



MLN Connects®

National Provider Call Transcript



**Centers for Medicare & Medicaid Services
Emergency Preparedness Requirements Call
MLN Connects National Provider Call
Moderator: Leah Nguyen
October 5, 2016
1:30 pm ET**

Contents

Announcements and Introduction 2

Presentation 3

 Overview of the Emergency Preparedness Final Rule 3

Keypad Polling 14

Presentation Continued 15

 Survey and Certification 15

 ASPR TRACIE 17

 Hospital Preparedness Program Overview and Opportunities for Engaging Community
 Partners 19

Question-and-Answer Session 22

Additional Information 38

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Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call.

All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on Emergency Preparedness Requirements. MLN Connects Calls are part of the Medicare Learning Network®.

The Emergency Preparedness Requirement Final Rule established national requirements for Medicare and Medicaid providers. During this call, we will discuss the new requirements and revisions in the final rule, as well as how to plan for both natural and man-made disasters while coordinating with other emergency preparedness systems. A question-and-answer session will follow the presentation.

Before we begin, I have a few announcements.

You should have received a link to the presentation for today's call in previous registration emails. If you have not already done so, please view or download the presentation from the following URL: go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. You will receive an email when these are available.

And, finally, registrants were given the opportunity to submit questions in advance of today's call. We will address many of your questions today and will also use them to develop future resources.

At this time, I would like to turn the call over to Lisa Parker from the Center for Clinical Standards and Quality at CMS.

Presentation

Lisa Parker: Good afternoon. I'm Lisa Parker. I'm the Director of the Division of Institutional Quality Standards here in the Center for Clinical Standards and Quality. We're really pleased this afternoon to have the opportunity to speak with you and to have actually finalized these regulations, which we have been working on for quite some time. We expect that these regs will help ensure that providers are adequately prepared to meet the needs of patients during a disaster, as well as establish a more coordinated response.

We want to thank you for your questions. We received hundreds. And while we're not able to individually address each of those questions, we will speak to some of the issues that you've raised during our presentations. And, then, there will be some websites and emails where you can submit unanswered questions. We'll give those at the end.

Overview of the Emergency Preparedness Final Rule

So, I just want to start with a bit of background about the Conditions of Participation, which—these regulations are actually Medicare and Medicaid Conditions of Participation. The conditions, which we refer to as CoPs, are health and safety regulations which must be met by Medicare and Medicaid participating providers and suppliers. And they serve to protect all individuals receiving services from those organizations. I'm sorry, I'm on slide 5.

The CoPs help ensure that all providers provide high-quality care and work towards continued quality improvement. The regulations apply to all individuals served by a participating facility, not just Medicare beneficiaries. And the requirements do -- the general requirements do vary by provider type. But there are some commonalities. For example, there are regulations regarding administration of various facilities, medical records, infection control, for example, quality assessment. So, emergency preparedness is just one of those sets of regulations.

The challenges for us in developing Conditions of Participation is really to develop requirements that will work for providers with varying characteristics and, while at the same time, striking a balance between patient safety and quality of care and

consideration of the burden on providers. And we really tried to strike that balance in this rule.

Compliance with the conditions is determined by survey, either by an accrediting organization or by a State survey agency. We did receive many questions about how these requirements relate to those of certain accrediting organizations. And, so, I just wanted to speak to that briefly.

We do have the authority to recognize private accreditation in certain settings for purposes of meeting Medicare certification requirements. This allows CMS, through a process called deeming, to consider health care organizations accredited by specific organizations as meeting our CoPs without participating in an additional survey or certification process by the State survey agency.

The standards of accrediting organizations recognized by CMS must meet or exceed our CoPs. So, if you are in compliance with the requirements of a recognized accrediting organization, then you would be considered as meeting our requirements as well.

One of the other questions that we received, before we get into the specifics of the regulation, is: "Do these rules apply to my facility?" The regulation lists the 17 provider and supplier types that the rule will apply to. And it ranges from everything from hospitals, long-term care facilities, religious non-medical health care institution, home health, organ procurement organizations, just to name a few.

The threshold question, we would say, in determining whether or not these rules apply to you is basically, do you already have to comply with other Conditions of Participation, such as those that I mentioned earlier—infection control, governing body, medical records? And do you participate as a facility in Medicare? Do you -- that is, do you serve our beneficiaries and do you receive payment?

I will note that the rule does not apply to physicians' offices as we do not have Conditions of Participation for physicians' offices. The rules do not apply for assisted living facilities, for example, and other types of providers that may not be recognized by Medicare and, therefore, not subject to the Conditions of Participation.

Okay. I am going to go to slide 6 now. We published a proposed rule December the 27th, 2013. And we had a public comment period, which we extended due to the scope and complexity of the proposed rule. The preamble of the proposed rule is a good resource. It does contain a lot of information, and it speaks to the state of emergency preparedness at the time. It talks about various presidential directives that have been issued regarding emergency preparedness. It talks about work done by our HHS colleagues, the Assistant Secretary for Preparedness and Response, lovingly known as ASPR, or – and the work also done by the CDC, the Centers for Disease Control.

In addition, the preamble of the proposed rule gives a brief review of State and local preparedness activities and notes the inconsistency and wild variation in those requirements.

We received nearly 400 public comments on the proposed rule. Commenters included individuals, health care professionals and corporations, national associations, health departments and emergency management professionals, and individual facilities that would be impacted by the regulation. Most commenters spoke about or focused on the hospital requirements. But, the majority of those comments could be applied to additional provider types. We also received comments specific to the requirements we proposed for other provider types.

So, generally, the comments talked about -- well, they were -- they supported the changes and spoke to the need for this type of regulation. Commenters also talked about the timeframes and requested that we delay implementation of the rule or actually phase the rule in by provider type. Commenters talked about overlap with existing standards and requested that we defer to existing standards or laws in certain cases. And, then, some commenters certainly focused on the burden associated with the proposed rule and thought that it may be impractical for certain provider types or too costly to actually comply with.

So, the final rule does respond to all of the comments that we received. So, it provides detail on all of the questions that were sent to us. And I would note that if you haven't had an opportunity to read the proposed rule, there is a link at the back. I believe that, you know, many of your questions could be answered by taking a look at it.

Okay. Moving on to slide 7. I'll give a bit of background about our goals and our thought process in developing this rule. We began working on it in the wake of Katrina when there was a clear need and, we believe, in fact, a demand for this type of regulation, as evidenced by numerous GAO and OIG reports that analyzed the state of preparedness after a disaster and, in addition, many of the inquiries that we would receive here at CMS once a disaster would happen.

