United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

November 19, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

I write with great concern about proposed changes to federal health regulations, ostensibly to reduce costs, for which the Centers for Medicare & Medicaid Services ("CMS") is seeking comments.[1] Among other provisions, the proposed rule would weaken the federal government's standards for emergency preparedness at nursing homes. These emergency preparedness requirements for nursing homes went into full effect just last year, more than a decade after the Office of Inspector General first called for reform in the wake of hurricanes Katrina and Rita. Yet the Trump Administration's proposed safety rollbacks would not stop at nursing homes—it would apply to emergency preparedness for virtually all medical facilities. In so doing, the Trump Administration's proposal not only strips residents and patients of common sense protections in order to pad the pockets of medical providers, but goes against the recommendations of well-respected national organizations charged with developing best practices for workplace and medical safety. The Trump Administration should rescind this proposal and reconsider ways to strengthen patient safety, rather than undercut it.

I recently released *Sheltering In Danger*, a report that primarily examines what led to the death of 12 residents in a Florida nursing home following Hurricane Irma, and the impact of Hurricane Harvey on multiple Texas assisted living and long-term care facilities ("LTC").[2] The report's findings clearly show that emergency planning and preparation had been inadequate prior to these hurricanes, and that poor communication with emergency officials compounded the problems during and after they made landfall. The report also examined the adequacy of the recently promulgated CMS emergency preparedness regulations—the very regulations CMS now proposes to weaken—and found that they would not have adequately addressed these shortcomings.

The need for more robust emergency planning requirements to prepare for natural disasters has not abated since last year's storms. During its investigation, my staff identified three nursing

[1] Medicare and Medicaid Programs: Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, 83 Fed. Reg. 183 (Sept. 20, 2018), at 47686, *available* at https://www.gpo.gov/fdsys/pkg/FR-2018-09-20/pdf/2018-19599.pdf.
[2] Press Release, *Wyden Finds Nursing Homes Unprepared for Natural Disasters*, Nov. 2, 2018, *available* at https://www.finance.senate.gov/ranking-members-news/wyden-finds-nursing-homes-unprepared-for-natural-disasters.

homes—two in North Carolina and one in Florida—that had to be evacuated during or after hurricanes Florence and Michael made landfall this year.

Sheltering In Danger, a copy of which is attached to this letter for inclusion in the rulemaking record, makes 18 recommendations to improve nursing home safety during natural disasters. The report calls for strengthening regulations that govern the content of facilities' emergency plans; improving preparation for sheltering-in-place and evacuation, and ensuring effective communication with emergency responders and other key officials. The Trump Administration's proposed rule not only fails to address the areas that report identifies as needing improvement, but actively weakens them by:

- Eliminating requirements for nursing homes and other medical facilities to document their collaborative planning efforts with government emergency preparedness officials.[3]
- Reducing the frequency of internal emergency plan reviews that nursing homes and other medical facilities must complete from once a year to once every two years.[4]
- Scaling back emergency training requirements for employees at nursing homes and other medical facilities from once a year to once every two years.[5]
- Lowering standards for the types of emergency drills that nursing homes and others medical facilities must conduct, and the frequency with which such emergency drills must be completed.[6]

Sheltering In Danger clearly demonstrates that nursing homes need additional training, coordination and collaboration in order to protect patients during hurricanes, forest fires, and other emergencies. The Joint Commission, the health care industry's national accrediting body, has stressed the "importance of planning and testing response plans for emergencies during conditions when the local community cannot support" health care organizations.[7]

The Administration's proposed weakening of emergency preparedness regulations move healthcare facilities in the opposite direction, while generating—at best—negligible savings for patients. Combined, the four emergency preparedness rollbacks would reduce average annual costs by just $2,100 across all types of medical facilities.[8] These miniscule cost reductions are similar for other provisions of the proposed rule. CMS estimated that 24 of the provisions in the proposed rule would generate savings, but six provisions cut average annual costs by less than $10,000 per facility, and nine others cut costs by less than $1,000 per facility per year.

