

Frequently Asked Questions (FAQs) About CMS Emergency Preparedness Regulation Training and Plan Testing Requirements¹

Q: CMS does not require an approved emergency preparedness plan from the local emergency official but must show coordination with local emergency management officials. What level of coordination will be considered acceptable for the facility emergency plan approval? Will a facility only need an approval for their emergency plan from the CMS servicing agency?

A: Providers and suppliers must document efforts made by the facility to cooperate and collaborate with emergency preparedness officials. While we are aware that the responsibility for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the rule states that providers and suppliers must document efforts made by the facility to cooperate and collaborate with emergency preparedness officials. Since some aspects of collaborating with various levels of government entities may be beyond the control of the provider/supplier, we have stated that these facilities must include in their emergency plan a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials. We also encourage providers and suppliers to engage and collaborate with their local HCC, which commonly includes the health department, emergency management, first responders, and other emergency preparedness professionals. Facilities are required to coordinate with local management officials, such as with their communication plans. For instance, facilities are required to have documentation of their efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts. Facilities are required to have contact information for emergency officials and who they should contact in emergency events; maintain an emergency preparedness communication plan that complies with both federal and state law; and be able to demonstrate collaboration through the full-scale exercises. We are not requiring official “sign-off” from local emergency management officials; however, if the state requires this action, we would expect that facilities comply with their state laws.

Q: What is the regulation’s definition or intent behind the word “community”?

A: We did not define “community”, to afford providers the flexibility to develop disaster drills and exercises that are realistic and reflect their risk assessments. However, the term could mean entities within a state or multi-state region. **The goal of the provision is to ensure that healthcare providers collaborate with other entities within a given community to promote an integrated response.** In the proposed rule, we indicated that we expected hospitals and other providers to participate in healthcare coalitions in their area for additional assistance in effectively meeting this requirement. Conducting exercises at the healthcare coalition level could help to reduce the administrative burden on individual healthcare facilities and demonstrate the value of connecting into the broader medical response community, as well as the local health and emergency management agencies, during emergency preparedness planning and response activities.

¹ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html>

Q: What does the term “training” encompass? Is the content and the extent of the training at the discretion of the facility?

A: A well organized, effective training program must include initial training for new and existing staff in emergency preparedness policies and procedures as well as annual refresher trainings. The facility must offer annual emergency preparedness training in which staff can demonstrate knowledge of emergency procedures. The facility must also conduct drills and exercises to test the emergency plan to identify gaps and areas for improvement. We expect facilities to delineate responsibilities for all of their facility’s workers in their emergency preparedness plans and to determine the appropriate level of training for each professional role. Therefore, facilities will have discretion in determining what encompasses appropriate training for the different staff positions/roles.

Q: Please define “all-employees” in the term of being able to demonstrate knowledge of emergency plans and procedures.

A: Employee’s or the term “staff” refers to all individuals that are employed directly by a facility. The phrase “individuals providing services under arrangement” means services furnished under arrangement that are subject to a written contract conforming with the requirements specified in section 1861(w) of the Act. We refer providers back to the regulation text for further information (81 FR. 63891).

Q: What kind of training will be developed specifically for providers and suppliers to prepare for implementation of the rule?

A: CMS does not expect to develop training specifically for providers and suppliers. Healthcare associations and state, local and other Federal healthcare agencies may provide training for providers and suppliers. However, training provided by these organizations is only a tool to assist facilities in preparing for implementation of the rule and does not mean that a provider or supplier is² in compliance by having received the training.

Q: If we choose to conduct a functional versus a community-based test of the plan, what kind of justification do we have to provide on why we chose one over the other? Do we have to demonstrate that we tested our coordination with referrers and hospitals and community providers under a functional assessment?

A: We are not specifying the format of documentation to allow for flexibility. However, we would encourage facilities who chose a functional versus community-based test to show why this approach was more favorable- i.e. community-based testing is not available due to the rural area/geographic location of the facilities.

Q: Regarding fulfilling the testing needs: Do we indeed to conduct two tests a year? And minimally one of them needs to be a community-based test? If an emergency presents itself between November 15, 2017 and December 31, 2017, would that satisfy one testing need?

² All of these FAQs can be found at the CMS website <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html> under “Downloads”.

Would that be the community-based need? And would that cover us for the period until November 15, 2018 or until the end of the calendar year 2017?

A: Facilities are required to participate in a full-scale exercise that is community-based or when an individual facility-based exercise when a community-based exercise is not accessible AND conduct an additional exercise that may include a second full-scale community or facility-based exercise or a tabletop exercise (as described in the regulations.) So yes, a facility is required to conduct two tests annually. If the facility experienced an emergency and had to activate its emergency plan between November 15, 2017 and December 31, 2017 that would satisfy one of the annual testing requirements and would exempt the facility from engaging in a community or facility-based exercise for one year following the date of the actual emergency event. The “annual” testing requirement will not be measured on a calendar year basis which is January 1 through December 31. The annual requirement will be measured from the date of the last actual emergency event or the date the exercise/testing took place.

Examples of Table-Top Exercises (TTX) or Full-Scale Exercises

Q: Some providers have asked CMS to provide examples for what exercises facilities should consider.

A: The training and exercise requirements of the regulation call for individual-facility and/or full-scale community-based exercises, the below are some examples of exercise considerations:

- Earthquakes
- Tornados
- Hurricane
- Flooding
- Fires
- Cyber Security Attack
- Single-Facility Disaster (power-outage)
- Medical Surge (i.e. community disaster leading to influx of patients)
- Infectious Disease Outbreak
- Active Shooter

Q: If a facility accepted patient transfers due to another facility’s real-world emergency, is the “accepting” facility exempt from the annual full-scale exercise requirement under 482.15(d)(2)(i)?

A: The receiving facility may be considered under the exemption above for 1 year following the actual disaster ONLY if it activated its own facility emergency plans. For instance, in a patient surge incident which led nursing home residents to be evacuated to a hospital, the hospital would be exempt if it activated its emergency plan. Note: This exemption is applicable to all provider and supplier types.

Q: If a state or local emergency response agency conducts its annual emergency preparedness exercise the 3rd week of November 2017 (past the CMS implementation date of November

15, 2017), will a facility be out of compliance if it does not participate in a full-scale community-based exercise by November 15, 2017, but instead participates in the state/local exercise during the third week of November 2017?

A: Facilities must be compliant with the two training exercises requirement by November 15, 2017. The regulation allows for facilities to conduct an individual facility-based exercise if a full-scale community-based exercise is unavailable. If the facility chooses not to participate in a community-based exercise prior to November 15, 2017 and does not complete an individual full-scale facility-based exercise (in place of a community-based exercise), it would be out of compliance.

Surveyors will likely cite the non-compliance as standard-level non-compliance (Level C for Long Term Care facilities) in this first year as modified enforcement. As with any other noncompliance, the facility would submit an acceptable plan of correction which would include plans to participate in the required training exercises. Facilities will be expected to demonstrate to surveyors that it has completed 2 of the required training exercises within the previous 12 months, or between November 15th and November 15th of the following year.

It is important to note that facilities which experience an actual emergency requiring activation of their emergency plan are exempt from the full-scale requirement for that annual year but must still meet the second exercise requirement (i.e. table-top exercise or exercise of their choice).