So, what we did was we looked at our existing Medicare regulations, and we determined that they were, in fact, inconsistent. While some providers had somewhat of a substantive set of emergency preparedness regulations, other providers had nothing. And we did not believe the existing regulations were sufficient to address the need for communication and coordination, contingency planning, and training.

So, we looked at existing standards to determine best practices. We worked with experts at ASPR to develop standards that meet our goals and core elements that can be implemented across provider types but that were also flexible enough to apply to diverse providers. So, requirements that could be implemented and effective, for example, in a large chain long-term care facility but also could be applied in a small single-owner facility in a rural area.

Our first goal was to address the systemic gaps identified in the reports I mentioned that analyzed the response after disasters. Our second goal was to establish consistency. And we worked to do that by providing a regulatory framework with core components that can be used across provider types as diverse as hospitals, WPOs—work and procurement organizations, home health agencies, while tailoring those requirements for individual provider types to their specific needs and circumstances as well as the needs of the patients they serve.

And then, finally, we really wanted to encourage coordination within communities and States, as well as across State lines. We really wanted to convey that it's imperative that providers think in terms broader than their own facility. And in both the proposed and the final rule, we encourage participation in health care coalitions and want to emphasize the benefits of collaboration such as the use of mutual risk assessments; the development standardized tools, plans, and processes; and also shared training exercises and resource management.

Slide 8. Okay. So, at this point, I will begin a brief walkthrough of the provisions of the final rule. The final rule is effective November the 15th, 2016. The implementation deadline is November the 15th, 2017. The rule will be in effect in 2 months, and we encourage facilities to start planning for compliance. We recognize that, as many commenters noted, certain facilities may need more time to come into compliance. So the rule will not be enforced—that is, facilities will not be surveyed on these requirements—until after the implementation deadline of November 15th, 2017.

We did receive a few questions about our authority to issue these rules. And we wanted to note that we have authority under the Social Security Act to establish requirements, as necessary, to protect the health and safety of patients. The specific statutory and regulatory citations are listed in the final rule.

The final rule identifies four elements essential to an effective emergency preparedness framework. Each element of the plan must be reviewed and updated annually. So, I'll just briefly mention them here, and then, I will speak about them in detail.

The first element is risk assessment and planning. And under this requirement, all providers must develop an emergency plan using an all-hazards approach, which would have them plan and identify in advance essential functions and who is responsible in a crisis. The facilities must develop policies and procedures developed and based on the emergency preparedness plan that speak to issues such as medical documentation and evacuation or sheltering in place.

There must be a communication plan that allows for an alternate means of communication, providing information to local authorities, sharing medical information, providing occupancy information, and the ability to provide assistance to other facilities in the community. And finally, the emergency preparedness program must contain a training and testing element, which basically requires that the facility train staff and test the plan through drills.

The hospital conditions are the most comprehensive as we believe that they are more likely to be the focal point during a disaster and in a better position to coordinate with other providers and officials. So the hospital rules serve as a template for the remainder of the providers, and the regulations are modified based on provider type. And I'll speak

a little bit about that further on in my presentation. But, for the same of consistency, all providers must meet these four elements for their emergency preparedness program.

Okay. Slide 9. The first element, risk assessment and planning. Each provider is required to develop an emergency plan based on a risk assessment. The risk assessment must be documented and use an all-hazards approach. An all-hazards approach is an integrated approach that doesn't specifically address every possible threat, but ensures providers have capacity to address a broad range of related emergencies. We would expect providers to consider business functions that should continue, risks that the provider is likely to confront, contingencies, the location of the provider, and also to determine whether arrangement with other providers is necessary to ensure continuity of care.

The emergency plan must also include strategies to address events identified in the risk assessment, plans for evacuating or sheltering in place, and also arrangements for working with other providers in the area. The plan must address the patient population, continuity of operations, succession planning, and operations. So, for example, with addressing operations, we would expect a facility to address the number of beds that they have available, the level of care that the facility provides, and the availability of staff and supplies during an emergency.

With regard to succession planning, we would address -- we would expect the provider to address issues such as lines of authority and also to ensure that the plan can be implemented promptly and efficiently. And then, finally, there must be a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials to ensure an integrated approach.

In response to public comments, we did make a change in this final rule wherein we're allowing a provider that is part of a health care system consisting of multiple separately certified health care facilities to have one unified and integrated emergency preparedness program. The integrated emergency plan and policies and procedures must be developed in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. In addition, a risk assessment must be conducted for each separately certified facility in the system.

We would note here that each separately certified facility must meet the CoP on its own. So, we encourage integrated health systems to leverage resources and to develop

plans at the corporate level. But those plans must address the specific and unique nature of each separately certified facility within the -- within that system. And one of the reasons that we did that is because, you know, there are some systems that may span a large geographic area and may, therefore, have different risks. So, we need to have each plan address the risks associated with that particular facility.

Okay. Slide 10. Policies and procedures. Each provider must develop and implement policies and procedures based on the emergency plan and the risk assessment. The policies and procedures must address a myriad of topics, and I'll highlight some of them here. There is a full list in the regulation.

The policies must address the provision of subsistence needs, alternate energy sources, sewage and waste disposal, procedures for evacuating or sheltering in place. There must be a system to track the location of staff and patients. There must be safe evacuation considerations, such as care and treatment needs, transportation ID, and evacuation location. The policies must address a means to shelter in place, taking into consideration the ability of a building, for example, to survive a disaster and proactive steps that can be taken prior to an emergency.

There must be a system to preserve medical documentation that ensures confidentiality in compliance with HIPAA. There should be procedures for the use of volunteers and the role of State and Federal health officials and then, also, arrangements with other providers to receive patients in the event of limitation or cessation of operations as well as the method for sharing medical documentation with a receiving provider.

Slide 11. This element is the communication plan, which requires that facilities develop a communication plan that complies with both Federal and State laws. The plan must include names and contact information for physicians, other hospitals, volunteers, State and local emergency preparedness officials. It must include primary and alternate means of communicating with staff and emergency preparedness officials and emergency management agencies such as cell phones or satellite systems. There must be a method to share medical records and patient information, including general location and condition.

And there also must be a method to share information regarding occupancy, the need of -- the occupancy, the needs of the provider, and the health care facility's ability to

provide assistance to other health care entities in the community that may be experiencing some difficulty during the emergency. The goal of the communication plan requirement is to ensure that patient care is coordinated within the facility, across health care providers, and with State and local public health departments and emergency management systems. And just as a reminder, all of the elements that I've mentioned must be reviewed and updated annually.

