January 24, 2023

Jeffrey A. Kraut
Chair, Public Health and Health Planning Council
Thomas Holt
Chair, Committee on Codes, Regulations, and Legislation
c/o Executive Secretary, Public Health and Health Planning Council
Empire State Plaza, Corning Tower, Room 1805
Albany, New York 12237

Via Electronic Mail

Re: 20-22 Amendment of Sections 405.11 and 415.19 of Title 10 NYCRR (Hospital and Nursing Home Personal Protective Equipment (PPE) Requirements)

Dear Mr. Kraut, Mr. Holt, and members of the Public Health and Health Planning Council:

I am writing on behalf of the members of LeadingAge New York -- non-profit and public providers of long-term and post-acute care services -- to offer comments on the above-referenced regulations relating to the personal protective equipment (PPE) stockpile requirements applicable to nursing homes. As you know, LeadingAge New York has previously submitted comments on these regulations pointing out that the methodology used to calculate the required PPE amounts has resulted in excessive inventory and waste. We were pleased to see that in this iteration of the regulations the Department has proposed changes in the methodology to rationalize stockpile requirements. Nevertheless, additional changes in the regulation and in State policy are needed to clarify its intent, avoid waste, support the financial viability of nursing homes given unreimbursed PPE stockpile costs, and ensure that adequate PPE is available and appropriately distributed during future pandemics. Our recommendations are set forth below.

## I. Use of Average Occupancy, in lieu of Certified Beds, to Calculate Required PPE Makes Sense, But Clarifications are Needed

The Department has proposed calculating the required PPE based on average annual occupancy rather than certified nursing home beds. We support this change, but request clarification regarding how it will be implemented. Under the proposed regulation, DOH would calculate average occupancy "annually by January 1st of each year," and nursing homes would have 90 days to come into compliance. Since this calculation has not been made by January 1, 2023, the regulation should specify an appropriate date on or after publication of the regulation for the calculation of 2023 stockpile amounts. In addition, the time period in which average census would be measured (e.g., the third calendar quarter or the prior 11 months) should be specified.

The use of average occupancy in the proposed regulation is an important step in the right direction. With approximately 16,000 certified nursing home beds in New York State not in use as of September 2022, the prior methodology has driven excessive stockpiling of PPE that, in many cases, will never be used before its expiration date. The use of average occupancy is aligned more closely (although not exactly) with most other methodologies (including the Hopkins model and the CDC model), which use COVID patient admissions or visits, rather than facility capacity, as the basis for their PPE projections.


13 British American Blvd. Suite 2, Latham, New York 12110-1431
p 518.867.8383 | f 518.867.8384 | www.leadingageny.org

## II. Regulations Should Account for Reusable PPE

The State's formula for calculating the required quantities of PPE should take into account reusable supplies, such as gowns. It appears that at least some Department of Health surveyors require the same quantities of reusable gowns as disposable gowns. However, if the formula indicates a need for 5,000 gowns and the facility is using reusable gowns with a 50-wash lifecycle, then the facility would require 100 gowns in its stockpile to meet a 5,000 use requirement, not 5,000 gowns. If the Department requires the facilities to purchase the 5,000 gowns, whether or not they are reusable, facilities will buy disposables which are less expensive on a per item basis, notwithstanding the impact on the environment and the fact that reusables would be more cost-effective.

## III. Regulations Should Account for the Varying Shelf Life of PPE and Use Sub-Regulatory Guidance to Define the Applicable Positivity Rate

The DOH regulation uses peak periods of COVID incidence to determine the amount of PPE required for stockpiles. If stockpile inventories must be based on worst case scenarios in terms of infection rates, the regulations should provide for different formulas for calculating the required quantity of each type of PPE based on relative shelf lives. In other words, the formula should provide for lower quantities of PPE types that have short shelf lives in comparison with those types that have long shelf lives. This would reduce the likelihood that PPE will expire prior to use.

In addition, we recommend removing the reference to the specific peak periods in Section 415.19 defining the "applicable positivity rate." Instead, those reference dates should be provided through sub-regulatory guidance (e.g., "Dear Administrator Letter"). This would allow the regulations to be better aligned with the current conditions going forward.

## IV. Medicaid Rates Must be Adjusted to Reimburse Nursing Homes for the Cost of their PPE Stockpiles

We support the aim of ensuring that sufficient PPE is readily available to nursing homes in the event of a surge in demand and supply chain failures. Historically, stockpiling PPE has been a government emergency preparedness function, and in many states and countries it remains one. We recognize that government PPE stockpiles fell short during the pandemic and that the allocation of limited public supplies did not prioritize nursing homes. Given the potential for shortfalls in the government supply of PPE, we understand the value of provider supplies in addition to government stockpiles.

However, it is important to recognize that *if providers are to assume the responsibility of stockpiling PPE, government payers must appropriately reimburse them for these expenditures*. Notwithstanding the Regulatory Impact Statement's conclusion that the stockpiles impose no long-term additional costs, the purchase, storage, and management of a 60-day stockpile of PPE is costly. In addition to the cost of the extra supplies, space must be acquired or dedicated, and staff must be retained and assigned to document, report, maintain, rotate, and dispose of the inventory. These expenses are not funded under the existing Medicaid rates. New York's nursing home Medicaid rates are based on *2007 costs, discounted by 9 percent.* According to the federal Medicaid and CHIP Access Commission, New York's gap between nursing home Medicaid rates and costs is among the largest in the country. With approximately 75 percent of New York's nursing home days paid for by Medicaid, the State bears a responsibility to pay for the new PPE stockpile requirement through the Medicaid rates. This cost was clearly not accounted for in 2007.

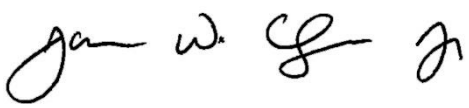
## V. Initiate a Collaborative Effort to Right-Size the Government Stockpile and Develop an Appropriate Allocation Methodology for the Next Supply Chain Disruption

We urge the Department's Office of Primary Care and Health Systems Management, Office of Aging and Long-Term Care, and Office of Public Health to ensure that government stockpiles are appropriately sized and that an appropriate plan is developed, in consultation with all stakeholders, for distribution of supplies in the event of another pandemic or supply chain disruption, based on agreed-upon principles such as regional prevalence or incidence, vulnerability of the population served, and nature of services provided.

The State should also consult with clinical experts on an ongoing basis to determine which supplies are needed in facility stockpiles given evolving epidemiology and development of new equipment.

Thank you very much for your consideration of these issues.

Sincerely yours,



James W. Clyne, Jr.

President & CEO

Cc: John Morley
Jaclyn Sheltry
Adam Herbst
Amir Bassiri