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TRANSCRIPT

Mr. Holt Good morning. I'm Tom Holt. I'm the Chair of the Committee on Codes, Regulations and Legislation. I have the privilege to call to order the Codes Committee and welcome members, participants and observers. I'd like to remind the council members, staff and the audience that this meeting is subject to the Open Meeting Law and is broadcast over the internet. The webcasts are accessed at the Department of Health's website. The on-demand webcast will be available no later than seven days after the meeting, for a minimum of thirty days, and then a copy will be retained in the department for four months. There are some suggestions of ground rules to follow to make this meeting successful. Because there is synchronized captioning it's important that people do not speak over one another. Captioning cannot be done correctly when two people are speaking at the same time. The first time you speak, please state your name and briefly identify yourself as a council member or DOH staff. This will be of assistance to the broadcasting company to record this meeting. Please note that the microphones are hot mics, meaning that they pick up every sound. Therefore, we ask that you avoid rustling papers next to the microphone and also be sensitive to personal conversations or sidebars as the microphones can pick those up as well. As reminder for our audience there's a form that needs to be filled out before you enter the meeting room, which record your attendance at these meetings. And it's required by the Commission on Ethics, Lobbying and Government and in accordance with Executive Law Section 166. This form is also posted on the Department of Health's website under Certificate of Need. In the future, you can fill out this form prior to your council meetings. Thank you for your cooperation in fulfilling our duties as prescribed by law. I'll now, call the meeting to order. We just have a couple of comments to begin with. Because we do have a couple of speakers that are signed up for one of the applications or one of the regulations that are before us this morning. For members of the public, you need to limit your comments to three minutes or less, and I'll be the timer for those. Presenters are limited to one per organization. Please be prepared to deliver your comments promptly after your name is called. Your name will be called in order. Move close to the microphone and deliver your remarks. We have four regulations on the agenda for today. First, for adoption, we have the Statewide Health Information Network of New York or SHIN-NY.

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

Mr. Holt Mr. Jim Kirkwood and Mr. Jonathan Karmel from the department are available and will provide us with information on this proposal.

Mr. Holt We think you might be on mute.

Mr. Holt Are you hearing us there?

Albany Yep, we can hear you.

Mr. Holt There you go.

Mr. Holt Thank you.

Mr. Kirkwood Thank you.

Mr. Kirkwood My name's Jim Kirkwood. From now in the office Health Insurance Programs and also working with formerly the Office of Public Safety. These regulations are intended to modernize the state health information network infrastructure that was been set up over about the past ten or fifteen years. The goal of the regulations is to align with federal standards and how the world of health information exchange is moving across the nation. As you all know, when it started with meaningful use around 2009/2011, there was sort of a ramp up for interoperability for health records. They're moving into the national networks and how they exchange data. What we're trying to do here partially is to align with those national networks to ensure that there's some integration going on between the state health information exchange that we support and also with the national networks. In addition, there was a budget appropriation in the previous budget year to support public health activities and support public health surveillance to be able to after COVID be able to modernize how we exchange data and get information to support public health response. Additionally, the regulations are intended to support the Medicaid 1115 waiver. Where we are, the SHIN-NY is basically the backbone of health in exchange for social care networks to ensure that screening information and assessment referral information can go back and forth between social care networks and facilities that are connected to the SHIN-NY. Specifically, what the regulations do is to standardize interoperability and have more specific interoperability standards with the intent being to align those with national standards that have been promulgated by CMS and the Office of National Coordinator for Health I.T, and also to be able to enable the statewide infrastructure to be able to support reporting. To be able to support that reporting, you know, necessarily for any kind of transmittal that would come from a statewide data repository. There's a stakeholder process that includes those that are regulated, you know, health care facilities, hospitals and others that are subject to the regulations. Everybody understands it's very clear and public what kind of information would both one, be gathered into that statewide data repository and then also what would be released to public health, either at the state or the local level. Additionally, there's we include a requirement for a statewide consent. We also want to standardize participation agreements across the SHIN-NY to ensure that all participants are sort of at an equal playing field across the state.

