you.

Mr. Holt Questions from the members of the committee or counsel?

Mr. Holt We do have four speakers who have signed up to speak to this proposed regulation. I'll call you in the order in which you signed up. Let me remind you that you have three minutes to speak. I'll give you a warning at the two-minute mark. If you come up first, and for those of you that have been here before, you know that it's important that you pull that microphone as close to you as you can and speak directly into the microphone.

Mr. Holt Please identify yourself.

Speaker 1 My name is Leland Lerman. Mr. Chairman, members of the committee, the result of the last three years of health policy have not been good for the State of New York. People in the State of New York who have studied the matter have come to a determination that the overall process of handling disease, public health in general needs to change. We are in particular interested in the development of some type of integrative medicine specialty on this board and within the Public Health Commission. We're really concerned because we see over and over policies and practices that are not working that are causing death and harm and injury being espoused as the only possible response to an epidemiological emergency. Right now, in Washington, D.C., you may be aware that there is an ongoing investigation into the suppression of alternative treatments for the coronavirus. There is also an investigation into the origins, as well as the problems with the approved responses, the MRNA injections and those other public health practices such as intubation and other protocols for handling respiratory diseases, which have demonstrated that they have severe flaws. I'm sure that most of this information is not entirely new to you, but it is something that has come to our attention on such a recurring basis. Many stories being told around the dinner table at the public, at the county fairs in Columbia County and other places, that it's really important that you understand that these issues are not going away.

Mr. Holt One minute remaining.

Speaker 1 Thank you very much.

Speaker 1 I notice that on April 3rd, you guys or some members of this committee are going to be at a more general meeting about prevention. We saw on the agenda for the prevention meeting a lot of intelligent responses and intelligent ways to work on creating a more thorough and holistic and integrative approach to the state's health policy. We commend you for that. We hope that you are able to receive public comment from professional epidemiologists and integrative medical specialists who have alternative views at that meeting as well. I understand that this commission has a lot of business to take care of on a regular basis and that members of the public, without matters of public health, M.D. and other qualifications are not considered to be entirely qualified to make these statements. I can assure you that I am speaking on behalf or the same statements

that I've just made would be spoken to you and medical doctors as well, who I hope to at one point bring to the committee's attention.

Speaker 1 Thank you very much.

Speaker 1 Have a great day.

Mr. Holt Thank you very much.

Mr. Holt Rose Angel Perez, please come forward and identify yourself.

Speaker 2 Hello, everyone.

Mr. Holt Good morning.

Speaker 2 Thank you for the opportunity to speak.

Speaker 2 My name is Rose Angel Perez. I am a resident of New York City, a lifelong activist. I took the mental health emergency course. I also am a healthy living consultant, a formal healthy living consultant for seniors. I come here as a member of the media to share a message from the attorney who took down the current quarantine regulation that was struck out as unconstitutional and illegal that we're kind of discussing a version of it today.

Video Recording What that regulation said that I got struck down. It basically gave this immense power to the Department of Health, to the Commissioner.

Mr. Holt I'm sorry. This is personal testimony that you're expected to give this morning and not a recording.

Speaker 2 I will rephrase it. As I mentioned, I'm a member of the media. I'm also on the ground, boots on the ground. First witness of how some of the policies that have been determined have created so much division and harm in our communities. We are currently discussing a potential for another quarantine camp regulation that has already been struck down, a version of it by the courts and is deemed unconstitutional and illegal. It talks about public risk, but it doesn't take account. It doesn't have due process. It doesn't take account due process. They can take you. They can quarantine you in your home. They can quarantine you in a detention center of their choice. If you need a lawyer of some sort, you got to figure it out by yourself. They say that the road to hell is paved with good intentions. I'm sorry to say that some of the decisions that have been made by maybe members here or some of your peers have not only contributed to the destruction of what we're seeing here in New York, the destruction of businesses and the lives of millions of people who have been affected by this push for vaccines and this push for public health under the guise of public health, people like me, people who question though some of the decisions that are made in rooms like this, people are not getting the full information. If we really do care about health, I think that we need to have an integrated approach and include things like looking into other approaches that's not just taking populations and segregating them and separating them, because it seems to me like we're living through another Nazi camp situation. A lot of people here in New York don't want to see it or say it, we felt like that. I do not want to see another Nazi Germany happening here in New York City.

Mr. Holt Your time is expired.

Mr. Holt Thank you for your comments.

Mr. Holt I'd like to ask Billy to come forward, please. State your name for the record and then we'll start the clock.

Speaker 3 Hello. My name is Billy. I'm here to say about this quarantine camp bill. As you heard, a similar version of it was struck down recently. Kathy Hochul's regulation, which was a problem. The reason it was struck down and I want you guys to all please listen, because I know sometimes its you guys had a long day, but please listen because this is very important. The reason it was struck down was there was no due process. I'm sorry, I have some notes here just to keep me on track. It allowed the Department of Health to choose who is the public health threat without needing proof to deem you a public health threat. No symptoms required. No test needed. It was simply at their discretion. I understand that your regulation or whoever put it together is a little different because they actually specify it's a health facility, which is a little different. The fact is, I want to know more. We want to know more. Are you going to give due process? Is there going to be a time restriction? How long can you quarantine somebody? Is is there an age limit? As of right now, if we're basing it off of the other regulation that was similar, they can do whatever they want to you while you're contained. Possibly force you to take medication and control your activities. No due process, no procedure established to prove that you were not contagious or to be allowed to leave. We already have a law in place for people deemed a public health threat. It's been in the books since 1953, Section 2120 of the New York Public Health Law. It's backed by science and law. It establishes a procedure for obtaining a quarantine or isolation order in light of a highly communicable disease. You need diagnostic proof. It respects due process. So far, these regulations do not respect the law. They do not respect science, not backed by science, because you need to test somebody. You need to find proof. You can't just say, I deem this person to health threat. Look what happened with COVID. No symptoms, but you have COVID. It's all nonsense, all fake science.

Mr. Holt One minute remaining.

