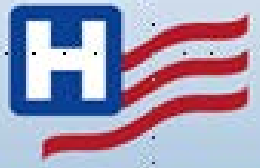
CMS Proposed Emergency Preparedness Rule



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Dedicated to optimizing the health care physical environment

Key Dates and Facts

- CMS released proposed rule Dec. 20; published in *Federal Register* Dec. 27
- AHA *Special Bulletin* issued Dec. 23; a more detailed AHA *Regulatory Advisory* will be issued shortly
- 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
  - CoPs and CfCs are intended to protect public health and safety and ensure high quality care to all persons.
    - Must comply with these requirements to participate in Medicare/Medicaid.
- Comments due on or before Feb. 25

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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)
13. Clinics, Rehab. Agencies, & Public Health Agencies as Providers of Outpatient Physical Therapy & Speech Language Pathology Services
14. Comprehensive Outpatient Rehabilitation Facilities (CORFs)
15. Community Mental Health Centers (CMHCs)
16. Organ Procurement Organizations (OPOs)
17. End-Stage Renal Disease (ESRD) Facilities

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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.

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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.

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Summary of Major Provisions

- 4 core elements to effective and comprehensive framework. These provide framework for the proposed rules for all provider/supplier categories
  - Risk assessment and planning
  - Policies and procedures
  - Communication plan
  - Training and testing

NFPA 99
Assess
Mitigate
Preparedness
Response
Recovery

- Emergency and standby power systems regulations proposed only for inpatient providers
  - Hospitals, CAHs, LTC/SNFs.

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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 PPS hospital

- Hospital and CAH proposed requirements almost identical
  - I use "hospital" in slides, but unless the slide points out difference, the CAH regs are identical.

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– Proposals

Burden and Cost Estimate: Hospitals

Requirement	Respondents	Burden Hours Per Respondent	Total Cost	Cost per Respondent
Risk assessment ICR (Non TJC accred)	1,518	36	$4,437,114	$2,923
EP plan ICR (Non TJC accred)	1,518	62	$7,719,030	$5,085
EP policies/ procedures ICR (TJC accred)	3,410	17	$4,852,430	$1,423
EP policies/procedures ICR (Non TJC accred)	1,518	33	$3,981,714	$2,623
Agreements with other hospitals ICR	4,928	8	$3,543,232	$719
EP communication plan ICR (Non TJC accred)	1,518	10	$1,149,126	$757
EP training/ testing ICR (Non TJC accred)	1,518	40	$3,178,692	$2,094
EP drills/exercises ICR (Non TJC accred)	1,518	9	$793,914	$523
EP drills/exercises econ. impact (Non TJC accred)	1,518	48	$5,100,480	$3,360
Generator testing (Accred)	4,059		$3,413,619	$841
Generator testing (Non accred)	869		$1,096,243	$1,261
TOTAL			**$39,265,594**	**$7,968**

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Burden and Cost Estimate: CAHs

Requirement	Respondents	Burden Hours Per Respondent	Total Cost	Cost per Respondent
Risk assessment ICR (Non TJC accred)	952	15	$903,448	$949
EP plan ICR (Non TJC accred)	952	26	$1,542,240	$1,620
EP policies/ procedures ICR (TJC or AOA accred)	402	10	$327,228	$814
EP policies/procedures ICR (Non accred)	920	14	$791,200	$860
EP communication plan ICR	1322	9	$686,118	$519
EP training/testing ICR	1322	14	$1,102548	$834
EP drills/exercise ICR (Non accred)	920	8	$448,960	$488
EP drills/exercises economic impact (Non accred)	920	20	$1,041,440	$1,132
EP Generator testing economic impact (Non accred)	915		$1,154,273	$1,261
Generator testing economic impact (Accred)	407		$342,287	$841
TOTAL			**$8,339,742**	**$6,308**

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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?

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Major Points of Concern

1. Current life safety codes: Use consensus codes and amended as necessary

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

3. On-site waste sewage: Establishment of individual waste treatment over burdensome

4. Justification for increased generator testing

5. Generator location: For new and replacement not existing

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Discussion Questions

- How closely do these proposed requirements align with what you are already doing? If these proposed regulations are implemented, would you already be mostly in compliance, somewhat in compliance, or barely in compliance? What are the most stark differences?

- What specific concerns do you have about the proposed requirements for developing an emergency plan, including addressing the needs of persons at risk and collaborating with authorities?

- What specific concerns do you have about the proposed requirements for implementing emergency preparedness policies and procedures, such as ensuring for subsistence needs, alternate sources of energy, the tracking of patients and more?

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Discussion Questions

- What specific concerns do you have about the proposed requirement to develop and implement a communication plan?
- What specific concerns do you have about the proposed requirements for training and testing?
- What specific concerns do you have about the proposed requirements for emergency and standby power systems?

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Questions?

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