Mr. Holt Thank you, Mr. Kirkwood.

Mr. Holt Comments from the committee or council?

Mr. Holt Mr. Kraut.

Mr. Kraut I just want to thank the department and the staff for responding to the comments we had made previously and addressing some of the modifications. Just two questions. When we talk about Medicaid purposes, you know, for the administration of the program, does that also include oversight and enforcement activity like audits, professional licensing reviews, fraud and abuse investigations? Do you see that data being used in this way as well?

Mr. Kirkwood No, that's not the intent. I think that generally, you know, the information that those kinds of activities would require is the original information that health care providers would be using. Kind of like what we're thinking about here is an abstract of information.

Mr. Kraut Right, right.

Mr. Kraut The statewide collaboration process that that kind of is going to be the oversight and the rules of the road, so to speak. Is that going to be the policy committee at SHIN-NY? Is that process outside of SHIN-NY?

Mr. Kirkwood It's going to be within the SHIN-NY, but it's going to be an additional committee to the state policy committee. More on the technical standards and how data is exchange and how that aligns with federal standards.

Mr. Kraut I think those are two great clarifications. I think those changes make it a much better regulation. Thank you.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt Ms. Soffel.

Ms. Soffel Denise Soffel, council member. I am interested in how SHIN-NY will be linking with community-based organizations that will be providing social determinants kinds of supports to health care providers and other entities. It's sort of mentioned, but it's not clear to me what kind of support, if any, what kind of expectations, if any, what kind of requirements, if any, are going to be put in place for community-based organizations?

Mr. Kirkwood Sure.

Mr. Kirkwood As part of the waiver, the social care networks, the application to be social care networks currently being assessed and hopefully coming to conclusion very soon. Those social care networks will have to have an I.T. system that supports screening, assessment, referral and basically case management for some of the activities for their network of community-based organizations. The community-based

organizations would be interacting with that health I.T platform. We have a requirement in the RFA for the waiver, the social care networks that would require that the that I.T platform becomes connected to the SHIN-NY to be able to do a qualified entity. The screening information could be made available there. Therefore, also made available back to a health care facility or organization that's providing clinical care.

Ms. Soffel It's the social care network, not the CBO that has responsibility for connectivity and all of that.

Mr. Kirkwood Exactly. One connection from the social care network rather than all this.

Ms. Soffel Got it.

Ms. Soffel Thank you.

Mr. Holt Dr. Watkins.

Dr. Watkins Good morning. Thank you for that great presentation. What I'd like to ask, though, is what impact with this have on our regional health information organizations, for instance. In the Western New York Region, we have Healthy Link. Would this have any impact on those organizations?

Mr. Kirkwood Our goal with their regulation is to ensure we don't want to throw the baby out with bathwater, right? We've been building up these organizations over time and ensuring they can support the communities across the state. I mean, Healthy Link in Western New York is a great example of how they're integrated with the community supporting population health activities. As the qualified entities support more of those population and health activities we don't expect. You know, we want to be able to connect the facilities in the most efficient way. That could mean going through a national network to make that data available to the SHIN-NY. We also want to ensure that the qualified entities that are supporting population health activities locally can be able to continue on. The goal is to keep them functioning and keep them really advancing and evolving over time to be able to support the activity that they're doing now.

Mr. Holt Thank you.

Mr. Holt Other questions?

Mr. Friedrich Marcus Friedrich here. Jim, thank you for the presentation. One thing that was not clear when I read this amendment. We just went through this COVID emergency. Can you talk a little bit about public health and how this will change our way how we handle future health emergencies in terms of projects that you or the department is currently doing or planning to do with this amendment going forward.