Speaker 3 Basically, I just want to ask, what is the purpose of this regulation? I need you guys to ask that gentleman who is pushing you guys to, oh, we got to push it because we need it. What's the purpose of it if we already have it in the books since 1953? It's well-established, it's based on science, and it's based on sound law. You can't just grab somebody and say, you're at risk. You're a public health threat with no proof. It doesn't make any sense. I want to ask you guys what is the need for this? Who is pushing this agenda? What's the reason for it? We already have it in the laws. Is Kathy Hochul pushing you guys because she couldn't get her health regulation passed? Is that what's happening here? I want to know. People want to know. If you guys try to pass this thing, I guarantee you it's going to be struck down in court because we're going to sue. Guaranteed.

Mr. Holt Thank you.

Mr. Holt Maria, if you would, please come forward and state your name for the record.

Speaker 4 Good morning. Thank you all for listening to me. I'd like to understand what communicable diseases besides COVID and monkeypox. Can you please tell me what other communicable diseases is included in this?

Mr. Holt Do you have a statement to make?

Speaker 4 I do. I have a question, though, because then---.

Mr. Holt It's in the regulation.

Speaker 4 I'm sorry. I did not read the regulation. I'd like to know if Lyme disease is included in there.

Mr. Kraut Well, if you have comments about the regulation, fine. If you didn't read it, you might want to do that before you comment on it.

Speaker 4 I'm pretty sure Lyme disease is in there.

Mr. Kraut Okay.

Speaker 4 There are 167,000 new cases of Lyme disease a year throughout America. Let's say in New York, where New York State is a high-risk area, it would be about 30,000 to 40,000 people. I have Lyme disease. I got it last year. My daughter also got bit by tick last year in Manhattan. We didn't go to the Hamptons. We didn't go to Upstate New York. This is in Manhattan. I would be taken then into this health facility without any due process. I also have a rare disease. I have thalassemia, so I get pints of blood every fourteen days. How do these health officials know anything about my disease? There is a huge amount of people that have rare diseases. We have over thirty million Americans with over 6,000 rare diseases living. How would you know how to treat these rare and ultra-rare diseases like thalassemia, like sickle cell disease, like spinal muscular atrophy? You are risking. You are overstepping your boundaries. You don't know how to treat these. You want to put us in a health facility where our health will worsen being in this health facility, because you see me as a threat because I have Lyme disease.

Mr. Holt One minute remaining.

Speaker 4 It's not even contagious Lyme disease. This is overstepping your boundaries. You're going to get a huge pushback because you're not considering people that have rare diseases and ultra-rare diseases as well. I think it's very racist and discriminatory towards people that have these rare diseases.

Speaker 4 Thank you.

Mr. Kraut You may want to read the regulation. It doesn't mention Lyme disease. Doesn't mention sickle cell.

Mr. Kraut I may be incorrect.

Mr. Holt Thank you for your comments.

Mr. Holt Turn back to the members of the committee and counsel.

Mr. Holt Any other questions or comments.

Mr. Holt All in favor?

All Aye.

Mr. Holt Opposed?

Mr. Holt That motion carries.

Mr. Holt This regulation now goes to the full council for its adoption.

Mr. Holt For information, we have the inclusion of health equity impact assessment as part of the Certificate of Need process. Just note for the record that Dr. Yang has expressed an interest in this. This regulation is being presented to this committee for information only and will be presented to this committee in the full Public Health and Health Planning Council for adoption at a later date.

Ms. Morne Good morning, everyone. Thank you for the introduction. I am Johanne Morne. I'm the Deputy Commissioner for the Office of Health Equity and Human Rights within the Department of Health. As stated, I'm joined today by Tina Kim, Deputy Director of the Office, and also Jason Riegert, Associate Counsel, who is on screen this morning. The Office of Health Equity and Human Rights worked closely with the Office of Primary Care and Health Systems Management and the Office of Aging and Long-Term Care to develop the proposed regulation and will continue to collaborate on the work behind the department's implementation of the Health Equity Impact Assessment requirement. The office has also engaged with community leaders, as well as stakeholders and organizations and those that represent organizations to inform the development of the regulation. As a way of background, a new Section 2802B of the Public Health Law will go into effect on June 22nd of this year, 2023, and require Article 28 health care facilities seeking the council or Commissioner of Health Approval for certain project applications to submit a Health Equity Impact Assessment. The purpose of the Health Equity Impact assessment is to encourage a health care facility to evaluate a specific project that is being proposed for implementation with an emphasis on engaging, gathering and incorporating meaningful community input. The proposed regulation adds a new Section 400.26 to Title 10 of the New York Codes, Rules and Regulations. The new section of regulation outlines and clarifies key components of the Health Equity Impact Assessment, defines key terms including independent entity, meaningful engagement, conflict of interest and stakeholders. It sets forth certain exemptions for when a Health Equity Impact Assessment is not required and requires the use of standardized documents for the completion of the assessment, clarifies the components required to be in the assessment and details how the department intends applicants to use the assessment findings. The proposed regulation also makes conforming changes to Section 600 and 710 of Title 10 to contemplate the submission of a Health Equity Impact Assessment. The proposed assessment exemptions include non-clinical infrastructure repair and maintenance and one for one equipment replacement projects that do not require prior approval, but instead only require a written notice prior to commencement of the project. Minor construction and equipment projects subject only to limited review unless such project would result in the elimination reduction, expansion or addition of beds and services establishment, whether new or change in ownership of an operator, including mergers and acquisitions. Unless such establishment results in the elimination of services, reduction of 10% or more in certified beds, certified services, operating hours, or change in location of services. Projects undertaken by diagnostic and treatment centers that serve 50% or more in Medicaid and or uninsured patients combined as outlined in the statute. Under the proposed regulation, the Health Equity Impact Assessment will include the following components, which will be submitted through a template issued by the department. The

independent entity will conduct meaningful engagement of the community and stakeholders, commensurate with the size, scope and complexity of the facility's proposed project. Description of mechanisms used for meaningful engagement. Documentation of the statements received from stakeholders and the community, including a summary of all statements with the department reserving the right to request complete copies of said public statements and comments. Documentation of the contractual agreement between the independent entity and the facility, as well as a signed conflict of interest policy form that will be issued by the department. Documentation of the independent entity's qualifications for conducting a Health Equity Impact Assessment and a narrative signed by facility leadership to attest that the assessment was reviewed by the facility proposing the CON project as well as to offer mitigation plans and strategies for potential negative impacts that have been identified as a result of completing the assessment. Finally, the proposed regulation includes a requirement that the applicant will submit a copy of the full CON or Certificate of Need application with proposed redactions for public viewing as required by the statute. Today, we are sharing the proposed regulation for the council's information with intent to publish the proposed regulation for a sixty day public comment period. The public comment period will enable the department to make appropriate adjustments to the proposed regulation and inform the finalization of guidance and program documents in time for when the requirement goes into effect.