So, next, we will talk about the training and testing requirements. We received some questions on that. And Ronisha Blackstone from the Emergency Preparedness team will discuss these requirements.

Ronisha Blackstone: Thank you, Lisa.

And good afternoon, everyone. Again, my name is Ronisha Blackstone. And I also work in the Center for Clinical Standards and Quality here within CMS.

And, so, I am on slide 12. And for the fourth element, the regulation requires providers to develop and maintain a training and testing program. This program must include both training and emergency procedures and participation in exercises to test the emergency plan at least annually. In response to the proposed rule, commenters shared concerns regarding the type of testing exercises that providers must conduct and the financial impact that testing requirements may impose. In the final rule, we have taken these concerns into consideration and revised the requirements in hopes of increasing flexibility.

For example, our initial proposal explicitly required providers to conduct one community-based testing exercise and one tabletop exercise as their two testing exercises per year. After consideration of the public comments, in the final rule, we require providers to conduct one community-based full-scale exercise and a second exercise of their choice. This will hopefully afford providers the flexibility to determine which testing exercise is most beneficial to them as they consider their specific needs.

Some of the comments we received during registration questioned the number of testing exercises required per year and raised concerns regarding the financial impacts imposed on facilities. We also received several questions regarding our use of the term "full-scale exercise" and clarification as to what this means.

First, as mentioned previously, providers are required to conduct two testing exercises annually, one community-based full-scale exercise and one additional exercise of their choice. In the event that a provider experiences an actual emergency that tests their plan, they would be exempt from the requirement for a community-based full-scale exercise for 1 year following the emergency event.

Second, we are aware that there are several terms used to describe types of exercises and understand that terminology may vary throughout the industry based on many concerns such as location or provider type. This was an issue that public commenters raised during the comment period, noting several industry terms that are used to describe differing testing exercises. And we received many suggestions for how to label our testing exercise in this regulation.

Our main focus is on the requirement for sufficient testing of the emergency plans to gather valuable information that can be used to analyze a facility's emergency procedures and revise them as necessary, rather than focus on the term used to describe the actual testing exercise because industry terms will continue to evolve and can change over time.

However, in the proposed rule, we referenced the U.S. Department of Homeland and Security's definition of a full-scale exercise, which is described as a multi-agency, multi-jurisdictional, multi-discipline exercise involving functional -- for example, joint field office emergency operation centers -- and boots-on-the-ground response -- for example, firefighters decontaminating mock victims. With that said, for purposes of the requirement for a community-based full-scale exercise, we expect facilities to simulate an anticipated a response to an emergency involving their actual operations and the community. This would involve the creation of scenarios, the engagement and education of personnel, and mock victims/patients. In addition, this would include the involvement of other providers, suppliers, and community emergency response agencies. Collaboration and engagement with community partners should be conducted not only to meet this requirement but for the purposes of determining each partner's role and capabilities in an emergency situation.

The intention of this requirement is to not only assess the feasibility of a provider's emergency plan through testing, but also to encourage providers to become engaged in their community and promote a more coordinated response within the facility, across

health care providers, and with State and local public health departments and emergency systems. Therefore, facilities who are normally excluded from community disaster planning or smaller facilities without close ties to emergency responders and community agencies are encouraged to reach out and gain awareness of the emergency resources and events within their community.

Furthermore, we understand that participation in a community-based full-scale exercise may not always be feasible or readily accessible. Therefore, if a community-based full-scale exercise is not feasible, the requirement does provide providers with the flexibility to conduct a testing exercise that is based on the individual facility.

For purposes of syncing terminology, we believe that this individual facility-based exercise would be the equivalent of a functional exercise which the Department of Homeland and Security describes as an exercise that examines or validates the coordination, command, and control between various multi-agency coordination centers -- for example, emergency operation centers or joint field offices.

A functional exercise does not involve any boots on the ground, that is, first responders or emergency officials responding to an incident in real time. This individual facility-based exercise must be sufficient enough to maintain knowledge and skills and adequately test the emergency plan.

And so, lastly, we understand that some facilities, especially smaller and more rural facilities, may experience difficulties conducting testing exercises and may have concerns regarding the potential financial burden. This final rule will include several adjustments to the requirements to address these concerns, including the 1-year delay of the implementation date. We believe this delayed implementation date will give small and rural facilities sufficient time for compliance.

We've also increased flexibility, as discussed earlier, by allowing for a separately certified health care facility within a health care system to elect to be part of the health care system's unified emergency preparedness program. In addition, we will discuss later in this call the support and resources available to providers through local and national health care systems and health care coalitions to further assist them with complying with these requirements.

So, that concludes my discussion on the fourth element of training and testing.

And we can move to slide 13. And I will hand the discussion back over to Lisa Parker.

Lisa Parker: Thank you, Ronisha.

I will discuss a final element which just applies to certain providers. And that is the requirement for emergency and standby power systems. We included additional requirements for hospitals, critical access hospitals, and long-term care facilities. The requirements are that generators be located in accordance with the National Fire Protection Association guidelines, that generator testing be conducted and also inspection and maintenance, as required by the NFPA, and finally that providers maintain sufficient fuel to sustain power during an emergency.

I would note that in response to public comments, we did revise these requirements. Instead of including specific generator testing requirements for hospitals, critical access hospitals, and long-term care facilities, as we proposed, the final rule requires testing, inspection, and maintenance as required by the NFPA, which would be 4 hours every 36 months.

And then, finally, we just want to note, as I stated in the beginning – oh, I’m sorry -- moving on to slide 14 -- as we stated in the beginning that the requirements of the regulation do vary based on the provider type. So, just a few examples we’ll cite here.

Outpatient providers are not required to have policies and procedures for the provision of subsistence needs, as we would expect these providers to close or to cancel appointments in the event of an emergency. So, we didn’t require them to have stores of food and water.

Home health agencies and hospices—these home care facilities—are required to inform officials of patients in need of evacuation from their homes as they are in a position to have this information.

And then, finally, long-term care and psychiatric residential treatment facilities, places where patients live, residential facilities—these facilities must share information from the emergency plan with residents and family members or representatives.

And, then, in addition, we note that in response to public comments, we also revised the requirements related to tracking patients and staff to reflect differences between residential-type providers where patients have a long-term stay and are expected to return to their facility if possible, home care providers, the tracking needs that would be expected in those facilities and, then, tracking for patients and staff in facilities where there may be a shorter stay for patients or where the patients will be transferred to another health care facility.

So, as Ronisha noted, we do expect that some facilities may have difficulty implementing these requirements. So, we want to note that our goal in these regulations was to allow as much flexibility as possible while maintaining consistency. So, we would hope that facilities are able to implement these requirements in a way that is -- that meets their patients' needs but is also commensurate with their resources.