Mr. Kirkwood We have six qualified entities across the state. One of the things we found that was we needed consistency across the state when it comes to data

standards, so that everybody is sort of operating at the same level. If a user of the system is connecting in Buffalo versus Montauk they're getting access to the same type of data across the state. How this would change is that we have a stakeholder process where stakeholders would get together and discuss the interoperability standards that would be required across the state, whether they're, again, connecting in Buffalo or connecting in Montauk. That would enable us to identify the data that should be shared across the state for public health purposes. Ensuring that we have a consistency across state. You know, during COVID there's a lot of across within hospitals and systems. There will be differences among how to use local codes and not using national standards necessarily all the time to be able to support when they're connecting to a qualified entity. We want to sort of raise the bar there. When that data gets into a statewide public repository for public health reporting there's consistency across the state. We understand that data is coming from this hospital. A diagnosis looks like this. You know, the same consistent way across the state. That can support the gathering of data. The goal is really to relieve some of the burden that was put on health care entities during COVID. Not everything is a manual activity. That's our goal here.

Mr. Friedrich Thank you.

Mr. Holt Thank you.

Mr. Holt Other questions?

Mr. Holt We didn't have anybody from the public signed up to speak. We'll move into the approval process.

Mr. Holt Do you want to make a reminder? Because we've got some new members here today joining us for the first time that the members of the committee that are voting on this are myself, doctors Yangu, Watkins and Rugge, Ms. Soffel and Mr. Kraut are the members that are actually voting on this actual regulation.

Mr. Holt We have a motion.

Mr. Holt We have a second.

Mr. Holt No further questions.

Mr. Holt All in favor?

All Aye.

Mr. Holt Any opposed?

Mr. Holt Motion carries.

Mr. Holt Thank you.

Mr. Holt Next we have for information reproductive health care standards. This regulation is being presented to this committee for information only and will be presented to the committee in the full Public Health and Health Planning Council and adoption for a later date. Ms. Emily DeLorenzo, Dr. Kirsten Siegenthaler, Mr. William Sacks and Mr. Brett Angle of the department are available and will provide us with information on this proposal.

Dr. Siegenthaler Good morning. My name is Kirsten Siegenthaler.

Dr. Siegenthaler Can you hear me?

Mr. Holt We can.

Dr. Siegenthaler I'm DOH staff. I will be sharing information about this regulation. The proposal is to modernize language within Title 10 of parts 12.13, 12.20 and then Title 18, Part 505.2. The reasons for this really are that these areas of regulation do not reflect the latest clinical information. They include an outdated definition of abortion, and they have language that does not align with the Reproductive Health Act of 2019, which is Public Health Law Section 25 A. The proposal will be to amend Title 10, Part 12 to repeal a current Section 12.13 and replace it with a new amended Section 12.21 to clarify that blood type and RH factor testing should be governed by the latest evidence based clinical guidelines. This will eliminate overdetermined treatment requirements that are inconsistent with current clinical guidelines. This new section would also be reorganized under a heading that addresses reproductive care standards, rather than protection of infants and children against hazards, which was the heading for 12.13. The next is to repeal Section 12.20, which requires that abortion care after twelve weeks of pregnancy provided only in a hospital or an inpatient basis. The reason for this change is that that level of care is not medically necessary. It represents an unacceptable cost and burden for patients. It's further inconsistent with the terms of the Reproductive Health Act. Under Title 18 Section 505.2 will propose to modernize the definition of abortion by expressly including medication and procedural services as deemed appropriate by patient and physician. It's important to note that medication abortion is actually the predominant form of abortion provided and that procedural services are also provided. That these should be the terms that are used and are used currently by health care practitioners. The change also clarifies abortion services may be provided by any health care practitioner licensed in New York State and acting within their lawful scope of practice. It clarifies that qualified practitioners should determine a patient's estimated duration of pregnancy in accordance with the requirements of the Reproductive Health Act Public Health Law 2599B and their use of evidence based clinical guidelines. It would repeal the subsection E3 II due to inconsistencies with the Reproductive Health Act. In this section reads, no physician or other person shall be required to perform or participate in a medical or surgical procedure, which may result in the termination of a pregnancy. These are the proposals that we have included for your information. They have not been posted for public comment. We are here today to share that information. Thank you.

