CMS Final Rule: Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers (9/16/16)

https://www.gpo.gov/fdsys/pkg/FR-2016-09-16/pdf/2016-21404.pdf

This final rule establishes 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 assist providers and suppliers to adequately prepare to meet the needs of patients, residents, clients, and participants during disasters and emergency situations."

These regulations are effective 11/15/2016. Implementation is required by 11/15/2017.

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CMS' final emergency preparedness requirements apply to 17 provider and supplier types:

- Religious Nonmedical Health Care Institutions
- Ambulatory Surgical Centers (ASCs)
- **Hospices**
- Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs (PRTFs)
- **Programs of All-Inclusive Care for the Elderly (PACE)**
- Hospitals
- Transplant Centers
- **Long Term Care (LTC) Facilities-Skilled Nursing Facilities (SNFs)/Nursing Facilities (NFs)**
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- **Home Health Agencies (HHAs)**
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals (CAHs)
- Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services

- Community Mental Health Centers (CMHCs)
- Organ Procurement Organizations (OPOs)
- Rural Health Clinics (RHCs); Federally Qualified Health Centers (FQHCs)
- End-Stage Renal Disease (ESRD) Facilities

- Definition: "An emergency or disaster is an event that can affect the facility internally as well as the overall target population or the community at large."

- Hospital requirements serve as the base. However there is some variation for other provider/supplier-type requirements in accordance with their respective characteristics and/or the nature of the populations 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 applicable providers and suppliers are required to meet 4 core elements identified by CMS as central to comprehensive and effective emergency preparedness.
- All 4 core elements focus on continuity of operations vs. recovery of operations:
    - **Risk Assessment and Emergency planning:** Based on a risk assessment, facilities must establish an emergency plan using 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."
            - E.G.s of risk assessment include management of consequences of natural or man-made disasters; fire, power, equipment, and/or water failures; a means to shelter in place or safe evacuation [as applicable]; communications interruptions; interruptions in the normal supply of essentials[as applicable], including subsistence needs, such as food, water, medical/pharmaceutical supplies, alternate sources of energy to maintain safe temperatures, emergency lighting, fire detection, extinguishing, and alarm systems, sewage/waste disposal.
        - Plans must be documented, facility and community-based, and address the population(s) being served, including the types of services the facility is able to provide in an emergency; continuity of operations.

    - **Policies and procedures:** Facilities must develop and implement policies and procedures based on the plan and risk assessment.
        - Policies and procedures must be reviewed/updated annually;
        - Must include procedures to track on-duty staff [as applicable–*see below*]; a system of medical documentation; development of

arrangements with other providers to receive residents/patients [as applicable] in the event of limitation or cessation of operations; use of volunteers.

- **Communication:** Facilities must 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.
  - Communication plans must include systems and needed information to contact appropriate staff; entities providing services under arrangement; residents'/patients' physicians; federal, state tribal, regional and local emergency preparedness staff and/or authorities.

- **Training and testing**: Facilities must develop and maintain training and testing programs that include initial and annual trainings, demonstrate staff knowledge of emergency procedures, documentation of training, and the conducting of drills and exercises at least annually to test the emergency plan.
  - Initial testing must be a 'full scale exercise'; subsequent exercises may be full-scale or tabletop.

- In response to comments, CMS did make changes from the proposed rule, including:
  - Adding flexibility for all provider types to choose the type of exercise it conducts for its second annual testing requirement;
  - Eliminating a requirement for additional hours of generator testing for LTC facilities;
  - Clarifying that tracking during and after an emergency applies to on-duty staff and sheltered residents/patients (removing tracking requirements for home-based hospice; requiring that HHAs have procedures to 'follow up with' on duty staff [vs. tracking]);
  - Eliminating the proposal that HHAs develop arrangements with other HHAs/other providers to receive patients;
  - Clarifying that individual plans for HHA patients are not intended to be extensive emergency preparedness plans, but the result of HHA/patient discussions that "…could be as simple as a detailed emergency card…"
  - Allowing a separately certified facility within a healthcare system to take part in the system's unified emergency preparedness program.

- The final rule includes / references local and national resources related to emergency preparedness, including reports, toolkits, and samples.
- CMS will issue interpretive guidance for the respective provider/supplier requirements.

- CMS will create a designated website for the emergency preparedness rule at https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/SurveyCertEmergPrep/index.html that will house information for providers and suppliers, including templates, provider checklists, sample emergency preparedness plans, disaster-specific information and lessons learned.
    - CMS will also post an all-hazards FAQ document to this site.

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- **SNF/NF:** 483.73 – Emergency Preparedness; Incorporates existing 483.75(m)(1) and (2). [p. 63909 – 63912]
- **HHA:** 484.22 – Condition of Participation: Emergency Preparedness. [p. 63914- 63918]
- **Hospice:** 418.113 - Condition of Participation: Emergency Preparedness; Incorporates existing 418.110(c)(1)(i). [p. 63900 – 63903]
- **PACE:** 460.84 – Emergency Preparedness. [p. 63904 – 63906]

September 15, 2016