So, moving on to slide 15, this is the link to the final rule. This is the link to the final rule. We certainly encourage you to take a look at it.

And, now, I'll turn it back over to Leah Nguyen. Thank you.

Keypad Polling

Leah Nguyen: Thank you, Lisa.

At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there will be a few moments of silence while we tabulate the results.

Ronni, we are ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

Operator: Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Leah Nguyen.

Leah Nguyen: Thank you, Ronni.

I'll now turn the call over to Caecilia Blondiaux from the Center for Clinical Standard and Quality at CMS.

Presentation Continued

Caecilia Blondiaux: Thank you, Leah.

Good afternoon. I am Caecilia Blondiaux, CeCe, with Survey and Certification Group here at CMS. And I will provide an update on some of the surveyor guidance as well as some training aspects related to the emergency preparedness rule.

Survey and Certification

I'll go to slide 17. The Survey and Certification Group is in the process of developing the interpretive guidelines. The surveyors will use the interpretive guidelines and survey procedures in State Operations Manual, and the interpretive guidelines will assist in the implementation of the new regulation. We're anticipating the interpretive guidelines to be complete by the spring of 2017. Unlike other Conditions of Participation, which, at times, are changes or added to existing appendices within the SOM, we are creating a whole new appendix and a whole new set of tags for surveyors for these requirements.

Slide 18. As Lisa mentioned, facilities have 1 year to come into compliance with these requirements. And if after 1 year a survey finds non-compliance, the same general process of enforcement will occur as done when other conditions are found out of compliance, such as termination of the provider agreement.

Slide 19. In an effort to assist providers and suppliers prior to the finalization of our interpretive guidelines, we've refaced our emergency preparedness website to include some information related to the regulation. We'll continuously update this website in

the next couple months with resources, such as some provider checklists, sample plans, and example forms.

Slide 20. We encourage stakeholders and emergency care -- and health care emergency preparedness officials to provide us with sample plans and/or resources which may facilitate organizations in meeting the requirements outlined in the regulation. Resources may be emailed to our email box. However, we want to clarify that the Survey and Certification Emergency website is geared towards quick checklists and information. For general and facility-specific health care emergency preparedness examples, case studies, plans, tools, and templates, and other resources, we recommend that individuals contact ASPR TRACIE, which Shayne will talk to you about shortly.

Slide 21. In regards to training, the Survey and Certification Group is starting to develop a web-based self-paced course with our contractors. While training is geared for our surveyors, we are also hopeful to have this available to providers and suppliers. We will provide additional training information as it becomes available to our States and regional offices.

I did want to take a minute to address some of the specific survey and certification questions we received with the registration.

We received some questions regarding the documentation, formatting of the emergency plans, continuity of operations, delegations of authority, and whether these can be included in the facility's emergency operations plan or if they should be separate plans. We want to clarify we're not specifying exactly how a facility should have emergency plans documented and in which order. Upon survey, a facility must be able to demonstrate and show where their plans are located, and the burden of proof is with the provider.

Additionally, if facilities have documentation formatted according to standards provided by State policies, we would accept this as we are not specifically specifying how facilities need to format their hard copy and electronic documentation. The facility is required to demonstrate compliance with the CoPs.

We've also received questions on how these regulations will be monitored for compliance, specifically, how each facility plans be monitored and reviewed and who will be doing the review. Additionally, we received a question asking if CMS is requiring local health and emergency officials to sign off verifying that these organizations have met the requirements.

We want to clarify that each provider and supplier will be surveyed for compliance with the requirements as currently done with any other existing CoPs. We are not requiring the facility's plans to be approved by State or local emergency officials. However, the regulation does require collaboration with State/local emergency officials, depending on the provider type. It is up to the provider if they want their facility to receive signoff from their plans from State/local emergency preparedness officials. Additionally, providers and suppliers have 1 year to implement the requirements. There will be no waivers for the requirements for compliance, and it will follow the same process for termination as within any other of the CoPs.

Finally, we also received inquiries on what the requirements or code for generator testing currently are. We -- as Lisa mentioned, we also want to clarify or address that inpatient facility generators must meet the requirements for inspection, testing, and maintenance of the emergency electrical systems found in NFPA 110 and 101 for emergency and standby power systems and the requirements for the life safety code. Emergency generator location requirements are applicable when a new structure is built or when an existing structure or building is renovated or when the emergency generator is replaced.

Finally, we want to emphasize that while this is a new CoP, these are new requirements in the whole spectrum of CoPs, which are currently -- which we currently require. This CoP will have a new appendix with the SOM, which will provide more guidance. At the end of this call, you'll be provided with contact information should you have subsequent questions or concerns.

Thank you. And I'll turn it over to Shayne at ASPR.

ASPR TRACIE

Shayne Brannman: Thank you, CeCe. And good afternoon, everyone.

I'm going to be talking from slide 23. I'll give you time to get to that slide.

ASPR's Technical Resources, Assistance Center, and Information Exchange—affectionately known as TRACIE—is a health care emergency preparedness information gateway that helps our stakeholders at the Federal, State, local, tribal, health care coalition, and non- and for-profit organizations within the continuum of health care systems have access to information and resources to improve preparedness, response, recovery, and mitigation efforts. CMS and ASPR TRACIE are partnering to provide required technical assistance and share resources and promising practices to help providers and suppliers start or update the documents mandated by the new rule consistent with emergency management and health care system preparedness best practices.

Providers and suppliers that are covered by this rule and their partners may use TRACIE as a resource to meet the requirements in the new rule. Individual facilities should feel free to check with ASPR TRACIE for our resources and sample plans, tools, templates, and questions about -- but all the questions about compliance, interpretation of the regulations, or about how your facility will be assessed should be addressed to your survey entity in CMS.

Let me quickly give you the three domains of TRACIE for reference purposes.

The Technical Resources section has two main components, a resource library containing published and gray literature and searchable by keywords. The second component are what we call Topic Collections. And the Topic Collections highlight key resources under specific health and medical preparedness topics. These collections are unique as they contain resources that were vetted and recommended by the ASPR TRACIE subject matter expert cadre.

Resources in the Technical Resources domain are available to help conduct hazard vulnerability assessments; develop emergency plans, policies and procedures, communication plans, trainings and testing; and conduct corrective action planning.

There is also general emergency management information that can assist in creating an overall emergency management program, including an exercise program. ASPR TRACIE's

Topic Collection can help organizations involved in implementing the CMS requirements with resources tailored to their specific needs.