Mr. Holt Thank you.

Mr. Holt Just a general question in terms of process for the department or whoever wants to address this timing. Again, I'm thinking about the new members coming out of the council. This is up for information for us now. Typically, how do these make their way through the process and when would we expect to see this and the other ones that we have for information today to come before us?

Dr. Siegenthaler I would have to defer to my colleagues in the Division of Legal Affairs for help with that.

Mr. Sacks What was the question?

Mr. Holt This is here for information for us just as are the other two regulations. Just a refresher for us as to how the process works. You know, when will we typically expect to see this back? Just for the new members of the council just might be helpful for them to understand that process.

Mr. Sacks Good morning, everyone. William Sacks, Division of Legal Affairs. The regulation in question is currently in the public comment period, which will be closing on July the 7th. The department then has a period of months on which to assemble its responses and to evaluate at that time whether any amendments and what we refer to as a revised rulemaking will be necessary, which would open another public comment period. If we choose not to do that, we will return to you immediately once our responses to the public comments are assembled and we will advance the package for approval.

Mr. Holt Thank you very much.

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

Mr. Holt Dr. Berliner.

Dr. Berliner I believe I heard you say that the new regulation would repeal part of the old regulation that required all practitioners to provide abortions. Is that correct?

Dr. Siegenthaler I don't know if maybe Will or Brett can help with that question. I mean, this would repeal that one sentence. I'm not understanding.

Dr. Berliner I mean, as I understand what you said the current law, the current regulation requires all practitioners to provide abortions if they're legally allowed to do so. That's going to be repealed.

Dr. Siegenthaler Yes.

Dr. Siegenthaler Go ahead.

Mr. Sacks Just the opposite. The current regulation contains what I would characterize as a personal conscience exemption from performing procedures that may be lifesaving, which we the department's position is that is inconsistent with the plain language of the Reproductive Health Act of 2019 and needs to be removed from the reg.

Dr. Siegenthaler It's the opposite. I'm sorry, but if I didn't say that correctly.

Dr. Berliner There won't be a conscience clause anymore if this regulation goes through.

Mr. Sacks Correct.

Dr. Berliner Thank you.

Mr. Holt Thank you.

Mr. Holt Other members of the committee or council?

Mr. Holt This regulation was presented just for information.

Mr. Holt We will move on now to Disease Outbreak Investigation and Response Clarifications. This regulation is being presented to the 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. Dr. Emily Lutterloh and Mr. Jason Riegert from the department are available and will provide us with information on this proposal.

Dr. Lutterloh Can you hear me?

Mr. Holt We can.

Dr. Lutterloh My name is Emily. I don't know. I want to tell you about the proposal for Section 2.6 of Title 10, which addresses investigations of disease. The proposal involves wording changes to make explicit that the department can issue guidance that impacts the conduct of those investigations. It generally brings the language of the reg more in alignment with actual practice. The need for these updates was made apparent last Fall based on public comment from NYSACHO and from the New York City Department of Health and Mental Hygiene that came about as a result to some of the regulation changes last Fall to Section 2. Examples of these changes, include language that allows the department to issue guidance that would then let the local health departments prioritize certain cases of disease for a full investigation. Examples related to the investigation changes last Fall involve like varicella in congregate settings, chlamydia in pregnant individuals obviously are examples that need a full investigation. Additionally, some other wording changes involve changing the word immediately to

with all due speed to account for the range of appropriate response times, depending upon which reportable condition is being dealt with. We also wanted to add as necessary to the provision that references with the training or assistance of the state Department of Health to acknowledge that many local health authorities will not always need such training or assistance. We wanted to add in consultation with the local health authority to the provision about determining the content and other characteristics of investigation updates to acknowledge that the local health department can likely provide valuable input there. We sought input from NYSACHO for these changes. We agree that they are needed.