Ms. Morne Thank you.

Mr. Holt Thank you, Ms. Morne.

Mr. Holt Just before we turn to the members of the committee and council, I want to acknowledge the receipt of several letters in response to this proposal. Those were distributed to the members of the committee and the council prior to today's meeting.

Mr. Holt Mr. Kraut, do you have a comment?

Mr. Kraut Just to start the process so everybody understands what the timeline we're trying to meet. This is for information only, right? It would then get published in the register for public comment. At the end of the public comment, it'll be modified or not, depending on what you receive. It'll come back to the council for permanent adoption. The expectation is that will occur within the next, I guess, by the June cycle. Just so everybody understands that's what they're trying to accomplish. Because I believe what you're trying to do is the effective date will be June 23rd going forward. Any application received prior to that date wouldn't be subject to these regulations. Anything received after that date, assuming we pass it will go forward. Just so people understand, that's the timeline we're trying to get. We want to get as many of the comments out from the public today to us, the full council in two weeks, so that process could proceed diligently because it's kind of this is a legislative directive to create regulations. The department has an obligation to comply as best as it can. I want to just make that clear for everybody.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt That's helpful.

Mr. Holt Again, turn to members of the committee and counsel for other comments or questions you may have.

Mr. Holt Dr. Kalkut.

Dr. Kalkut Yes.

Dr. Kalkut Thank you for the summary.

Dr. Kalkut I'm sure that the committee and the council support the intent of the law and what you've done with the regulations. For me, it's all about how it's implemented and where the issues are. You've mentioned a formatted, I guess, synopsis or decision tree, which I think would be helpful for the assessors, for the facility and probably for the department in assessing the assessment. Is there a draft form of that that's available?

Ms. Morne That document is in the draft form. However, the intention is that as we receive input and comment both through the public comment process as well as through these discussions, we would be able to finalize that draft.

Ms. Kim Thank you for your question.

Ms. Kim Just to make sure we clarify. The documents that we are developing do not go beyond what is articulated in the proposed regulation in terms of the exemptions. The checklist and other documents that are developed is basically to implement the exemptions that are articulated in the proposed regulation as you see it.

Dr. Kalkut Not data gathering, but to qualify for the exemptions. Is that how you see it? Maybe I didn't understand what you said. The template of formatted is for data gathering by the assessor.

Ms. Kim Correct.

Ms. Kim There will be a template that is developed and issued by the department that will create a standardized format through which the information for the Health Equity Impact Assessment will come in. There are other related supplemental program documents that are also in development, one of which you mentioned about a decision tree, which we have also called a checklist. I just wanted to clarify that the checklist does not go beyond what is articulated in the proposed regulation in terms of the exemptions that the department has identified in order to focus the scope of the requirement to certain projects.

Dr. Kalkut Thanks.

Dr. Kalkut You describe the qualities or the characteristics of the independent assessor. You have a conflict of interest, a narrow one, which I think is helpful for these assessors. What type of organization can do this? Again, you have and it's perhaps an unfair question, but who in New York State or would you... Can hospital associations do these assessments, for instance? Are those plausible use of assessors? One of the concerns is just sort of narrow that the window for this. The other is you don't want to have an assessment done and then there's a question about the quality of that assessment or the characteristics of the people who did the assessment.

Ms. Morne Sure.

Ms. Morne Based on the comment that's already been received through the stakeholder meetings or conversations that we've had; the department is not making a particular endorsement. We want to offer the opportunity for there to be a broad opportunity as to

who would be conducting these assessments. What is key in determining who the independent assessor will be is to ensure there is no conflict of interest. The conflict of interest that was referenced will be very specific. Looking at those parameters that have been set as far as the expectation of experience or expertise from the independent assessor, and also to certify that there are no conflicts, whether that be a fiscal nature or any other form of potential conflict. Our intention here and recognizing that facilities are going to be starting this discussion is to provide a broad opportunity as to who can assist with the completion of a Health Equity Impact Assessment.

Dr. Kalkut Final question, I give you, my word. In two of the exceptions, one for limited review and minor construction and also for establishment applications, the exception is based of not requiring Health Equity Independent Assessment. Is if there is elimination of services or adding of services, changing of hours for hospitals bed. Meaningful change that may affect access in particular, the range of services available in a community. That seems to me to be an excellent way to sort of narrow the number of assessments that need to be done, because I think it will be a substantial workload for the department and certainly for the council and anybody else involved in this. That gets right to the heart of the matter of improving equity in the state, in the communities, but making it getting to implementation. Can we do this without causing undue delays extra costs while really focusing on health equity, reducing disparities. You don't want to close a service or transfer service somewhere else without a review that shows how that will have an impact. Certainly, in recent cases that has been a key issue. I'd ask that change in services may be the filter here to get the most impact of this law and the implementation of that law and narrow the focus, narrow the window that goes through these independent assessments.

Dr. Kalkut Thanks very much.

Ms. Kim Thank you.