The second domain of TRACIE is the Assistance Center, which provides person-to-person direct assistance from TRACIE technical assistance specialists Monday through Friday, 9 to 5 eastern standard time.

And then the third element of TRACIE is an Information Exchange, which provides an opportunity for peer-to-peer online discussion boards in near-real-time sharing and the ability to have controlled and password-protected domains.

It is my pleasure now to introduce Melissa Harvey, who is ASPR's director of the Division of National Healthcare Preparedness Programs, for her part of the presentation.

Melissa?

Hospital Preparedness Program Overview and Opportunities for Engaging Community Partners

Melissa Harvey: Thank you so much, Shayne.

I'm going to start on slide 25 to give an overview of what the Hospital Preparedness Program is for anyone on the call who might not be familiar with it.

The Hospital Preparedness Program is a cooperative agreement that ASPR has with all State health departments in the United States, as well as three directly funded cities—that's New York, Chicago, and Los Angeles County—the District of Columbia, as well as our territories and freely associated States. And the goal of the cooperative agreement program is to enable the health care system to save lives during emergencies that exceed the day-to-day capacity of the health and emergency response systems.

We intend to do this recognizing there are a tremendous number of health care facilities that need to be prepared. So, we do this by developing what we call regional health care coalitions that incentivize the diverse and often competitive health care organizations that have differing priorities and objectives to work together both during the planning phase of an emergency and also during the response.

Slide 26, please. These regional efforts help each patient receive the right care at the right place at the right time by distributing resources, having the health care facilities as well as their State and local partners share information and maintain situational awareness, and ensure what we call load sharing, making sure that patient distribution is even and not all patients are going to any one particular facility.

HPP is the only source of Federal funding that supports regional health care system preparedness. And it promotes a sustained national focus to improve patient outcomes, minimize the need for supplemental State and Federal resources during emergencies, and enable rapid recovery.

Slide 27, please. This slide shows what we call a health care coalition, so various types of health care entities, everything from hospitals and long-term care facilities, emergency medical services, State and local partners, including emergency management and public health departments, as well as other types of health care entities and local government partners.

The whole purpose is, again, to have a breakdown of those competitive barriers and have all different types of health care facilities and partners working together to share information in advance of an emergency and during an emergency and make sure that the resources exist to be able to provide care when it exceeds the day-to-day capacity.

Health care coalitions are very variable. We have 500 of them across the entire country. Many of them are in very different stages of development and are governed and structure differently, everything from a hospital-leading health care coalition among all of the members in its geographic area to local public health departments serving as the leaders and everything in between to individual 501(c)3 organizations or other types of standalone organizations. The bottom line is it doesn't necessarily matter. We don't have one particular favorite way that a coalition should be organized and structured. But the key here is to get the partners around the table to help each other plan for emergencies and to respond in a coordinated way.

Slide 28, please. This slide shows health care coalition membership. So right now, as I mentioned, we have 500 health care coalitions and nearly 27,000 health care coalition members. Health care coalitions, many of them started prior to 9/11. Some of them have been really working on their development only since 2012 when it became a

Hospital Preparedness Program requirement. As a result, that shows some of the variability across the country, again, in how they're governed, structured, and matured.

So, there's various different types of providers inside of health care coalitions. And you'll see here that we have 83 percent of all hospitals in the United States currently as members of health care coalitions. And then, from there, participation rates decline a little bit.

So, many of you on the phone who might be from—whether it's skilled nursing facilities, home health agencies, end-stage renal disease or dialysis clinics, rural health clinics—there's various other types of providers and health care coalitions that are excited to see you become members of their health care coalitions and, hopefully, will be ready to assist you with the Conditions of Participation and the requirements of this rule.

That brings me to slide 29. And that's where we'd like to talk a little bit about how the Hospital Preparedness Program can help you when it comes to this rule. In terms of the health care coalitions, we really anticipate that this is a tremendous opportunity for health care coalitions to engage new members and new providers and also affords health care coalitions a tremendous opportunity to achieve greater organizational and community effectiveness.

And this is really in two different ways. It's very important for a health care coalition to be able to demonstrate its value to its members and its members' executives. And by helping to meet its members' needs through the Conditions of Participation, whether it's planning or communications or exercising, these health care coalitions really can demonstrate their value to their members. It also, for those coalitions that are structured and set up in a way to accept funds, can present an additional revenue source should they kind of play a consulting role for their members in terms of helping them with planning and meeting the other requirements of the rule.

So, again, we have about over 26,000 health care coalitions -- health care members of health care coalitions. They are already engaged in community preparedness and may already meet or exceed the baseline level of preparedness in the CMS rule.

But these health care coalitions can serve as an accessible source of preparedness and response best practices. And we hope that you as providers and suppliers will engage them as well as ASPR TRACIE as you strive to meet the Conditions of Participation.

With that, I am going to turn it over to the moderator, who can open it for question and answer.

Question-and-Answer Session

Leah Nguyen: Thank you, Melissa. We will now take your questions. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star one to get back into the queue, and we'll address additional questions as time permits.

All right, Ronni. Ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity.

Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Jocelyn Montgomery.

Jocelyn Montgomery: Hello. Can you hear me?

Leah Nguyen: Yes, we can.

Jocelyn Montgomery: Hi. Jocelyn Montgomery. I work for the California Association...

Leah Nguyen: We can't hear you now. Are you -- are you still on?

Operator: She disconnected.

Leah Nguyen: Okay.

Operator: Your next question comes from the line of Marianne Salem.

Marianne Salem: Hi. My name is Marianne Salem from Solaris Senior Living of Stuart. And I was wondering, are assisted living facilities able to participate in this program?

Lisa Parker: So, assisted living facilities are certainly welcome to adopt these requirements and what we believe are some best practices. But they are not required to comply as assisted living facilities are not a Medicare-recognized provider type.

Marianne Salem: Okay. Thank you.

Operator: Your next question comes from the line of Jennifer Kennedy.

Jennifer Kennedy: Hi. This is Jennifer Kennedy with the National Hospice and Palliative Care Organization. I wondered about the opportunities for hospices to join the coalition, and how would a hospice provider go about that.

Melissa Harvey: Thank you so much. This is Melissa Harvey from ASPR. And we certainly would value participation from hospice providers in health care coalitions.

The best way to go about joining a health care coalition is to contact your State Department of Public Health Emergency Preparedness Division.

And that division -- the director of that division can put you in touch with the health care coalitions in your area. As well, we are working with CMS to make sure that we can show you a map of where the health care coalitions are and put you in touch with the ASPR field project officers for your area, who can also connect you to the health care coalition. So, please stay tuned and continue to visit the CMS website for more information on that.