Mr. Holt We've got some background noise coming in.

Mr. Holt We're getting resolved.

Mr. Holt Go ahead and proceed.

Dr. Lutterloh Thank you.

Dr. Lutterloh We've discussed them multiple times with NYSACHO. I believe that you're in receipt of a March 5th letter from NYSACHO where the changes that describe the changes that were proposed that we're proposing. They partially address the concerns that NYSACHO described in that letter. Both NYSACHO and New York City had some additional requests related to changes that were made to this section during the pandemic, such as the ones that relate to local health department assistance for state led investigations and who is the investigation lead for investigations into state regulated facilities. Those are not addressed in this regulation. We discussed with NYSACHO whether we wanted to make these changes that we all agree on and that are fairly easy changes to make now, or whether we wanted to have the more lengthy and necessary discussions about the more difficult changes and do everything all at once. The consensus that it was that we wanted to make these changes now because like I said, they will help bring the reg more in alignment with current practice. We do anticipate that the additional concerns about other aspects of this section will be brought up and were addressed in the letter that you have from March 4th or March 5th. This was posted to the State Register on Wednesday, June 5th for the sixty-day comment period which ends, August 5th. We hope to present it for adoption at a PHHPC meeting thereafter.

Mr. Holt Thank you.

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

Mr. Holt Dr. Watkins.

Dr. Yang Hi. It's Patsy Yang. It was a 2023 letter from NYSACHO about funding. Does this kick in? Is it required to have an emergency declaration of public health emergency

declaration for 100% reimbursement to local health authorities for these levels above Article 6? Do you know what I'm talking about? That's addressed in your amendment.

Dr. Lutterloh That is not addressed. I'm going to have to defer to my Division of Legal Affairs for that, because that is not at all related to the wording changes that we're suggesting in this update.

Dr. Lutterloh This proposal does not make any changes that would impact that to the best of my knowledge.

Mr. Sacks There is no new restriction being placed on the Commissioner's discretion to issue an imminent threat to public health declaration with this regulatory back.

Dr. Yang Thanks.

Mr. Holt Thank you.

Mr. Holt Any other members?

Mr. Perry I was just going to comment that I really appreciate you working with NYSACHO to move this forward. I know we talked about this at length, when this was being adopted. I believe that at the time we were told that you were going to work to put some of these suggestions into the actual regulation in due time, but you just wanted to move forward with it. I'm glad to see that's been brought back up and that we're going to soon adopt some of these most urgent changes that NYSACHO has addressed. Thank you.

Dr. Lutterloh Thank you.

Dr. Lutterloh We agree this is the follow up to that. These were easy ones. We agree they need to be done and NYSACHO agrees they need to be done.

Mr. Holt Thank you.

Mr. Holt Now, one last time around. It's always hard to see people to your immediate left.

Mr. Holt Again, this was for information, and this regulation will be presented to the full council for information and will come back to us at a later date.

Mr. Holt Lastly, for information, we have the Program of All Inclusive Care for the Elderly Licensure or PACE. This regulation is being presented to the committee for information only. It will be presented to this committee in the full Public Health and Health Planning Council for adoption at a later date. Mr. Mark Furnish and Marthe Ngwashi of the department are available and will provide us with information on this proposal.