Mr. Kraut Just following that, I think as Gary said and I think everybody here, this is something we've been wanting. We want this information in the room. We have schedule sixteen to look at public need impact. We have a lot of information in there. I know from our conversations that that information is going to be harmonized. We still have information the applicant is providing as part of the CON that is somewhat redundant to what's coming in the Health Equity Impact statement. There are two groups now. Third, if we're dealing with long term care, looking at different aspects of CON. That's the point I think Dr. Kalkut is making, is making sure there's coordination among the various bureaus and the bondsmen, I might add, if it's a long-term care application so that we do not get delayed in the processing. On the other hand, we also have you heard the announced policy initiative of the Governor to streamline and reduce the projects under CON so that activity will come in tandem with this. I think to Dr. Kalkut's point, it'll be honing down the key essential projects. For example, this morning we approved a transformation grant competitively given out by the state to a safety net hospital. We would be they would be required to do a Health Equity Impact statement. To what end? To what end are you really doing that? I know, you know, Ms. Kim said, you're following the regulations. I get your hands are tied a little. It also means we don't have to consider. I can't fathom it. It's on like the face of the facts. It's going to improve health equity, looking at the community served and giving care. The cost is significant, more significant that's in the regulation. Let the public comment deal with that issue. It's just the burdensome of a regulatory process that has no positive outcome on the thing. Those are the things except for the things that I think we've seen plenty of examples in this room where we would be advantaged in that conversation. I think what will happen is the process of thinking about a project and

preparing the CON and filing and doing these assessments on those projects that are problematic. I think it'll improve the process because the issue here is everybody realized the Health Impact Statement doesn't impact the CON preparation. All that work is done. The decision has been made by the organization to file a CON and to do the assessment. I'm sure when they think about these projects, they will look at the lens of the impact of health equity and if they themselves determine it has a negative impact, I doubt very much we'll see applications like that. Now, you may get differences of opinion, but those opinions have to be based on fact and actions. I think there's going to be some self-correcting mechanism as we get through here. I think when the decision tree is clear and we know which ones are in scope and which are out of scope, I would just say that I know the concerns I'll personally express because I have a about 108 different CONs we've written in the last couple of years. If I'm upgrading an operating room on the face of it. What equity impact are we talking about? There are certain infrastructure emergency rooms. I'm hoping we'll have some commonsense approach to those things because these are not choosing among alternatives. We've made decisions, safety, infrastructure. Those are things that you have to do to keep the lights on and to keep a safe environment. I think there'll be a process here, and I think we're going to have to learn and work together to make sure we meet the intent of this regulation, which I think we're all going to be very positively supportive of.

Ms. Morne Thank you for that.

Ms. Morne If I could just comment just to the first point, as it relates to the fact that if you were to look at the different schedules, there are areas of overlap. We have done due diligence in making sure that we are not repetitive in asking applicants to repeat and repeat again information that we already have.

Ms. Morne Thank you.

Ms. Morne Thank you for the other comments.

Mr. Holt Thank you.

Mr. Holt Mr. La Rue.

Mr. Thomas Good morning. I'm Hugh Thomas, member of council.

Mr. Thomas I want to follow up on Dr. Kalkut's comment about one thing. I think that as you are hearing from the beginning, as you're thinking about it. The rubber is really going to hit the road on changes in service. In particular reductions in service. That's where the difficult the statute and the regulations are completely appropriate and necessary for the State of New York and public health. There is a financial reality that is clearly applying in this industry today. I was on a call yesterday with some members of the Governor's Office on this topic. We're going to be faced, unfortunately, with making very difficult decisions that will probably not be acceptable under the health equity analysis that your team is going to do or we're going to have an independent assessor. How are we going to reconcile those things? What's the Medicaid programs position going to be on it? Because we're not going to be able to do everything we presently do as we go forward. That could have a disparate impact. Just a perspective. You don't have to respond. I just wanted to share that. That's going to be a really difficult part of this work from my chair because it's all laudable work, but you can't be everything to everyone all the time. When you're not that's when this will be triggered from my chair.

Mr. Thomas Thank you.

Ms. Morne Thank you.

Mr. Holt Now, Mr. La Rue.

Mr. La Rue Mr. La Rue actually asked almost the exact question I was going to ask, because I'm trying to understand how this is going to play out logistically. We see a CON application, like right now it says the department recommends. It doesn't recommend. Will there be a section on a CON application where the department, based on equity issues, says we do not recommend? Is that how that would work?

Ms. Kim The Health Equity Impact Assessment would be one of the many components that inform the ultimate kind of recommendation from the department upon evaluation of the entirety of the CON application.

Mr. La Rue Where my concern gets you go back to the 3.5-hour staffing legislation, which to date we have not received any of the funding on or the inadequate Medicaid rates. You've got a provider whose entire mission is addressing inequities in the health system and serving the community. You've got a program that can't survive because of inadequate funding. Where's the rubber hit the road there?

Mr. Kraut Because I have a perspective that I'll share.

Ms. Glock Obviously, we haven't ironed out all of the final implementation details, but the Center for Planning, Licensure and Finance have been working very closely with Joanne and Tina and Casey in the Office of Health Equity and Human Rights to implement this. At this time, the thought is similar to when we incorporated the Long-Term Care Ombudsman program, which was another legislatively mandated recommendation. They will do a review of the process. They'll be assigned. They'll do a review. There will be information in the exhibit regarding their recommendation and the review for the council members to read. That is, you know, one review, as was pointed out with Joanne and Tina responds, that's one review of several that come into play for the department's total recommendation. I don't know. I think some of this is going to be as we implement. We'll see how this plays out. Your point is well taken, Scott, that at times there's a safety reason, even perhaps why people are proposing certain changes that will have to be part of that consideration.

Mr. Kraut I have a slightly different perspective. It goes something like this. The regulatory system we have in place today is a completely inadequate, irrelevant and anachronistic for the health care delivery system we are operating. I just put it out there. We have well-meaning, intentional transactional regulatory legislative issues, but not dealing with some of the fundamental underlying challenges of the type you described, or Mr. Thomas described. I think this is where the department has to do its job. The Health Equity Analysis has to give us that information. OPCHSM have to do their work. The ombudsman has to do theirs. The long-term care has to do theirs. We have to now use independent thinking and common sense in accepting all of those inputs and deciding what's right in a bigger system. As Mr. Thomas says, there's some hard things ahead of us. There are some workforce issues. There's economic. Health system's going to change in ways that people are not going to like. These are the cards we're dealt. We will make decisions based on the best available information. Good data will drive good decision making. This is a good piece of data to have. We are not required to follow the recommendations of the

department of the independent assessor of anybody else other than we have to take this information and deliberate there. There have been times when the department has approved, and we have not agreed with the department. There have been times when the department has disapproved and we've not agreed with the department. There'll be a process the department is committed to doing. We still have the three requirements; public need, financial feasibility, character and competence and then that variable any other item we want to put on to there. The department is going to look at the first three making a recommendation. You're not even making a recommendation. They're just processing the independent assessor's recommendation to us. That's all. We can then make a decision based on the information. I think sometimes we're going to find this very, very important and differentiating and making a decision and sometimes based on...I don't know what we're going to find, so I don't want to say it. Sometimes we'll just say, I understand why they did that, but these other factors go. That's why our job actually becomes more important to some extent as all these things get added onto the regulatory environment. We have to make sense of that here. What we're hoping, as I said before, we see a wind reform also limits those things that are coming here that are truly important.