Jennifer Kennedy: Oh, great. Perfect. Thank you so much.

Operator: Your next question comes from the line of Glen Gill.

Glen Gill: Good morning. It's Glen Gill. Do you have any estimates of the cost of compliance with this regulation? Any estimate at all, please?

Lisa Parker: Yes. This is Lisa Parker. The regulation actually includes a full regulatory impact analysis where we detail the estimated costs associated with each provider. I can tell you that, in total – I'm sorry. I am looking for the information.

In total, we estimate that the rule will have an impact of -- give me one second and I will give you that number -- of \$373 million in the first year and \$25 million in Year 2 and subsequent years. But, if you are associated with a specific provider type, you can go to the reg and it's all spelled out for you there. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Frances Comeau.

Frances Comeau: Are PACE organizations included in this regulation?

Lisa Parker: This is Lisa Parker. Yes. PACE organizations are included.

Frances Comeau: Okay. Thank you very much.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Kara Rath.

Kara Rath: Yes. Does this have -- do DMEs have any -- do they fall under this coalition?

Lisa Parker: Are you talking about durable medical equipment providers?

Kara Rath: Yes, ma'am.

Leah Nguyen: Hold on for one moment.

Lisa Parker: Durable medical equipment providers are not subject to the requirements of these regulations.

Kara Rath: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Andrew Koski.

Andrew Koski: Yes, hi. This is Andrew Koski from the Home Care Association of New York State. And, I think, while many of us do support -- you know, pieces of this provision are very important, we also realize it's going to cost our agencies money to abide by them. And I'm wondering why CMS never appropriated money for this new mandate.

Lisa Parker: Okay. So, with any Condition of Participation what would need to be implemented, we do not appropriate funds. We believe that these provisions need to be complied with within the context of the Medicare reimbursement that facilities do already receive. So, in addition to that, though, we do think that there are many resources that facilities can leverage to comply with these requirements that are free and publicly available.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jocelyn Montgomery.

Jocelyn Montgomery: Hi. I'm going to talk fast. Can you hear me?

Leah Nguyen: Yes, we can.

Jocelyn Montgomery: Great. This has to do with the arrangements with long-term care facilities and other providers to receive residents. So, we're looking at an emergency transfer situation. And I'm wondering, have you clarified at the national level the provisions in the 1135 waiver in a situation where that waiver has not been activated?

So, in other words, in California we've had major evacuations due to fires and other things without ever an 1135 waiver. And providers are left to the interpretation of the

local State Survey Agency offices about how that may be done and whether it's a permanent transfer with full discharge rights and so on.

So, I'm hoping there's some clarification somewhere about the provisions of a temporary relocation of a resident and what the exceptions are in the absence of a waiver. I haven't been able to find it on TRACIE. Is there guidance or will there be guidance forthcoming?

Caecilia Blondiaux: Hi. This is CeCe from CMS. I just -- we have some on our website currently on the CMS Survey and Certification Emergency Prep website that's within the slide deck. And I'll be happy to follow up. There are some instances where an 1135 waiver might not come to play. So, we -- it's treated like a private business mostly with the transfer agreements. But I'd be happy to follow up if you want to shoot me an email.

Jocelyn Montgomery: That would be great. What was your name?

Caecilia Blondiaux: Caecilia Blondiaux. And my email address is within the slide deck.

Jocelyn Montgomery: Okay. Thank you so much.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Kerstin Powell.

Kerstin Powell: Yes. Hello. Can you hear me?

Leah Nguyen: Yes, we can.

Kerstin Powell: I'm wondering -- I'm calling from the Port Gamble S'Klallam Tribe. And we participate in Medicare Part A as a federally qualified health center. Do we need to abide by this?

Lisa Parker: This is Lisa Parker. Yes, ma'am, you would.

Kerstin Powell: Thank you.

Leah Nguyen: Ronni, can we take our next question?

Operator: Yes. Your next question comes from the line of Julio Estrada.

Julio Estrada: Hi. Good morning. Julio Estrada here, West Hills Hospital in Reno, Nevada. My question is, is there a revised Emergency Management Element of Performance that is specifically for behavioral health facilities that I can access? Or how can I get that?

Lisa Parker: Okay. We think that you could use the ASPR TRACIE resources. Shayne, did you want to speak to that?

Shayne Brannman: Yes. I'm sorry. Absolutely., you could come to ASPR TRACIE and we can take care of that for you. And if you want to talk to us directly, just email Ask ASPR TRACIE and we will be glad to contact you and get that information.

Julio Estrada: Oh, okay. Great. So -- but, there is a revised Emergency Management Program then, right?

Shayne Brannman: It's -- I think it would be best if you email us and then we can talk with you one-on-one to kind of walk you through the process tailored to the organization that you're representing.

Julio Estrada: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Bill Bell.

Bill Bell: Yes. This question has to deal with emergency generators. Is it required in the new language that every nursing home, including NFs and SNFs, have an emergency generator? And if so, do they also have to have enough power to be able to heat and air condition a building?

Leah Nguyen: Hold on for one moment.

Caecilia Blondiaux: Hi. This is Caecilia again. So, a long-term care facility generator must meet the requirements under the National Fire Protection Association and the Life Safety Code. So, I would refer you to that. I know the generator location requirements are applicable for new structures and an existing structure or a building that's renovated or when the emergency generator is replaced. So, long-term care facilities must have a generator. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jana Michels.

Jana Michels: Hi. Yes. I'm from a critical access hospital. And I would like clarification. There are requirements from the Joint Commission. And now with your requirements with regard to testing and training, we have to do so many drills a year for Joint Commission in addition now to yours. Are our drills going to be -- have to be separate from what we use for the Joint Commission as opposed to what you're requiring from the CMS? So does that add more drills per year or can we use the same drills for both surveying entities?

Lisa Parker: This is Lisa. The Joint Commission is a recognized accrediting organization with CMS. So, if you meet the Joint Commission requirements, then you would meet these emergency preparedness requirements as well.

Jana Michels: Great.

Lisa Parker: So there should be any need for any extra drills.

Jana Michels: Okay. Thank you very much.

Operator: Your next question comes from the line of Joseph Lopez.

Joseph Lopez: Yes. My question would be -- I'm from Mora Valley Community Health Services. We're a federally qualified health center. And our question in participating is, how do we tie it with -- how do we practice out of scope and do medicine at facilities at remote sites. Our malpractice insurance and all that kind of tell us where to be and what to do, including our State government.