Mr. Furnish Good morning, everyone. Its Mark Furnish with the Department of Health to talk about the Program for All Inclusive Care for the Elderly, which is PACE. Now, before I get into what this regulation does, I wanted to give an overview of what PACE is and what the PACE program is designed for, and a little history on that. PACE provides comprehensive medical and social service to certain elderly individuals, mostly of whom are duly eligible for Medicare and Medicaid benefits. The inception of the PACE program began over fifty years ago in California, where senior care providers provided a model that helps seniors age independently, not a nursing home.
Integrating/coordinating every aspect of all care for participants, including medical care, prescription drugs, transportation, home care, socialization, meals, and other benefits. It's one stop shopping that prevents a nursing home, prevents people going into nursing homes as late as possible. Now, the core elements of a PACE model of care is an interdisciplinary team of health professionals, which provide participants with coordinated care, a comprehensive benefit package that enables members to remain in the community rather than receive care in nursing homes, operation of a PACE center where members receive medical care, socialization and other pay services and cap financing, which allows providers to deliver all service participants needs rather than those reimbursed under Medicare or Medicaid fee for service plans. It's a combination Medicare managed plan and a diagnostic and treatment center. Also, home care service agencies. Now, what are the benefits of PACE that they have found over the time that PACE has been around for the past fifty years? They found reduced hospital admissions. PACE members have 24% lower hospitalization rates than other duly eligible beneficiaries who receive Medicaid nursing home services. Better preventative care. Participants receive better preventative care specifically, and respect for hearing and vision screenings, flu shots, and pneumonia vaccines. High rate of community residents. 95% of PACE members live in a community instead of nursing homes. High caregiver satisfaction. 96% of family members are satisfied with pay support. 97.5% of caregivers would recommend PACE. That's what PACE is on the national level. Now, let's pivot to New York. New York is one of thirty-one states that have elected to offer PACE services to duly eligible members, which the first PACE program started in the mid 1980's. Now, right now, there are only nine/soon to be ten PACE plans in the state. Why is that level so low? It looks like an attractive model that we want to increase. New York is unique in that in order to become a PACE provider you have to get three licenses. You have to get the Article 44 Medicaid/HMO license, which right now is currently done. You have to apply and get it through the Office of Health Insurance Programs. You also got to get an Article 28 Diagnostic and Treatment Center license, which right now is the Office of Primary Care and Health Systems Management. It comes to PHHPC for final approval. You have an Article 36 home care or LHCSAs, which can either be contracted out. If you don't contract it out, you need that license as well, which goes to the Office of Aging and Long-Term Care at the department and to PHHPC. It was a real cumbersome and bureaucratic issue we noticed with that. Two years ago, the legislature and signed into law was Article 29EE, which creates a brand-new license for PACE only. It comes to the Public Health and Health Planning Council for approval. It's just like in Article 28 or an Article 36 that you currently review and do now. However, the law is a new license. A PACE organization who wants to do it comes

in. One application reviewed by one single staff. Comes to PHHPC for final approval. Now, to backtrack a little bit, the state isn't the final say of a PACE program. CMS has to approve it as well. They look at the state assurance letter for the Article 44 managed care plan. What this would do is it would come to the department in a single application. It would fill out all those components of a diagnostic and treatment center, although would be a 29EE, not an Article 28 Diagnostic and Treatment Center. The Article 44 Medicaid plan would be in the application. They would answer their Article 36 requirements. That's what the law says. The law also says that anything that mentioned in the law means that Article 28 for Diagnostic and Treatment Center still applies. Managed care plans are still under Article 44 and home care services are under Article 36. The protections that are there don't go away. The law did say, though, that we have to write regulations, which is what this, we're talking about today. It sets up the how to apply procedural way that we're going to do this. One application, the three components, that it goes to PHHPC, what to do when one part is approved, and another is not. Because in the past we've had issues where the Article 28 Diagnostic and Treatment Center will come to you, but the Article 44 is not done yet. You're like, well, wait a minute. Why are we doing this first? That eliminates that chicken and the egg argument that we've had in the past or problem, not an argument. We never argue here. We get rid of that issue. There are other things that we have to look at like what happens if it comes to the Public Health and Health Planning Council, and you don't approve it? What happens then? What are the rights of the applicant? That's in here. What if they decide to change their name? That's in here. Fiduciary agents, all the things that are in regulation now for Article 28 and 36, in terms of how to apply for a license is done here. It's just we had to do it separately for an Article 29EE. This is the How-To manual on how we're going to proceed forward. It doesn't really speak to policy about PACE. That'll be developed over the course of the program. This is the How-To manual on how to get an application in; the fees, what happens, the procedural, voting, things like that. With that, I will, open it up to questions.

