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November 19, 2018

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3346-P
P.O. Box 8010
Baltimore, MD 21244-1810

Submitted electronically to: http://www.regulations.gov

Re: Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction

Dear Administrator Verma:

AARP appreciates the opportunity to comment on this proposed rule regarding regulatory provisions to promote program efficiency, transparency, and burden reduction. AARP's comments will focus on the emergency preparedness provisions and selected other provisions impacting individuals and their family caregivers.

AARP, with its nearly 38 million members in all 50 States, the District of Columbia, and the U.S. territories, is a nonpartisan, nonprofit, nationwide organization that helps empower people to choose how they live as they age, strengthens communities, and fights for the issues that matter most to families, such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

Emergency Preparedness Requirements

Emergencies or disasters can strike anywhere at any time, and it is important for Medicare and Medicaid participating providers and suppliers to have well developed, feasible, and practiced emergency preparedness programs and plans in place. In September 2016, the Centers for Medicare & Medicaid Services (CMS) finalized a rule imposing emergency preparedness requirements on most Medicare and Medicaid facilities. We use the term "facilities" generally as CMS does in the proposed rule to

refer to hospitals and other affected Medicare and Medicaid providers and suppliers where applicable. In some cases, we refer to specific providers, such as nursing homes (long-term care [LTC] facilities). The rule requires a facility to have an emergency preparedness program that includes: risk assessment and emergency planning; policies and procedures; communication plan; and training and testing. The rule was effective November 15, 2016 and had to be implemented by November 15, 2017, thus the rule is relatively new and facilities have not had extensive experience yet under the final rule. Implementation may become smoother and less burdensome over time as facilities gain more experience with their emergency preparedness programs.

In general, we urge CMS to allow more time for facility implementation of and experience with the emergency preparedness final rule before proposing and making changes to the final rule. Emergency preparedness programs are essential for all providers and can be critical to ensuring the safety and well-being of individuals in emergencies. In some scenarios, individuals may be injured and even die in emergencies and disasters, as has unfortunately been the case with nursing home residents. Effective emergency preparedness programs can help reduce harm, injuries, and deaths due to emergencies and disasters, including but not limited to hurricanes. Nursing home residents can frequently have multiple chronic conditions or other complex health needs; dementia or Alzheimer's disease; and need assistance with getting out of bed or a chair, mobility, eating, dressing, managing medications, medical/nursing tasks, or other tasks. Thus, most nursing home residents, if not all, would require assistance for their safety and well-being in the event of an emergency or disaster.

Annual Review of Emergency Program

Facilities participating in Medicare and/or Medicaid are now required to review their emergency preparedness programs annually. This includes review of their emergency plans, policies and procedures, communication plans, and training and testing programs. CMS is proposing to change this requirement to require facilities to review their program at least every two years. While CMS expects facilities would "routinely revise and update their policies and operational procedures to ensure that they are operating based on best practices", this is not a requirement of the regulation. The current rule requiring annual review of emergency preparedness programs ensures at least an annual review of these important plans. Much can change over two years. Given changes and updates that may be needed, current best practices, changes in the resident population, as well as possible changes in facility leadership and staff, local health care providers, transportation companies and other vendors, the characteristics of nursing home residents described above, and prior challenges ensuring the safety and well-being of nursing home residents during disasters, we strongly urge CMS to retain the current requirement for annual review of emergency preparedness programs and withdraw the proposal to make this requirement biennial especially for nursing homes (LTC facilities).

Documentation of Cooperation Efforts

Facilities are currently required to develop and maintain an emergency preparedness plan that includes a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facilities' efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. Because CMS believes elements of this requirement are unduly burdensome on facilities, CMS proposes to eliminate the requirement that facilities document efforts to contact the above emergency preparedness officials and their participation in collaborative and cooperative planning efforts. Coordination, collaboration, cooperation, and planning with emergency preparedness officials is vital to emergency preparedness and successful on-the-ground efforts in an actual emergency or disaster. We note the regulation requires a process for cooperation and collaboration, but it is the documentation that helps demonstrate the implementation of this process and efforts by the facility for cooperation and collaboration. Especially for nursing homes, we urge CMS to maintain, and not remove, the documentation requirements described above.