Mr. Kraut I'll just leave it at that.

Mr. La Rue At at the risk of getting myself in trouble. The legislature, this isn't obviously the first time they've passed an expectation without funding tied to it. I run a nursing home in the poorest congressional district in the United States, in the South Bronx. It loses $5,000,000 a year on a 120-bed facility. It's almost 100% minority. It is 100% minority staff. The funding is so inadequate that it's the church that keeps the doors open. If you want to solve inequity and if the legislature is listening and you're up in Albany right now, fund it. Help us solve the problem.

Mr. Holt Thank you for those comments.

Mr. Holt Are there any other?

Mr. Holt Yes, Dr. Soffel.

Dr. Soffel Good morning. I want to start by saying we received a letter from some of the consumer advocates that was very supportive of the proposed regulation. I want to say kudos to you because the consumer seal of approval does not come easily. They tend to be a fairly critical bunch. Well done. I have a couple of questions. First of all, as I read the regulation, it really addresses the process, but it doesn't address what the assessment is actually considering. What is the it that we are looking at? Is that spelled out in the template that you will be requiring that people use? What analysis must be undertaken as part of this?

Ms. Kim Thank you for your question.

Ms. Kim Yes, the template will follow a lot of what is articulated in statute in terms of what is to be included. It is to be an assessment of the unintended positive and negative impacts of a project and how this particular focus on medically underserved groups, which was outlined in statute and to make sure that the community voices, especially members of medically underserved groups, were considered in the planning of the project. The template will closely follow what is articulated in statute in terms of what is to be included. It will also include a focus to make sure that there are specific impacts as it relates to medically underserved groups.

Dr. Soffel Thank you.

Dr. Soffel My second question is almost related. I know that in the statute they spell out who are the underserved, underrepresented groups that need to be considered. Will that be articulated in the template? Because that's not in the regulation right now.

Ms. Kim Yes.

Ms. Kim The template will offer a breakdown of each of the medically underserved groups as outlined in statute. It will ask specific questions on the unintended positive and negative impacts of a project specific to each subgroup, so to speak, of medically underserved populations listed in the statute.

Dr. Soffel My final question is closing the facility doesn't require Health Equity Impact Assessment. It seems to me that the closure of a facility could have an enormous health equity impact. I'm a little troubled that somehow this doesn't address the enormous impact that it can have on a community of a facility closure. I'm sort of curious about why the omission.

Ms. Kim Thank you for that question.

Ms. Kim The department understands that it is important to understand and evaluate the impacts on communities as it relates to closures pursuant to Section 2802G, I believe. The closure plans are considered outside of the realm of the Certificate of Need process. The closure plan process is its own separate process outside of the Certificate of Need application process. Our understanding of that is pursuant to what is already outlined in statute, closure plans do require an after-closure plan that asks for basically a review that allows for public comment. Because the closure plans are outside of the Health Equity Impact Assessment realm, it is not included here.

Dr. Soffel That is troubling. That is very troubling to me. I don't know what the solution is, but it feels like a big hole in this.

Mr. Kraut There's a historic precedent for that, and it's to give the department there's sometimes emergencies that require that. I don't think it's a simple answer. There's a rationale for it. It's also tied into the financing, bond holders, the department, the regulatory oversight labor agreements. It was specifically excluded from CON. There's a historic precedent. When you get into it, you could understand why. Again, it's one of those things.

Dr. Soffel Perhaps we need a statute that requires a Health Equity Impact Assessment on closure plans.

Mr. Holt Dr. Yang.

Dr. Yang Thanks.

Dr. Yang I just had a quick question. I noted that DTCs are called out as exempt if they reach a threshold of 50% or more for Medicaid and uninsured. I was just curious why they were called out from among sort of more the question of how this aligns with the sort of the philosophy and the goals of the safety net provider program altogether in terms of financing support and encouragement of safety net as a philosophy and as an operation.

Mr. Riegert I was going to just make mention that this statute actually specifically exempts diagnostic, and treatment centers whose patient populations are over 50% combined patients enrolled in Medicaid are uninsured. That's actually directly from the statute. We just included that into the regulation so that all of those exemptions are there in one place.

Ms. Morne Did that answer your question?

Mr. Holt It did not.

Ms. Morne I think the question lies in the authors of the legislation as to what the thinking is. I think that's the question. Why, in fact, were those specific entities excluded?

Dr. Yang Why DTCs and not all safety net providers, for example or how this whole thing will align with the safety net programs.

Mr. Kraut There's room for improvement, let's just say that. This is not the first bite at the apple. I think this is going to be an iterative process. We'll see what value it provides, and we'll learn from it and hopefully modify it. Again, we have enormous discretion in this room, regardless of what happens. We've been asking for this type of analysis in our prevention agenda, alignment with public need. What are you doing to address inequities in the service area? In a way, we started the conversation here asking for more information, and now it's codified. Maybe not as well thought about. You've heard the comments, but it's a start. We'll work on making it because we can add. We can add things to the regulation that's not specified in the legislation. We have that right. We can do that by questions, by turning applications. We've got to get it rolling. I don't believe any safety net should be attached to this, because they're going to do all these things. That's one of the reasons because you have to let them survive.

Mr. Robinson Thank you.

