From: Evvie Munley [mailto:EMunley@LeadingAge.org]
Sent: Friday, January 10, 2014 3:58 PM
To: State Executives
Subject: [execforum] CMS Proposed Rule: Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers

FYI and distribution.

Please be advised that the comment period for the CMS Proposed Rule: Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, which would have closed on Tuesday, February 25, 2014, has been extended to Monday, March 31, 2014.

Thank you to those who have already submitted comments.

If you have recommendations / additional recommendations for change or amendment, please respond to me, emunley@leadingage.org, by Tuesday, March 25, 2014.

Thank you in advance.

Evvie

CMS Proposed Rule: Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers

For your review and distribution, following is the link to the December 27, 2013, Federal Register publication of the Centers for Medicare and Medicaid Services (CMS) Proposed Rule: **Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers**

http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-30724.pdf

This proposed rule would establish national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to ensure they adequately plan for both natural and man-made disasters, and coordinate with

federal, state, tribal, regional, and local emergency preparedness systems. It is also intended "…to ensure that these providers and suppliers are adequately prepared to meet the needs of patients, residents, clients, and participants during disasters and emergency situations."

While many of the included healthcare providers are already required to have emergency/disaster plans in place, CMS cites a lack of uniformity and insufficiency in both existing requirements and provider preparedness in proposing these regulations.

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- "For the purpose of this proposed regulation, emergency' or `disaster' can be defined as an 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 such as a governor, the Secretary of the Department of Health and Human Services (HHS), or the President of the United States."

- CMS has identified four core elements that are central to a comprehensive and effective emergency preparedness system:
  - **Emergency plan:** Based on a risk assessment, develop an emergency plan using an all-hazards approach focusing on capacities and capabilities.
    - Risk assessment and planning: This proposed rule would require that prior to establishing an emergency plan, a risk assessment would be performed based on utilizing an 'all-hazards' approach. "An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the provider and supplier considering the particular types of hazards which may most likely occur in their area."
  - **Policies and procedures:** Develop and implement policies and procedures based on the plan and risk assessment.
  - **Communication:** Develop and maintain a communication plan that complies with both Federal and State law. Resident/Patient care must be well-coordinated within the facility, across health care providers, and with State and local public health departments and emergency systems.
    - Patient care must be well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems to protect patient health and safety in the event of a disaster.
  - **Training and testing**: Develop and maintain training and testing programs, including initial and annual trainings, conducting drills and exercises or participate in an actual incident that tests the plan.
    - A well-organized, effective training program must include providing initial training in emergency preparedness policies and procedures. The facility must ensure that staff can demonstrate knowledge of emergency procedures and provide this training at least annually.

Facilities would be required to conduct drills and exercises to test the emergency plan.

- CMS' proposed emergency preparedness requirements would apply to 17 provider and supplier types.
    - The proposed hospital requirements and expectations serve as the base, from which other provider-type requirements follow.
        - CMS' proposal includes variations across provider and supplier categories and/or in accordance with the unique nature of the populations being served. "The variations are based on existing statutory and regulatory policies and differing needs of each provider or supplier type and the individuals to whom they provide health care services."
- All providers and suppliers would be required to establish an emergency preparedness plan that addresses the four core elements.

- **Providers and Suppliers Impacted**
    - **LeadingAge' comments will focus on the providers as identified/highlighted below. To assist in review, the page numbers referencing these providers in both the Preamble and specific regulations, respectively, are included.*

1. Religious Nonmedical Health Care Institutions
2. Ambulatory Surgical Centers (ASCs)
3. **Hospices: D. p. 79106 – 79107; Part 418 – p. 79183 - 79184**
4. Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs (PRTFs)
5. **Programs of All-Inclusive Care for the Elderly (PACE): F. p.79107 – 79108; Part 460 – p. 79185 – 79186**
6. Hospitals
7. Transplant Centers
8. **Long Term Care (LTC) Facilities-Skilled Nursing Facilities (SNFs)/Nursing Facilities (NFs): H. p. 79109 – 79110; part 483 – p. 79187 - 79189**
9. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID): *I. p. 79110 – 79111; Part 483 – p. 79189 - 79190
10. **Home Health Agencies (HHAs): J. p. 79111 – 79112; Part 484 – p. 79190 - 79191**
11. Comprehensive Outpatient Rehabilitation Facilities (CORFs)
12. Critical Access Hospitals (CAHs)
13. Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
14. Community Mental Health Centers (CMHCs)
15. Organ Procurement Organizations (OPOs)
16. Rural Health Clinics (RHCs); Federally Qualified Health Centers (FQHCs)
17. End-Stage Renal Disease (ESRD) Facilities

- **CMS is requesting feedback on several specific proposals:**
    - All in-patient/resident providers would be required to have policies and procedures to maintain various subsistence needs for residents/patients and staff (including, but not limited to food, water, supplies, etc.). Comment is requested on whether this should be a requirement; in what quantities; and for what time period these subsistence needs would be maintained.
    - Testing of emergency generators: The CMS proposal calls for hospitals, critical access (CAHs), and long term care facilities to test their emergency generator systems annually for 4 hours at 100% of the power load. Since this would exceed current NFPA testing and inspection expectations, CMS is requesting feedback and information on this proposal, and, in particular, on the associated costs *[CMS' estimated costs are found at 2. Generator Location and Testing; p. 79171].*
    - Development and implementation of emergency preparedness policies and procedures: CMS is proposing that these policies and procedures be reviewed and updated at least annually. Comment is requested on the timing of the proposed updates.

- **Comment is also requested on alternative approaches to implementation [Column 3; p. 79179]:**
    - Targeted approaches to emergency preparedness - Covering one or a subset of provider classes rather than imposing it on all at once.
    - A phase in approach - Implementing the requirements over a longer time horizon, or differential time horizons for the respective provider classes. The current proposal calls for implementation for all within 1 year from publication of the final rule.
    - Variation of the primary requirements - For example, the current proposal calls for requiring two annual training exercises. Feedback is requested on whether both should be required annually, semi-annually, or if training should be an annual or semi-annual requirement.
    - Integration with current requirements - Comments are solicited on how the proposed requirements will be integrated with/satisfied by existing policies and procedures which regulated entities may have already adopted.

Comments are due to CMS by CoB, February 25.

As always, your input and that of your members is considered both critical and invaluable. **Please respond to me [emunley@leadingage.org] with any recommendations for change and/or amendment ASAP, BUT NO LATER THAN MONDAY, FEBRUARY17.**

Once again we thank you in advance for your assistance!

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