Residents and patients, moreover, are unlikely to benefit from the proposed rule changes, since CMS states that for all of the provisions of the proposed rule, "the initial savings will accrue primarily to providers," and that "how much of these savings flow to insurers and patients depends primarily on the payment and reimbursement mechanisms in place for each affected

---

[3] Contents of the Emergency Plan, *supra* note 1, at 47726
[4] Review of the Emergency Preparedness Program, *Id.*, at 47725.
[5] Training, *Id.*, at 47727.
[6] Testing, *Id.*, at 47728.
[7] The Joint Commission, "Approved: Revisions to Emergency Management Standards for Critical Access Hospitals, Hospitals, and Long Term Care," *Perspectives*, vol. 27 no. 6 (June 2007).
[8] Based on staff analysis of Table 1 of proposed rule, *supra* note 1, at 47691.

entity for those particular costs."[9] CMS has not even attempted to quantify the life-extending benefits or medical cost reduction benefits of the proposed rule's various provisions, which strongly suggests there will be little or no public health benefits from its proposal.[10]

Eliminating proof of coordination with emergency officials

Nursing homes and other medical facilities would no longer need to document coordination efforts with local, tribal, regional, state and federal emergency preparedness agencies, under the proposed rule, which the Administration estimates would save just one hour of compliance work, generating average annual savings $105 for most facilities.[11] These savings are miniscule when compared to the potential catastrophes that can result from inadequate upfront coordination with relevant agencies.

Sheltering In Danger closely examined the Rehabilitation Center at Hollywood Hills, the Broward County nursing home where 12 people died in 2017, after power was knocked out to its air conditioning unit. The investigation showed that the facility's failure to effectively communicate the worsening situation with local and state officials, and its electricity supplier, were major contributors to the disaster there. The report recommended that CMS and states should expand emergency plan requirements to require identification of community resources, such as local hospitals, that can supplement the emergency capabilities of LTCs, especially with regard to health and safety services. It also specifically recommends that emergency plans should be required to include evidence of coordination with those resources, and that facility communication plans should be developed in stricter coordination with local and state emergency planners and agencies.

The problems identified by my investigation are not new. In 2006, the Government Accountability Office reported that hurricane responses in the mid-2000s suffered from a lack of cooperation, coordination and planning, citing findings by the White House, two Congressional committees, and the Office of Inspector General for the Department of Homeland Security.[12] For CMS to, in any way, discourage nursing homes and medical facilities from greater coordination would be antithetical to promoting patient safety.

This provision of the proposed rule also is at odds with recommendations by safety experts, who underscore the need for effective communication plans, and comprehensively documenting reviews of emergency plans. The National Safety Council states that workplaces should "provide the preferred means for reporting fire, medical and other emergencies that occur."[13] The Joint Commission's update to its emergency management standards, repeatedly underscores the importance of documenting emergency plans and other preparatory measures.[14] The Joint

---

[9] *Id.*, at 47744.
[10] *Id.*, at 47744-47745, Table 18.
[11] *Id.*, at 47726 (Table 9).
[12] Government Accountability Office, "Disaster Preparedness: Limitations in Federal Evacuation Assistance for Health Facilities Should Be Addressed," GAO006826 (July 20, 2018), at 10, *available* at https://www.gao.gov/products/GAO-06-826.
[13] Richard T. Vulpitta and Dean R. Larson, "National Safety Council, On-Site Emergency Response Planning Guide for Office, Manufacturing, and Industrial Operations," National Safety Council, 2nd Ed. (2011), at 6.
[14] The Joint Commission, *Emergency Management Standards Supporting Collaboration Planning*, 2016, at 14, *available* at https://www.jointcommission.org/assets/1/6/EM_Stds_Collaboration_2016.pdf. *See* Standard EM.03.01.01, EP1, EP2 and EP3.

Commission also states specifically that a medical facility should "prepare for how it will communicate during emergencies."[15]

By eliminating the requirement that medical facilities document their efforts to coordinate with agencies, CMS is effectively encouraging facilities to assume that communications and coordination will remain the same from year to year. People's roles and responsibilities change frequently at governmental and non-governmental organizations, as does their contact information. It is critical that facilities be required to prove they have made the upfront effort to coordinate with appropriate agencies. It forces facilities to ensure steps are taken to ensure emergency plans are up to date, and can help determine negligence when events go badly wrong.