Mr. Robinson I'm pulling together some comments from Mr. La Rue and others that I think we actually support this kind of an analysis. I think it's really a good thing. I think our desire to better understand quality indicators as we look at applications. Looking at health equity is a quality indicator. It's very, very important that we do that. I think, though, that what is important for the department to speak to with regard to the State Office of Budget and actually in giving feedback to the legislature is that many of these applications will get caught up not only on the health equity issue, but the economics that are a consequence of that, right? The higher the proportion of Medicaid and indigent care that a facility, a program provides, the more vulnerable the program is and therefore the more vulnerable the very services that we're trying to ensure are provided to those that do not have the kind of access that are needed can be exposed to. This is not necessarily feedback on the regulation per say, which again, I think is a very good step forward. I think though, that the economic consequences of this really have to be more clearly articulated up the chain, so to speak, so that as budget decisions are made going forward, that the impact of ensuring that that access in health equity is fundamental to the entire health system across the state, that the resourcing to be able to do that is also there. I think that's not you specifically and your office, but I think your office should raise the flag that that matter is coming before you and that there are others both in the department and in the state office of budget and elsewhere that need to look at that.

Mr. Kraut Dr. Soffel, when I made the statement. I just went to check the regulatory requirements for the closure plan. The one thing I'll just add, and I think it addresses the concern you have is the closure plan is under the authority of the Commissioner. The Commissioner has the full authority to approve, disapprove or require additional information in rendering a decision to approve or disapprove. I suspect as closure plans come; a good practice will be to ask the applicant what's the impact on health equity. There is a provision in there about that consideration already. It just doesn't come into this room, that's all. There is a process in place in the department that addresses that concern. I would say those powers are broader than ours because it's anything. They want to ask they can ask an applicant.

Mr. Holt Thank you.

Mr. Holt There are several members of the public who have signed up to speak this morning. We're going to go to them now. We'll have an opportunity to come back to additional time for questions or comments that members of the committee or council may have. State your name for the record. As a reminder, you'll have three minutes to speak and give you the warning that one minute is remaining.

Speaker 5 I'm Mark.

Mr. Holt Mark, I'm sorry.

Speaker 5 Sorry, my writing must not have been adequate. I'm Mark. I am Director of Metro New York Health Care for All. We're a coalition of community groups and labor unions here in New York City that work together on health issues and we're part of our collaboration of health advocates across the state, known as Community Voices for Health System Accountability.

Mr. Holt Is your microphone on? And if not, if you could just pull more closely to you.

Mr. Holt Thank you.

Speaker 5 Is that better?

Speaker 5 Great.

Speaker 5 Thank you.

Speaker 5 First of all, I want to thank the department for taking on this initiative and Ms. Morne and her staff for leading on this and really engaging the consumer advocacy community on this. It's a welcome new day, shall we say. Your whole new division and department that you're leading working with, Dr. Basset got created. We're really excited about your existence and stand ready to work with you on this and other issues that are going to come to your section of the department. I just want to thank you for your regulations talk about the qualifications of the independent assessor, so that the independent assessor really is independent and making note of the conflict-of-interest issue. Thank you for that. I also want to call importance, and there has been discussion already here about what happens in a closure because that is certainly an issue where services are lost to the community, and it has impact and there's discussion of who has responsibility for that. I just want to flag that we too in the consumer advocacy are very concerned about that and want to make sure that issues of health equity are directly

addressed in that conversation, whether it's under the Commissioner or under this council or any other aspect.

Mr. Holt One minute remaining.

Speaker 5 I just want to highlight that we stand ready to work with that. There is a piece of legislation in the Legislature introduced in both the Senate and the Assembly this year about local input for Community Health Care Act. We're working with both those legislators to help refine that legislation and hopefully get it through the legislature this year. One question I had as I was just listening to this conversation. You were talking about the template, talking about the unintended consequences, both pro and con. I would hope that this body, as well as the applicant, would also look at the intended consequences of addressing health equity as part of your conversation and assessment. Because it's not just something that happens on its own. Health equity has to be intentionally addressed in an application. I hope that as the body considers CON applications it will look at that also.

Speaker 5 Thank you.

Mr. Holt Thank you very much.

Mr. Holt Next, Faith Daniel come forward and state your name into the record, please.

Speaker 6 My name is Faith Daniel.

Mr. Holt Thank you.

Speaker 6 Good afternoon, everyone. My name is Faith Daniel. I was born and raised in New York City and received my MP from Columbia's Mailman School of Public Health. I'm a facilitator for Communities Voices for Health System Accountability. CVHSA is a statewide network of health care advocates who collectively focus on ensuring that New York States oversight of health facilities considers community concerns about proposed transactions and the likely impact on health equity. I believe the Health Equity Assessment Act is an important step towards improving the state review of proposed health facility changes by explicitly including consideration of the likely impact on health equity. A key element of this is reviewing process must be direct and meaningful engagement of those medically underserved people whose access to care would be affected. I commend the department's Office of Health Equity and Human Rights for its efforts to spell out in these proposed rules what meaningful engagement should mean. I know that the Office of Health Equity and Human Rights has taken its own steps to engage representatives of medically underserved people to the formation of its Community Stakeholder Council on Health Equity and Human Rights that I had the privilege of speaking on. Thank you for that. I strongly believe that the decisions that will impact communities access to health care should be informed by their views. I appreciate that there finally will be a mechanism for community members voices to be heard. That is why the guidance provided by the department to assessors pertaining to meaningful engagement will be very important to ensure community voices are fully and accurately represented. I appreciate the definition of meaningful engagement to include providing advance notice and opportunity for stakeholders to provide comment through multiple suggested means, including phone calls, community forums, surveys and written statements. I especially welcome the exception that meaningful engagement must be culturally competent.

Mr. Holt One minute remaining.

Speaker 6 On the type of stakeholders on being engaged and the example of offering people with disabilities a range of auto visible or modalities to complete an online survey. I recommend that the department emphasize an additional guidance to independent assessors that meaningful engagement must mean incorporating a multifaceted approach to getting community input. In particular, the assessor must be expected to utilize multiple modes of outreach, not just a few phone calls to public officials or community groups to reach an appropriate, diverse representation of community members. All modes of outreach, both written and verbal must be anchored in language justice and reflect the most commonly used languages in the impacted community. I encourage the department to provide assessors with a template of the key elements, which you all have stated on how an independent health equity assessment should be conducted and how it should be reported out. By making a user-friendly impact assessment report readily available to the community members and stakeholders who have been engaged, the department will provide a necessary check on the adequacy and accuracy of the assessment.

Mr. Holt Your time has expired.