Lisa Parker: This is Lisa. I guess what I would say in response to that question is that these requirements would supersede any State requirements that you have. To the extent that if State requirements are more restrictive than our regulations, then you would follow the State requirements. But if the State requirements are not more restrictive, then you would follow these regulations.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Maria Castaneda.

Maria Castaneda: Hi. Good afternoon, everyone. My name is Maria Castaneda. I'm Secretary/Treasurer of 1199SEIU United Healthcare Workers East. We represent health care workers in the State of New York, Florida, Massachusetts, New Jersey, and Maryland/D.C. We all know as front-line health care workers we are expected to respond to emergencies and disasters to take care of patients and our communities.

And my question is, are there resources allocated for front-line workers' training so that we can respond to all these emergencies like chemical attacks, epidemics and pandemics, internal conflicts. I know after Hurricane Sandy -- because I'm based in New York -- we were able to get training grants with both union and management and our nursing homes and hospitals did training for emergency preparedness.

And I think, we can use some training dollars for front-line health care workers so that we can all be responsive to the emergencies when -- and preparedness is the best protection for emergencies and disasters.

Lisa Parker: Thank you so much. And we certainly all here recognize the importance of health care workers and first responders. And, so, while there is no specific funding associated with these requirements, as Caecilia noted earlier, we will be making our surveyor training available to the general public, the health care workers, and anybody who's interested. In addition, we believe there will be training -- free training also available through ASPR.

Leah Nguyen: Thank you.

Shayne Brannman: Good afternoon. This is Shayne Brannman, Director of ASPR TRACIE. And on our website we have already developed Topic Collections on responder safety health and other resources that I think it would be of invaluable assistance to you and your questions. And, again, you can contact us if you want to have a further discussion about that at Ask ASPR TRACIE.

Melissa Harvey: Thanks. And this is Melissa Harvey. Regarding health care coalitions, that's one of the critical roles of a health care coalition, is to provide training to health care coalition members as well as exercises. And ideally that training is done at the health care coalition level rather than the facility level so that, as you -- as you mentioned with, you know, with pandemic scenarios and personal protective equipment, all the members of the coalition receive similar training on similar types of equipment, which means it could be much more easily shared during those types of emergencies.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Kevin Davis.

Kevin Davis: Yes. I just want to validate and make sure. I thought I heard you say that if we comply with Joint Commission, that your standards are not as stringent as Joint Commission's?

Lisa Parker: The accrediting organizations, including Joint Commission -- their standards have to meet or exceed our standards. And there will be a process by which they will come in and ensure that their standards are updated and that they match with these requirements. But, yes, if your -- if your facility meets the Joint Commission, which is a recognized accrediting organization, then you will be deemed as meeting the standards of these regulations.

Kevin Davis: Great. Okay, thanks.

Lisa Parker: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of John Zaglio.

John Zaglio: Hello. It's John Zaglio from Kent Hospital in Warwick, Rhode Island. I know this kind of question was kind of addressed a little bit earlier. But I'd like to get some clarification. Does the rule require hospitals to connect their chillers and associated cooling equipment to emergency power? Because they are not required to do that at the present time.

Lisa Parker: I'm sorry. Would you repeat that question, please?

John Zaglio: Yes. Does the rule require hospitals to connect the chillers and associated cooling to emergency power?

Caecilia Blondiaux: So, I would say it would be a Life Safety Code and to would look up the Life Safety Code requirements. But...

John Zaglio: It's not -- it is not required right now by Life Safety or -- so, I'm wondering if this is a change with CMS, because the way it's worded, it kind of requires us to maintain temperature.

Caecilia Blondiaux: Right.

John Zaglio: ...with the alternative power. So, the question becomes, are you looking for us to put our chillers on emergency power?

Mary Collins: Well, this is Mary Collins. What we do require under the policies and procedures is that you have emergency power to support the requirements for health and safety for those patients—food, water, and other emergency activities. I'm not really familiar with what you're describing. So you would have to take a look at your plan and make sure that you would have emergency power to comply with the policies and procedures. Thank you.

John Zaglio: Okay. Thank you.

Operator: Your next question comes from the line of Mark Rettig.

Mark Rettig: Yes. Hello. Yes. I'm Mark Rettig from Life Care Center of Sarasota. My question has to -- mostly deal with Caecilia Blondiaux. On your survey and certification emergency preparedness website, it -- I was looking for specific information related to risk analysis and also to the very important topic of active shooter.

On this page, it says it would be updated regularly. But it hasn't been updated since 11/20/2014, and even you yourself today had said it would be updated. I'm just wondering when it would be updated so we could get this important information. Thank you.

Caecilia Blondiaux: Thank you. Thank you for that. So our emergency prep website has been updated as far as, you know, adding the components of the emergency plan. It's not just specifically to the emergency preparedness rule. It's more an all of -- all-encompassing website that should be a tool for providers to use. I would defer you for specific technical assistance to ASPR TRACIE. But we are continuously updating that website with our contact information as well as more resources. If you have specific resources you'd like us to post, feel free to email them to me and we'll -- we'll post them or refer them to TRACIE. Thank you.

Operator: Your next question comes from the line of Gary Grahn.

(Unidentified female): Yes. Could you please explain the difference between the full-scale community-based exercise and a functional drill?

Ronisha Blackstone: So, this is Ronisha Blackstone. And, so, the requirement -- the requirement in the rule is for providers to conduct one community-based full-scale exercise. And so, in the proposed rule, we refer to the Department of Homeland and Security's definition of a full-scale exercise, which is described as a multi-agency, multi-jurisdictional, multi-discipline exercise involving functional and boots-on-the-ground response. If a community-based exercise is not feasible or readily accessible for a provider, the rule does allow providers to conduct an individual facility-based exercise.

And so, this individual facility-based exercise would be described as a functional exercise, which the Department of Homeland Security describes as an exercise that examines or validates the coordination, command, and control between various

multi-agency coordination centers. A functional exercise would not involve any boots on the ground, whereas the full-scale exercise would.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Maria Lera.

Maria Lera: Hi. I'm from a critical access hospital. And we're 13 miles away from a nuclear facility. And every year we have a FEMA exercise that we train for and, then, we have a full-scale evaluation for -- FEMA comes down and they certify us if we pass or not pass. And would that be -- will it meet the compliance as far as the community-based full-scale exercise?

Lisa Parker: Well, we would say that the plan -- your emergency plan has to be based on an all-hazards approach. So, certainly, because you're close to a nuclear facility, that would be one of the hazards that would be possible in your area. But your exercise should address all hazards, not just based on that particular type of disaster.