Reducing the amount of review, training and drills

Three other provisions of the Administration's proposed rule would severely undermine emergency preparedness of medical facilities, including nursing homes. The proposed rule would reduce the frequency of internal emergency plan reviews that nursing homes and other medical facilities must complete to once every two years. It would scale back emergency training requirements for employees from once a year to once every two years. It also would lower standards for the types of emergency drills that nursing homes and others medical facilities must conduct, and the frequency with which such emergency drills must be completed.[16] Each provision stands in stark contrast to the findings of my investigation, and best practices developed by national safety experts.

The facilities reviewed in *Sheltering In Danger* would have benefited from more frequent reviews and revisions of their emergency plans, which were gravely deficient. Moreover, the actions of facilities' administrators and staff during the actual emergencies demonstrated that the training and testing regimes were not effective. They failed to prepare the facilities to deal with likely emergencies—in this case, hurricanes—and failed to identify deficiencies in the emergency plans that could have easily been corrected. The report recommended that CMS and state regulators should have a more active role in reviewing and approving emergency plans. The report also recommends that regulators should strengthen requirements to improve their content, and ensure that medical staff be integrated into both upfront planning and actual response. However, without sufficient internal review, training, and drills, none of these improvements would do much to help when an emergency actually occurs. The three provisions in the proposed rule would therefore negatively alter current regulations, rather than improve them.

The National Safety Council advises that workplaces should "conduct training and practice with proper equipment for employees who are called on to perform special duties, such as rescue, medical duties, hazardous response, fire fighting (sic), etc."[17] Likewise, organizations should "conduct training and practice for employees," and "update the [emergency] plan at least annually and communicate revisions as needed to employees."[18] The Joint Commission likewise states that emergency plans should be reviewed annually, and that the plan be put activated twice

[15] *Id.*, at 6. *See* Standard EM.02.02.01
[16] *Supra* note 1, at 47725-47728.
[17] *supra*, note 13, at 6.
[18] *Id.*

a year.[19] Furthermore, while CMS has suggested that "tabletop sessions" could replace emergency testing/drills, the Joint Commission specifically states that "tabletop sessions, though useful, are not acceptable substitutes for these exercises."[20]

CMS also must recognize that nursing homes, in particular, have very high employee turnover rates.[21] As a result, at any given point in time, many facilities will have front line and managerial staff who have very little experience working together, and may not have a clear understanding of their roles and responsibilities in an emergency response. In sports, a head coach would be loath to field a team that has not practiced together for an important game; CMS should not allow nursing homes to go into an emergency without sufficient preparation and practice.

As with the other parts of its proposal, the Administration estimates that these regulatory changes would do little to lower costs for individual facilities, which means patients would see little or no financial benefit. Eliminating annual review of emergency plans would save LTCs facilities an average of $1,632 annually, and some other types of medical facilities less than $600 a year.[22] Scaling back training requirements would save LTCs an average of $525 annually, and some facilities as little as $200 a year.[23] Finally, rolling back emergency plan testing would save affected medical facilities an average of just $243 a year.[24] These small savings do not justify the potential adverse consequences, including loss of life, which could result from poor emergency preparation.

Conclusion

Sheltering In Danger identifies major deficiencies with the current CMS regulations governing emergency preparedness for nursing homes. It makes concrete proposals that CMS could take to quickly and substantially improve guidance and regulations to better protect some of the nation's most vulnerable citizens. It is troubling to see CMS decide to further roll back its already inadequate safeguards with this proposed rule, which does more to cut corners than cut costs.

Please include this letter and its attachments in the record for this proposed rule (CMS–3346–P). Thank you for your consideration.

Sincerely,

Ron Wyden

Ron Wyden
Ranking Member

Enclosure: *Sheltering In Danger*

---

[19] *supra*, note 14, at 14. *See* Standard EM.03.01.01 EP2, and EM.03.01.03 EP1.
[20] *Id., see* Note 3 of EM.03.01.03 EP1.
[21] Dana B. Mukamel, et al., "The Costs of Turnover in Nursing Homes," *Medical Care* vol. 47 no. 10 (October 2009), at 1039-1045,*available* at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2761533/.
[22] *supra*, note 1, at 47726 (Table 8).
[23] *Id.*, at 47728 (Table 10).
[24] *Id.*, at 47729 (Table 11).