Mr. Holt Mr. Bishop, if you would come forward, state your name for the record, please.

Speaker 7 Good afternoon. Lloyd Bishop.

Mr. Holt The closer the better with the microphone, please.

Speaker 7 Hi. I'm Lloyd Bishop, Senior Vice President for Community Health Equity at the Greater New York Hospital Association. I was to join my colleague, Susan Waltman, who typically handles CON issues, but she is under the weather today so I'm here. Take health equity very seriously. You've heard some examples of that today. I see that firsthand working with our members day to day on these issues. However, for today, for the purposes of this discussion, it is really about implementation and especially about how the screen is going to work. Because we don't have those documents in front of us right now, we do make the following recommendations to help guide that discussion. First, health equity impact assessments should be undertaken only for those applications that would involve a substantial or material reduction expansion or additions of a hospital service. We believe this is consistent with the goal and purpose of the statute of the underlying statute, including addressing the issues for medically underserved communities. Second, we appreciate that the draft regulations that a health equity assessment would not be required for minor construction and equipment projects will not be subject to limited review unless the project would result in the elimination reduction, expansion or addition of beds or services. However, again, to be consistent with the underlying statutes focus, we respectfully request that the word substantial also modify this exemption so that only limited review projects that would require an assessment would be those that would result in a substantial elimination reduction, expansion or addition of beds and services. We believe the same exemption should apply to service delivery applications.

Mr. Holt One minute remaining.

Speaker 7 Lastly, we request that the exemption be expanded to include not just limited review, but all reviews unless the project would result in a substantial reduction, expansion or addition of beds and services. It may well very well be that DOH's checklist and standard format may address these issues, but we want to respectfully make those recommendations to guide the process going forward. We have additional questions,

operational and implementation questions that were referenced today. We do think that the cost of this is underestimated, and we believe the regulatory burden is also underestimated to other recommendations that providers should be permitted to put forward with their applications community service plans or any other health equity related reports that can support this work. Finally, we do note that there are already significant delays in the CON process. We understand in great part this is because of staff shortages. We are aware that DOH is trying to address these issues.

Mr. Holt Thank you, Mr. Bishop.

Speaker 7 Thank you.

Mr. Holt Lois Utley.

Speaker 8 Good afternoon, I guess it is now. I'm Lois Utley, an independent health advocate based here in Manhattan. I'm one of the people who fought really hard to win the enactment of the Health Equity Impact Assessment Act. I'm hopeful that it would begin to provide the department and this council with valuable information about how proposed changes in health facilities would actually affect medically underserved people. I'm delighted to see implementing regulations now moving forward. I certainly commend the department's Office of Health Equity and Human Rights for its work in drafting these proposed rules. There is much to like in the rules, but also some things that concern us, such as the hospital closing issue that's not included. I want to focus on two of the exemptions from the requirement for an impact assessment. First, the section that would exempt mergers and acquisitions unless the project could bring about the elimination or a substantial reduction in services. I do support the department's definition of substantial as a reduction of 10% or more, but I do want to urge that the 10% be calculated as a reduction in the particular type of services that would be affected, not in the overall services of a facility. For example, the breast cancer treatment would be reduced. I believe it should be considered as a percentage of cancer treatment, not all of the entire hospital services. Otherwise, it would be too easy for a facility to minimize the impact of the reduction particularly on medically underserved people who rely on that type of service. I'm also concerned that facilities proposing mergers or acquisitions will state in their application that there will be no elimination or reduction in service.

Mr. Holt One minute remaining.

Speaker 8 Once the transaction is approved, they will then move to eliminate those services. The California Attorney General's Office, which acts in a CON like capacity for that state has addressed this problem by requiring merging health systems to maintain for ten years provision of certain services deemed likely to be targeted for elimination or reduction. I suggest that in order to qualify for an exemption, merging facilities here in New York be required to pledge not to reduce or eliminate services for a period of time. Alternatively, you could use that model of the limited life CON that you invented for the new surgery centers to make sure that they serve numbers of Medicaid, insured and uninsured patients. I thank you for your consideration of these comments and really urge that we exercise caution in creating new exemptions that could become major loopholes.

Speaker 8 Thank you.

Mr. Holt Thank you.

Mr. Holt Joe.

Speaker 9 Thank you.

Speaker 9 Good afternoon. My name is Joe. I'm Executive Vice President and Vice Dean at NYU Langone Health. Many of my comments might seem redundant because many of the issues have been covered already at some of the other testimony as part of the discussion this morning. At the outset of my testimony, I'd like to say how important it is that this discussion on the focus of health equity is for the entire state. It's critical that everyone have a fair and just opportunity to attain the highest level of health and achieving the health equity throughout the state and addressing the historical and contemporary injustices that have happened and to overcome the economic, social and other barriers to good health and proper care, and most of all, to eliminate the preventable health disparities. It's obvious that the writers of the legislation thought that one of the most important things that we could do, and I agree with them, is to prepare health equity impact assessments in connection with the CONs. To do that, though, we need to think about in the process of doing that the scope of what we need to do when we put together these assessments and how we prepare the assessments and then what the role of the assessment will be in the approval or disapproval of the CONs, all of which I think have been discussed in this process. We have to also think about the fact of how the CON process here in the state of New York, how comprehensive the CONs are in New York compared to almost anywhere else in the country, and how inclusive it is. This has been addressed, as I've heard, and I'm looking forward to reading the rules and regulations and commenting on them in the next sixty days, because as part of my long discussion, but I won't get into it is the need for carve outs. It appears that the regulations will in fact have certain carve outs, which I think are important because many of the constructions.

Mr. Holt One minute remaining.

Speaker 9 Construction CONs that we have nothing to do with expanding our business at all. It's renovations and rehabilitation so that we can provide the proper care as necessary. I do think that we need to have doing the analysis for material impacts that we have for our patient care. I do think that we need to look at again, in the preparation of the assessment template. I think that is extremely important and I can go into great detail and will in the comment period on how that could be worked out. I do think when it comes to conflicts of interest, we need to be very careful how we look at the conflict of interest. There are many people that can do economic analysis in connection with this, but we also have to understand that many of these firms also do business with hospitals all throughout the state. We have to understand that while they may help us with working on our I.T systems or they may have a division that works on economic analysis, just working on one part of a hospital---

Mr. Holt Thank you.

