The Department of Health and Human Services

New Emergency Management Requirements for Healthcare

September 2016

This week, emergency preparedness requirements for the healthcare industry will be significantly modified. The Department of Health and Human Services has finalized a new rule that will significantly alter the requirements of all Medicare and Medicaid eligible healthcare facilities.

The rule is titled "Medicare and Medicaid Programs: Emergency Management Requirements for Medicare and Medicaid Participating Providers and Suppliers". The Centers for Medicare and Medicaid Services (CMS) first published in December 2013, a Notice of Proposed Rulemaking that would establish national emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers. CMS began this procedure three years ago to ensure health care providers and suppliers adequately plan for natural and man-made disasters, and coordinate with federal, state, tribal, regional, and local emergency preparedness systems. The new rule also ensures these providers and suppliers are adequately prepared to meet the needs of patients, residents, clients, and participants during disasters and emergency situations. The final rule will be published in the Federal Register on September 16, 2016 and be effective 60 days after publication; it must be fully implemented by the end of 2017.

Number of Facilities and Estimated First Year Cost to Implement

Facility	Number of Participants	Total Cost in Year 1 (millions of $)
RNHI	18	0.04
ASC	5,485	22.37
Hospices	4,401	22.43
PRTFs	377	1.47
PACE	119	0.65
Hospital	4,793	46.14
Transplant Ctr	770	0.00
LTC	15,699	68.81
ICF/IID	6,237	22.30
HHA's	12,335	75.62
CORFs	205	0.93
CAHs	1,337	10.83
Organizations	2,135	9.59
CMHCs	198	1.09
OPOs	58	1.13
RHCs & FQHCs	11,500	57.37
ESRD	6,648	34.29
TOTAL	**72,315**	**$373 Million**

Source: CMS Rule, Table 130, pg. 540

CMS estimates the proposed rule change will impact emergency preparedness for 72,315 providers and suppliers. First year cost to implement for all providers and suppliers is estimated at $373 million; 2nd year and thereafter costs are estimated at $25 million. The rule provides no new federal assistance for the purposes of compliance and, no proposals were made to provide any federal assistance. Comments submitted to the docket by healthcare companies and industry associations during the public comment period for the proposed regulation strongly expressed disagreement with CMS's estimated costs, stating the estimates were too low.

IMPACT OF PROPOSED RULE FOR EMERGENCY PREPAREDNESS

The rule directs new and more specific emergency preparedness requirements for 17 categories of Medicare and Medicaid providers and suppliers; these requirements address shortcomings experienced during emergencies over the past 15 years. CMS identified three key elements needed to ensure healthcare is available during emergencies: safeguarding human resources, ensuring business continuity, and protecting physical resources. The new rule also requires coordination and additional planning and training for responses to natural and man-made disasters with the goal of saving patient and staff lives.

To achieve the three elements of continuity of healthcare services during emergencies, CMS identified four core elements central to an effective and comprehensive framework for

participating providers and suppliers. The four elements are: risk assessment and emergency planning, policies and procedures, communication plan, and training and testing. CMS lists specific requirements for each of the 17 categories of providers and suppliers to achieve under these four elements. Standardization of preparedness planning and actions will also be improved across all Medicare and Medicaid providers and suppliers. CMS believes this will facilitate coordination between facilities and with local, tribal, state, and federal emergency and disaster response agencies.

The proposed rule responds to concerns from the Congress, the health care community, and the public regarding the ability of health care providers and suppliers to plan and execute appropriate emergency response procedures to disasters. We developed this proposed rule taking into consideration the extent of regulatory oversight that is currently in existence.

(Federal Register, Vol 78, No 249, December 27, 2013, Part II, Medicare and Medicaid Participating Providers and Suppliers, Proposed.)

RECENT EXPERIENCES WITH EFFECTS OF DISASTERS ON HEALTHCARE

The effects of natural and man-made disasters on healthcare facility patients and staff, and their communities are frequently the subject of national and international media coverage. The loss of lives combined with the public and private support necessary to assist communities in their recovery has raised concerns on preparedness planning and response capabilities and has contributed to the efforts that led to this rulemaking.

The September 11, 2001 attack on America resulted in 2,997 American lives lost. The estimated economic loss to New York City during the first 4 weeks and the airline industry for the two years after the events of September 11, 2001 is estimated to be $123 billion. This event caused public officials and emergency services provider to focus greater efforts focused on federal, state, and local preparedness, coordination, and response capabilities for natural and man-made disasters.

The U.S. government began a series of investigations, reorganization of federal agencies, and establishment of new regulations aimed at preparing government and healthcare organizations for such disasters.

Less than four years later successive Hurricanes in 2005 “Dennis”, “Katrina”, “Rita” and “Wilma” struck the US Gulf of Mexico states causing over $143 billion in damages; the majority of the damages resulted from Katrina. It is estimated that 215 people died in hospitals and nursing homes as a result of Katrina alone. In general, weather related events cause many deaths and injuries each year. According to the National Weather Service, each year there are nearly 500 deaths and over 2,000 injuries resulting from severe weather events such as tornadoes, floods, winter storms, and others weather events.

Contagions also threaten health facilities. As recently as October 2014 a single case of Ebola at Texas Presbyterian Hospital in Dallas caused one death and the loss of $8.1 million, or 25.6% in Texas Presbyterian’s net revenue for the period of October 1-20, 2014. The hospital’s daily census during this same period saw a 21.1% decline in patients from 428 to 337. Clearly the public was avoiding Texas Presbyterian during the period of the contagion.

A report conducted by Health and Human Services Office of the Inspector General completed in 2005 entitled, “Nursing Home Emergency Preparedness and Response during Recent Hurricanes” studied emergency preparedness measures both for the nation and for the Gulf States. The report found nationally and in the Gulf States that 94% of nursing homes nationwide met the limited federal regulations for emergency plans then in existence, while only 80% met the federal standards for emergency training. However, the OIG found that nursing homes in the Gulf states experienced problems even though they were in compliance with federal interpretive guidelines. The OIG report stated the main reasons for these problems were lack of effective planning; failure to properly execute emergency plans; failure to anticipate the specific problems encountered; and failure to adjust decisions and actions to specific situations. The OIG also found that some facility administrators deviated, many significantly, from their emergency plans or worked beyond the plans, either because the plans were not updated or plans did not include instructions for certain circumstances.

(Federal Register, Vol 78, No 249, December 27, 2013, Part II, Medicare and Medicaid Participating Providers and Suppliers, Proposed.)

CONCLUSION

The Centers for Medicare and Medicaid Services’ new regulations for emergency preparedness at US healthcare facilities will have a significant financial and organizational impact on healthcare providers and suppliers nationwide. Despite comments received from many industry groups and participants that the standards were too tough and too expensive, CMS made very few modifications to the proposed rule that was first introduced in the December 2013. CMS’ has maintained that the lives saved from a comprehensive change in emergency preparedness will be worth the costs to the healthcare industry. Many of the commenters on the rule maintained that CMS’ estimate of first year cost impacts on the industry of $373 million was far too low.

Clearly affected facilities will require immediate analysis and review of current procedures in order to comply and receive continued certification. The relatively short compliance window will certainly cause strain for many organizations, both budgetarily, as well as organizationally.

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