So, it's hard for us to say at this point that it would -- that it would meet. But it may if it, you know, could apply to all hazards.

Maria Lera: Right. Because it's a -- you know, it's geared towards radiation. But it involves the local authorities, it involves nuclear employees, it involves our staff. So -- and it involves the EMS and it's kind of all coordinated.

Leah Nguyen: One moment.

Lisa Parker: Perhaps you should send an email in to the Survey and Certification email address, and we could take a closer look at it.

Maria Lera: Okay.

Lisa Parker: Thank you.

Maria Lera: Sure. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Penny Pierce. Penny, your line is open.

Question withdrawn. Your next question comes from the line of Fred Peterson.

Fred Peterson: Good afternoon. I'm with the Hospital and Health System Association of Pennsylvania. Thank you for doing this today. It's been very informative.

My question regards the deeming authorities recognizing accrediting organizations. Obviously, the Joint Commission jumps to mind. Then there's Det Norske and the Osteopathic Association. If we get to long-term care, we've got the CARF. I'm just wondering if over the 17 provider types -- provider and supplier types you have a specific list of what organizations you would consider having deeming authority and, if so, where would we find that?

Leah Nguyen: Hold on one moment.

Shayne Brannman: This is Shayne Brannman from ASPR TRACIE. And while our CMS colleagues are conferring, from our standpoint, we actually are developing a quick at-a-glance guide to be able to do that. It's to delineate what the requirement is in the rule and other types of authorities that also require like safety codes, NFPA, Joint Commission for each of the 17 provider types. And we are hoping to have that done before the end of the year.

Lisa Parker: Okay. So, that information is not in the final rule. But, yes, there are many accrediting organizations. And we are certain that that information is somewhere on the CMS website, and we will work to also have it posted on our EP website.

Fred Peterson: Thank you very much. Appreciate that.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Debbie Siler.

Debbie Siler: This is Debbie Siler of Mercy Rehab Hospital Springfield. As a rehab hospital, we have compliance issues. We have to -- 60 percent of our patients have to be compliant with the CMS 13 diagnosis. So, if there were a citywide disaster and we would be needed to take patients from another hospital, would that 60 percent compliance rule be suspended for a certain period of time?

Leah Nguyen: Hold on one moment.

Lisa Parker: So, we were doing some caucusing here. We think that that could be an issue addressed by an 1135 waiver. But it depends on the level and scope of the emergency. So...

Debbie Siler: Okay.

Lisa Parker: ...it would depend on specific situations.

Debbie Siler: Okay. So, heaven forbid that should ever happen, then we would just kind of take it as it comes, then, right?

Lisa Parker: Yes. And communicate with your State and local officials and with CMS. Yes.

Debbie Siler: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Donna Evans.

Donna Evans: Yes. Hi. This is Donna Evans. I was curious. We actually have outpatient rehab facilities, but they are located within senior living communities. So all of our patients are residents of those communities and, therefore, default basically back to the community in the event of an emergency. I do have emergency preparedness policies in place, obviously, and our employees do assist the community with any means they may have as soon as we've made sure that all the patients are successfully turned back over to the community.

But, I was just hoping you could give me some guidance there. Right now, my policy also -- we have our own, but it also points to the fact that we would then default to the community's plan because, of course, they're the ones that are ultimately responsible for those residents. Any feedback you could give me would very helpful. Thank you.

Leah Nguyen: Hold on a moment.

Lisa Parker: Okay. That's a question that we would ask that you send to the email. Are you saying that...

Donna Evans: Okay.

Lisa Parker: ...you are an assisted living facility or a rehab? It's not clear what kind of provider type.

Donna Evans: We are an outpatient rehab provider. But we -- our parent company owns communities, assisted living and dependent living, that kind of thing. So, we are in -- located within those communities, and our goal is to service our residents. We are -- we are a provider under Medicare, though, and we have our own separate space that meets all the Medicare requirements that is strictly our space. But, of course, it's right there and they walk right out and become a resident again, so....

Lisa Parker: So the certified Medicare provider piece would need to meet these conditions and would need to be able to demonstrate compliance separately from the entity that is not Medicare-certified.

Donna Evans: Okay. Thank you.

Leah Nguyen: Thank you.

Lisa Parker: Thank you.

Operator: Your next question comes from the line of Clinton Taylor.

Clinton Taylor: Yes. This is Clinton Taylor from Hendrick Medical Center, Abilene, Texas. And I, again, appreciate this presentation that you've done. The question I have has to

do with the rules that you've made on the exercises. One, I understand about the full-scale exercise. The other one was -- you had mentioned that the second exercise could be -- would be a -- by choice of the institution -- the organization. Can you clarify more on what you're looking for in that?

Ronisha Blackstone: Yes. So, this is Ronisha Blackstone. And, so, in the regulation, we give a few examples. So, a tabletop exercise that includes a group discussion led by a facilitator using a narrated clinically-relevant emergency scenario -- that would be feasible. In addition, we heard through public comments that, under the Joint Commission, hospitals are required to conduct two tests -- full-scale testing exercises a year already.

So, if you were a hospital, you may choose your second exercise to be another full-scale exercise so that you wouldn't have to do something different. So, it's really -- the purpose of the requirement is really to be -- increase flexibility for the providers to determine what would best fit their needs and their situation.

Clinton Taylor: Okay. That answered that. I just -- one followup though. Since Joint Commission is supposed to follow the standards of CMS, I'm just wondering are they going to change their requirement for the two exercises?

Lisa Parker: This is Lisa. The Joint Commission may meet or exceed our standards. So, we really don't know what their plans would be. But, if they want to keep the two full-scale exercises, they'd be okay doing that.

Clinton Taylor: Okay. I understand that. Thank you.

Leah Nguyen: Ronni, we have time for one final question.

Operator: Yes. And your final question comes from the line of Michael May.

Michael May: Yes. I was just wondering if you guys -- I didn't catch the dates of when this was going to go into effect -- it was November -- what -- 15th of 2016? Can you just go over those dates again real quick?

Lisa Parker: Sure. This is Lisa. The rule is effective November the 15th, 2016. And the implementation deadline, the deadline by which all facilities must actually have their plans and be in compliance, is November the 15th, 2017.

Michael May: Okay. Thank you.

Lisa Parker: Thank you.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email general questions about compliance and interpretation of the regulations to the address listed on slide 20 of the presentation.

In addition, feel free to check with ASPR TRACIE for resources, sample plans, tools, and templates at asprtracie.hhs.gov/cmsrule or email the ASPR TRACIE team at askasprtracie@hhs.gov.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 32 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on emergency preparedness requirements. Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

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