Speaker 9 Thank you.

Mr. Holt Thank you very much.

Mr. Holt Ms. Roach.

Speaker 10 Good afternoon. I'm Karen Roach. I'm the Vice President of Regulatory Affairs at the Health Care Association of New York State. We represent public and non-profit hospitals, health systems and post-acute.

Mr. Holt A little bit closer would be helpful.

Mr. Holt Thank you.

Speaker 10 Strongly supports the pursuit of health equity and improved access to health care for medically underserved communities. Certainly, we support the intent of the regulations. We also appreciate the extent of outreach to stakeholders that Joanne and her team have done. We feel like they certainly are listening. At the same time, we understand that you're bound by the legislature that we're here to implement and arguably could have used some more work in the legislature. A lot of the important points have been covered. A lot of it is process. Again, we're all committed to the same objective, but this is certainly causing a lot of anxiety in terms of implementation, the timeline. I know our members are very concerned about identifying which independent entity would be qualified and pass the conflict-of-interest test and then whether they'll have the capacity. Are there going to be a limited number of entities that are qualified that might get approached by several institutions at the same time? To that end, we're very interested to see the sub regulatory guidance that is anticipated and also might suggest if there's any kind of interim process where a facility could reach out to get a read or maybe you've already had conversations informally with particular entities that you might be able to give an indication of whether they would pass the checklists that you're providing. Second, we do know that obviously, the COVID pandemic has taken a toll on our health care providers and understand that the Department of Health has been under the same pressures over the last three years, leading to turnover and fewer people to do increasing work.

Mr. Holt One minute remaining.

Speaker 10 As has been stated, we're concerned that this requirement will add additional burdens both for the department and on the providers that could create more delays in the CON process. We certainly look forward to working with the department on identifying some other streamlining that could be done to take projects out of the CON system. Finally, we are concerned that the estimated cost to conduct these assessments is underestimated in the regulatory assessment and certainly could pose a hardship to safety net providers. We agree with the comments that perhaps all safety net providers could be exempted from this requirement, recognizing that their core mission is doing exactly what this assessment is seeking to assess. We do plan to submit more detailed comments on the regs.

Mr. Holt Thank you.

Speaker 10 Thank you again for the opportunity to comment.

Mr. Holt Thank you very much.

Mr. Holt That concludes the list of folks from the public who had signed up in advance to speak. I want to thank the members of the public for coming forward and participating in this ongoing process of discussion.

Mr. Holt We'll go back now and open it back up to the members of the committee and counsel, if there are questions.

Mr. Holt Dr. Kalkut.

Dr. Kalkut I think it's hard to estimate how important this can be because clearly equity goes beyond health care. That's what we have in front of us. That's what we can influence. I think we will have to, and I think Jeff said it's an iterative process. We're going to learn by doing. Because this is different, that the current criteria are limited, have been referred to as anachronistic. This is is fresh. This is in a regulatory way; I think many providers are looking at how their changes in their services will impact on communities. This now becomes a regulatory need. I think it's another reason to think about moving this in a stepwise way and taking the strongest factors like closing a hospital, for instance, or closing a service in a hospital that has been longstanding and and having community members, particularly vulnerable community members be dependent on it. Let us learn as we move forward with that.

Dr. Kalkut Thanks.

Mr. Holt Thanks, Dr. Kalkut.

Mr. Holt Apologies. There was another individual who had intended to speak who is here. I'd ask Heidi Siegfried to come forward and remind you that you have three minutes. If you'd state your name into the microphone directly for the record and then we'll get started.

Mr. Holt Can you make sure that the green button is on.

Speaker 11 Oh, there we go.

Speaker 11 Can you start me over again.

Mr. Holt Go ahead.

Speaker 11 I'm Heidi Siegfried. I'm the Health Policy Director at the Center for Independence of the Disabled in New York. Our mission is to make sure that people with disabilities, all types of disabilities, mobility impairments, hearing, seeing and cognitive mental health, self-care have the services and policies they need to live independently in the community. We joined this coalition, Voices for Health System Accountability, because we are considered in the statute as one of the medically underserved groups. There are a lot of great provisions in the statute about considering the needs of people with disabilities. We see this statute and process as one that could be preventative and not burdensome. The idea is that if we look closely at serving people with disabilities adequately before we start doing things, we might avoid later burdens. Thirty years after the Americans with Disabilities Act, people with disabilities are are continuing to encounter difficulties navigating the health care system, which they do experience as a burden. We see that providers don't have exam tables that are raising and lowering. We have had employees who have had to have a pap smear done while they were seated in their wheelchair. We find that the health system doesn't really understand how to accommodate people who have cognitive or sensory disabilities that might require more time for them to be served. We really feel like that this is a process that could be helpful to the health care system.

Mr. Holt One minute remaining.

Speaker 11 In meeting the needs of people with disabilities. We did not agree, by the way, in the sausage making process of legislation. You do have actors who come forward and say, but we're already doing a good job. We serve low-income people. We serve people who use Medicaid and are uninsured, but they also may not be serving them as well as they could. That was an exemption that we did not agree with, but it was said put into the statute. We hope that as this process that is being outlined in the regulations as it goes forward, that it will shine a light, that it will allow for hearing the experiences of people who are using the health care system, the experiences of all types of people, so that the health care system can be made more accessible.

Speaker 11 Thank you.

Mr. Holt Thank you.

Mr. Holt We'll come back then to the members of the committee and counsel to see if there are other questions that you'd like to be discussed at this point.

Mr. Holt Seeing none, then this regulation will now be presented to the full council for information at its upcoming meeting.

Mr. Holt That concludes my report.

Mr. Holt Thank you.

Mr. Kraut I think that concludes the agenda for today. I want to thank everybody, members of the public, people who have been in the room and thank the department for all the work you've done. It's a productive day. We look forward. The next meeting is going to be held two weeks. It's on a Tuesday and not a Thursday.

Mr. Kraut What date?

Mr. Kraut Tuesday, April 18th, New York City.

Mr. Kraut Thank you very much.

Mr. Kraut We are adjourned.