Background and Purpose

- Challenges faced from natural and man-made disasters since 9/11 terrorist attacks.

- Definition of “emergency” or “disaster”: Event affecting the overall target population or the community at large that precipitates the declaration of a state of emergency at a local, state, regional, or national level by an authorized public official.

- CMS reviewed a variety of emergency preparedness (EP) guidance from federal agencies, states, accrediting bodies and standard setting bodies.
  - Many key resources listed in proposed rule.
  - AHA will be posting these as well.
Justification

• CMS also reviewed its existing EP regs
  – Conclusion: not comprehensive enough
    • Doesn‘t address communication, coordination, contingency planning or training
  • CMS concludes: Existing law, guidelines, accrediting organization EP standards, fall short of what is needed for healthcare to be adequately prepared for a disaster
  • Thus, proposed EP regs intended to establish:
    – “a comprehensive, consistent, flexible, and dynamic regulatory approach to EP and response that incorporates the lessons learned from the past, combined with the proven best practices of the present.”
    – Regs would encourage providers and suppliers to coordinate efforts in communities and across state lines.
Key Dates and Facts

• CMS released proposed rule Dec. 20; published in *Federal Register* Dec. 27

• Proposed rule establishes emergency preparedness requirements for 17 types of Medicare/Medicaid providers and suppliers

• Revises the Medicare/Medicaid Conditions of Participation (CoPs) for providers and Conditions of Coverage (CfC) for suppliers

• **Comments due on or before Feb. 25**
Categories of Providers and Suppliers

1. Hospitals
2. Critical Access Hospitals (CAHs)
3. Rural Health Clinics (RHCs) & FQHCs
4. Long-Term Care Facilities (Skilled Nursing Facilities (SNF))
5. Home Health Agencies (HHAs)
6. Ambulatory Surgical Centers (ASCs)
7. Hospice
8. Inpatient Psychiatric Residential Treatment Facilities (PRTFs)
9. Programs of All-Inclusive Care for the Elderly (PACE)
10. Transplant Centers
11. Religious Nonmedical Health Care Institutions (RNHCIs)
12. Intermed. Care Facilities for Indiv. with Intellectual Disabilities (ICF/IID)
14. Comprehensive Outpatient Rehabilitation Facilities (CORFs)
15. Community Mental Health Centers (CMHCs)
16. Organ Procurement Organizations (OPOs)
17. End-Stage Renal Disease (ESRD) Facilities
Comment Submission

Submit comments in one of four ways:


   Follow the "Submit a comment" instructions.

2. By regular mail to the following address ONLY:

   Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-3178-P, P.O. Box 8013, Baltimore, MD 21244-8013.

   Please allow sufficient time for mailed comments to be received before the close of the comment period.

Comments due on or before Feb. 25
3. By express or overnight mail. You may send written comments to the following address ONLY:
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

Comments due on or before Feb. 25
4. By hand or courier to the following addresses:

For delivery in Washington, DC--
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.,
Washington, DC 20201

For delivery in Baltimore, MD--
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

For hand or courier deliveries see the proposed ruling for additional information

Comments due on or before Feb. 25
Summary of Major Provisions

• 5 core elements
  – Emergency Preparedness Program & Plan
    – Based on Risk Assessment
  – Policies and Procedures
  – Communication Plan
  – Training and Testing of Program/Plan
  – Emergency Power Systems
    – Emergency and standby power systems regulations proposed only for inpatient providers (Hospitals, CAHs, LTC/SNFs.)
Proposed Hospital Regs Act as “Template” for Other Providers/Suppliers

• Proposed rule: Hospital regs are “template” for proposed rules for others, except some modification/tailoring to reflect unique needs of other provider/supplier types.