Mr. Holt Thank you, Mr. Furnish.

Mr. Holt Members of the committee or council?

Mr. Holt Mr. Robinson.

Mr. Robinson Yeah, just a general question not related to the approval process, but the criteria for eligible applicants who are owners of the PACE program. I think we've seen probably with the encouragement of CMS private sector venture funds and others starting to enter into this world of PACE. What do these regulations do or say with regard to that particular category of owner operator?

Mr. Furnish Sure.

Mr. Furnish It follows the guidance issued in the statute, which says that an incorporator/director/sponsor/stockholder/ members and operators. That is your basic not for profits, your LLCs, your business corporations are still allowed in the Article

29EE, the statute. That's what we allowed for in the regulations as well. We use that language directly from the statute.

Mr. Holt Thank you.

Mr. Holt Other questions from members of the committee or council?

Mr. Holt We do have one member from the committee who has who signed up to speak, Mr. Luke Tobler from the New York State PACE Alliance. There's a button right there at the base of that thing. When it's when it's green it's hot. Pull it as close to you as you can. I'll time you. I'll let you know at the three minutes, please.

Mr. Tobler Thank you.

Mr. Tobler My name is Luke Tobler. I'm here on behalf of the New York State PACE Alliance. Our membership consists of all nine of the state's operating PACE programs, as well as three prospective PACE applicants. I'm joined by Hudson Health Waters, Hudson Headwaters Health Network, who is going to provide commentary of their own. I'd like to start by thanking the committee members for this opportunity to provide comment on the proposed regulations for the licensure of PACE under Article 29EE of the Public Health Forum. Thank you to Mr. Furnish for providing more background on the program of all-inclusive care for the elderly. It is primarily authorized by amendments to both Titles 18 and 19 of the Federal Social Security Act and is the only program that's personally authorized to provide home and community-based nursing home alternative model of care to older individuals. Since its inception, PACE has been the subject of numerous studies and evaluations which have uniformly found the program to be highly advantageous in terms of the quality of care provided, the satisfaction to its participants, and its cost savings. PACE has been described as the gold standard of geriatric care. A 2021 Department of Health and Human Services report concluded that, quote, the PACE program stands out from our analysis as a consistently high performer. During the COVID-19 pandemic the program participants in PACE demonstrated half the mortality rate of nursing home residents and assisted living residents. New York was one of the first states to authorize PACE in the late 1980's. It was first introduced as a demonstration program. By 2011, New York had nine operating PACE programs throughout the state. Unfortunately, today, New York still only has nine operating PACE programs, even though the growth of PACE in other states has accelerated, and despite expressed interest in PACE by numerous potential sponsors and many counties with PACE deserts. Part of the reason for the inability of PACE to expand in New York must be attributed to the state policies and regulations that emanated from the mandatory enrollment for those needing Medicaid funded long term care services and managed long term care partial capitation plans. Aside from also providing Medicaid funded long term care services, PACE has little in common with MLTCP's. PACE covers a holistic set of Medicare benefits in addition to Medicaid long term care services. It employs an eleven-person interdisciplinary care team planning process and is required to directly provide services at a physical site location, what's called the PACE Center. Yet, PACE has been subject to the same statutory base as