Annual Emergency Preparedness Training Program

Facilities are required to develop and maintain a training program that is based on the facility's emergency plan. This emergency preparedness training must be provided at least annually and a well-organized effective training program must include initial training in emergency preparedness policies and procedures, per CMS. AARP opposes CMS' proposal to require that facilities provide training every two years instead of annually, particularly in the case of nursing homes. It is unrealistic to expect staff to remember emergency procedures that may have been taught almost two years earlier. Training provides a helpful reminder and refresher of critical preparedness for and response actions in a disaster or emergency. Emergency training could be part of any other annual training the facility provides. With often high staff turnover in nursing homes, annual training helps ensure proper coordination with nursing home staff and leadership at all levels. We do support the proposal to require additional training when a facility's emergency plan is significantly updated, and note that at least in some cases, this could be done as part of regular annual training.

Hospice, Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment

CMS proposes to eliminate the requirement that the interdisciplinary team consult with a pharmacist or person with extensive knowledge of drugs who is either an employee or under contract for this purpose.

While AARP appreciates the intent behind this proposed change, it is unclear why it is needed given CMS' position that many hospices are already meeting the requirement through normal business practices. In the absence of formal research examining the

issue and its role as a beneficiary protection, AARP believes that the regulation in question should not be eliminated.

Hospices are currently required to provide a copy of the hospice's written policies and procedures on the management and disposal of controlled drugs to the patient or representative and family. CMS proposes to replace the requirement that hospices provide a physical paper copy of policies and procedures with a requirement that hospices provide information regarding the use, storage, and disposal of controlled drugs to the patient or representative and family, which can be developed in a manner that addresses the perspective and information needs of patients and families. CMS proposes to require that, regardless of the format chosen, the information must be provided in a manner that allows for continual access to the information on an as-needed basis. We agree it is important that information is presented to individuals and their families in a way that they understand, find useful, and can continually access when needed. However, we urge CMS to require that, regardless of the format that hospices choose, they must also offer to provide a physical paper copy of the information to individuals, their representative, and family so that individuals who prefer information in this format still have access to it.

Home Health Agencies and Patient Rights

CMS proposes to remove the requirement in §484.50(a)(3), as first implemented in January 2018, that home health agencies (HHAs) "Provide verbal notice of the patient's rights and responsibilities in the individual's primary or preferred language and in a manner the individual understands, free of charge, with the use of a competent interpreter if necessary, no later than the completion of the second visit from a skilled professional as described in §484.75." The requirement that notice of patient rights be provided in writing would be retained along with the requirement that information be made accessible in plain language and in a manner that is accessible and timely to persons with disabilities and those with limited English proficiency (thus the verbal notice requirement for all patient's rights and responsibilities is removed). CMS would require oral notice of rights for certain information specified in statute. We urge CMS to retain the existing verbal notice of patient rights and responsibilities. Individuals and their representative or family may find it helpful to discuss their rights and responsibilities directly with HHA staff. It also offers individuals an opportunity to directly ask questions when their rights and responsibilities are being explained.

Hospital Quality Assessment and Performance Improvement Program and Infection Control

CMS allows one governing body to oversee multiple hospitals in a multi-hospital system. CMS is proposing to allow multiple hospitals under one governing body to have one unified Quality Assessment and Performance Improvement (QAPI) Program and infection control program. AARP is concerned that grouping QAPI and infection control scores will mask poor performance. Although most hospitals now belong to multi-hospital systems, and it is tempting to streamline reporting requirements under a single

legal entity, consumers need to have hospital specific information and individual hospitals need to be held accountable. Grouping hospitals together for quality and performance measurement could mislead consumers about the site-specific care they are receiving.

AARP appreciates the opportunity to comment on emergency preparedness and other provisions affecting beneficiaries and their families, and we urge CMS to consider and address our comments in the final rule. If you have questions, please contact me or Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at 202-434-3770.

Sincerely,

David Certner
Legislative Counsel & Legislative Policy Director