• In general:
  – Inpatient provider proposed regs (e.g. CAH, SNF, LTC) similar to hospital standards.
  – Outpatient providers: can close, cancel appointments, but still may need to shelter or evacuate.
  – CMS expects implementation to be different based on category or provider – CAH vs. Large Hospital

• Hospital and CAH proposed requirements almost identical
Emergency Preparedness Program:

- Emergency Plan:
- Policies and Procedures
- Communications Plan
- Training and Testing
- Emergency and Standby Power Systems (for inpatient providers only)

CMS would require all these program elements to:
- Be developed and maintained by the hospital/CAH
- Reviewed and updated at least annually
**Emergency Management Plan:**

- “All-hazards approach”
- Based on Risk Assessment
- Include Strategies Addressing Emergency Events
  - As Defined in Risk Assessment
- Address Patient Population & Persons at Risk
- List Types of Services Provided in Emergency
- Delegation & Succession Plan
- Process to Ensure Cooperation & Collaboration
  - Local, Tribal, Regional, State, & Federal
- Process to Develop Arrangements with Alternate Care Sites
- Review and Update Annually
Hospital/CAH Proposals
Emergency Management Program and Plan

Policies and Procedures:

- Develop & Implement Based on:
  - EP Plan, Risk Assessment & Communication Plan
- Address Subsistence Needs
  - Patients & Staff Sheltered in Place or Evacuated
- Address Alternate Source of Energy for:
  - Temperature, Emergency Lighting, Fire Detection & Alarm
- Address Provision of Sewage & Waste Disposal
- System to Track Location of Staff & Patients
- Ensure Safe Evacuation
- Address Shelter in Place
- System of Medical Documentation
- Ensure Preservation & Protection
- Address Use of Volunteers
- Address Role under Waiver in Accordance with Section 1135
  - Alternate Care Site
- Review and Update Annually
Communication Plan:

- Provide Contact Information for F, S, T, R & L EM Authorities
- Primary & Alternate Means of Communication
  - Staff & F, S, T, R & L EM Authorities
- Means to Share Medical Documents
- Means to Release Patient Information
- Means to Provide General Condition & Location of Patients
- Means to Provide Occupancy, Needs & Abilities

- Review and Update Annually
Hospital/CAH Proposals
Emergency Management Program and Plan

*Training and Testing Program:*

- Provide Training to All New & Existing Staff
  - Maintain Documentation
  - Provide Annually
- Participate in a Community Mock Drill Annually
  - If not Available – Annual Facility Drill
- If Event Experienced Exempt for 1 Year
- Conduct Paper-Based Drill Annually
- Analyze Response and Maintain Documentation
  - Revise Plan as Needed

- Review and Update Annually
Emergency Power Proposals:

- Hospital Store Emergency Fuel per 2000 LSC
- Test Emergency Power System 4 Hours Annually
  - 100% Anticipated Emergency Load
- Same for CAH’s & LTC Facilities

Additional Recommendations:

- Recommend Subsistence for Volunteers, Visitors & Local Community
- Consider Secondary Source for Electronic Records
- Emergency Power System Located to Protect From Disasters
## Burden and Cost Estimate: Hospitals

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<thead>
<tr>
<th>Requirement</th>
<th>Respondents</th>
<th>Burden Hours Per Respondent</th>
<th>Total Cost</th>
<th>Cost per Respondent</th>
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## Burden and Cost Estimate: CAHs

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CMS Request for Comments on Alternative Approaches to Implementation

CMS requests comments on the following issues.

1. **Targeted approaches to emergency preparedness:** Should CMS cover one or a subset of provider classes to learn from implementation prior to extending the rule to all groups?

2. **A phase in approach:** Should CMS implement the requirements over a longer time horizon, or differential time horizons for the respective provider classes? CMS proposes to implement all of the requirements 1 year after the final rule is published.

3. **Variations of the primary requirements:** E.g., CMS has proposed requiring two annual training exercises. Should both should be required annually, semiannually, or should training be an annual or semiannual requirement?

4. **Integration with current requirements:** How can the proposed requirements be integrated with, or satisfied by, existing policies and procedures which regulated entities may have already adopted?
Major Points of Concern

1. **Current Codes**: Use consensus codes and amended as necessary

2. **All-Hazards Approach**: Use of existing HVA Risk Based Approach.

3. **Sewage and Waste Disposal**: Establishment of individual waste treatment over burdensome

4. **Increased Generator Testing**

5. **Generator location**: For new and replacement not existing

6. **Interpretations of Proposed Rules and Recommendations**