partial capitation plans, requiring it to follow the rules and regulations designed for MLTCP's. Except for when it's been in conflict with PACE's federal requirements that have created a complicated and costly regulatory framework of state and federal requirements. As Mr. Furnish mentioned, PACE organizations must be licensed as managed long term care plans, clinics and home care agencies under Article 44, 28, and 36 of New York's Public Health law, creating a daunting array of regulatory requirements that discourage the expansion of PACE in New York and hindered the program's ability to provide services. The draft regulations before the Codes Committee represent what the PACE Alliance and its membership believes to be a major step forward in resolving this problem. In 2022, Governor Hochul signed the PACE Act into law. This legislation, which is similar to what was recommended by the Department of Health and introduced by the Governor's Executive Budget is intended to distinguish PACE as a unique program that that provides the Department of Health with the opportunity to adopt regulations and develop a system of oversight that will encourage, rather discourage, the growth of PACE.

Mr. Holt You're at three minutes. If you could start wrapping up your comments, that would be great. Thank you.

Mr. Tobler You got it.

Mr. Tobler We're pleased that the Department of Health is proceeding with streamlining the licensure and establishment process of PACE. We believe this is only the first step among many things the department could do. We urge the full council and committee to approve these regulations with the recognition that it's only the first step needed to support this federally authorized and permanent nursing home alternative model of care in our state. We look forward to working with the department and encourage the growth at PACE so that every New Yorker has the opportunity to enroll and benefit in this high performing, cost effective program. Thank you for consideration and the opportunity for our comment today.

Mr. Holt Thank you, Mr. Tobler.

Mr. Holt We also have Dr. Tucker Slingerland who signed up.

Mr. Holt If you'd just state your name for the record and your organization you're representing.

Dr. Slingerland Sure.

Dr. Slingerland Hello. I'm Tucker Slingerland. I'm CEO of Hudson Headwaters Health Network and also CEO of PACE at Hudson Headwaters. We are applicant number ten, I think, in the pipe. Here really today to really talk through two items that I think are really important. A little bit of background. Hudson Headwaters Health Network is a federally qualified health center. Actually, next week, we'll have our 24th location covering the Adirondacks and surrounding communities. We have about 180,000 patients seeing

about 10,000 patients a week. There's certainly one person in this room who was there at the beginning, Dr. Rugge, but that work has led to positioning us to do things that are innovative and unique. That was really the attraction that PACE brought. We take care of a lot of patients. Often, I'm sitting across from families wondering, what the next step is for their loved one. There's definitely a role for nursing homes. We provide rounding services and about a half dozen nursing homes, some for profit, some not for profit. There's a purpose for those locations, but we absolutely believe that there has to be a better option for people before they execute that option. With our background in homeward bound/palliative care/primary care, we really, really believe that we can provide this service in the Adirondacks. It can be a test case. The gauntlet, though, is the current process, which, as Mark, thoroughly outlined, really does require vetting application aspects through---

Mr. Holt If you could keep your comments focused just on the actual regulation before us, that'd be great.

Dr. Slingerland Okay.

Dr. Slingerland We feel that these regulations are key there. They will streamline the process. An Article 29 is absolutely the solution. We wholeheartedly support that for the efficiencies. In those regulations, ideally over time there will be comfort and consideration related to the capital requirements necessary for these endeavors to be launched. There is a reason these haven't been launched in the last decade. That is for two reasons. The inefficiencies of the application, which you're addressing and the very high bar of entry, which for us is about $20 million. Money well spent for 225 applicants and people who will benefit from the program, but to scale it and to be able to recommend it to other federally qualified health centers, to other not for profit provider led entities. These issues in the regulations hopefully are addressed. Thank you very much. We're encouraged to see what happens with Article 29.

Mr. Holt Thank you very much. Appreciate your comments.

Mr. Holt That's all we have from the community who had signed up.

Mr. Holt Again, this was before us for information only and will come back to the full council at a future date.

Mr. Holt That concludes this morning's committee meeting.

Mr. Robinson Mr. Holt, you're done with Codes?

Mr. Holt We are.