

CMS and Disasters: Resources at Your Fingertips

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Introduction

This document provides information and resources for Centers for Medicare and Medicaid Services (CMS) disaster and emergency related programs.

NOTICE: ASPR TRACIE developed this Resources at Your Fingertips document to provide easy to understand information and quick references for those affected by the CMS Emergency Preparedness Rule and other CMS disaster and emergency related issues. This document is not meant to be an exhaustive list of requirements nor should it serve as a substitute for the regulatory text, the interpretive guidance, the State Operations Manual, or consultation with State Survey Agencies and CMS.

This document will be updated regularly as new information and resources are developed.

CMS Emergency Preparedness Rule

CMS issued the [Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule](#) to establish consistent emergency preparedness requirements for healthcare providers participating in Medicare and Medicaid, increase patient safety during emergencies, and establish a more coordinated response to natural and human-caused disasters. The U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (ASPR) worked closely with CMS in the development of the rule. This document provides links to numerous related resources applicable to a variety of providers and suppliers.

The rule was published on September 16, 2016 and is effective as of November 15, 2016. The regulations must be implemented by affected entities by November 15, 2017.

This rule applies to [17 provider and supplier types](#) as a condition of participation for CMS. The providers/suppliers are required to meet [four core elements](#) (with specific requirements adjusted based on the individual characteristics of each provider and supplier):

1. Emergency plan—Develop an emergency plan based on a risk assessment and using an “all-hazards” approach, which will provide an integrated system for emergency planning that focuses on capacities and capabilities.
2. Policies and procedures—Develop and implement policies and procedures based on the emergency plan and risk assessment that are reviewed and updated at least annually. For hospitals, Critical Access Hospitals (CAHs), and Long-Term Care (LTC) facilities, the policies and procedures must address the provision of subsistence needs, such as food, water and medical supplies, for staff and residents, whether they evacuate or shelter in place.
3. Communication plan—Develop and maintain an emergency preparedness communication plan that complies with federal, state and local laws. Patient care must be coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management systems to protect patient health and safety in the event of a disaster.
4. A training and testing program—Develop and maintain training and testing programs, including initial training in policies and procedures. Facility staff will have to demonstrate knowledge of emergency procedures and provide training at least annually. Facilities must conduct drills and exercises to test the emergency plan or participate in an actual incident that tests the plan.

A quick reference chart was developed by CMS that highlights the requirements by provider type. **Please note:** This quick reference chart is not meant to be an exhaustive list of requirements nor should it serve as a substitute for the regulatory text. The [17 provider and supplier types](#) are listed below and categorized based on whether they are inpatient or outpatient, as outpatient providers are not required to provide subsistence needs.

Table 1. Affected Provider and Supplier Types (updated January 24, 2018)

Inpatient		Outpatient	
Facility Type	Final Rule Reference	Facility Type	Final Rule Reference
Critical Access Hospitals (CAHs)	Section II. N	Ambulatory Surgical Centers (ASCs)	Section II. E
Hospices	Section II. F	Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services	Section II. O
Hospitals	Section II. C	Community Mental Health Centers (CMHCs)	Section II. P
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	Section II. D	Comprehensive Outpatient Rehabilitation Facilities (CORFs)	Section II. M
Long Term Care (LTC)	Section II. J	End-Stage Renal Disease (ESRD) Facilities	Section II. S
Psychiatric Residential Treatment Facilities (PRTFs)	Section II. G	Home Health Agencies (HHAs)	Section II. L
Religious Nonmedical Healthcare Institutions (RNHCIs)	Section II. D	Hospices	Section II. F
Transplant Centers	Section II. I	Organ Procurement Organizations (OPOs)	Section II. Q
		Programs of All Inclusive Care for the Elderly (PACE)	Section II. H
		Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)	Section II. R

ASPR TRACIE developed facility-specific requirement overviews that can be found on our [ASPR TRACIE CMS resources page](#).

ASPR TRACIE developed [CMS EP Rule Integrated Healthcare Systems Implications](#) to outline the information available to healthcare system emergency planners about the integrated healthcare system requirements in the rule. It includes excerpts from and links to legal language and input from ASPR TRACIE subject matter experts regarding their experience organizing emergency preparedness programs for integrated healthcare systems.

If a facility is unclear on whether the CMS Emergency Preparedness Rule applies to them, please consider the following:

1. Review the 17 providers/suppliers affected. A list is available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html>

2. If a facility is still unclear on what provider/supplier type they are based on reviewing the list, it is recommended that they check with their facility CFO, CEO or management, or the financial billing departments for their CMS Certification number (CCN).
3. The CCN number identifies what provider or supplier type the facility is certified under by Medicare. The CCN for providers and suppliers paid under Part A has 6 digits. The first two codes are the State Codes, the following 4 codes are those reserved the provider type. For example, codes 0001-0879 are typically reserved for Short-term (General and Specialty) Hospitals. Facilities can refer to <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R29SOMA.pdf> to search for the State Codes and applicable 4 code reserved designations for providers.
4. Compare the CCN and identified provider/supplier type to the 17 provider/supplier type affected by the CMS Emergency Preparedness Rule list.

Facilities can now use the QCOR tool to determine if they are a provider/ supplier type certified under Medicare – i.e. CMS Certification Number (CCN). In order for the tool to work properly, individuals should use Google Chrome, clear your cache, and insert the following link: <https://pdq.cms.hhs.gov/main.jsp>. Once on the site, select "Basic Search" on the left side under Tool, and type in your facility name. The tool will then populate what the facility is certified as. (Note, this is sensitive, so you may need to try iterations or partial names of facilities to get a direct hit). (Updated October 11, 2017)

The Yale New Haven Center for Emergency Preparedness and Disaster Response Emergency Preparedness has developed and published a [CMS Conditions of Participation & Accreditation Organizations Crosswalk](#) in collaboration with a number of national subject matter experts. Emergency and disaster related program, policy, communication, training and exercise elements of regulatory and accreditation standards were mapped to the CMS Emergency Preparedness Conditions of Participation. Every effort was made to ensure that the mapped regulations and accreditation standards matched as closely as possible. However, this document should be used only as a resource for reviewing and updating healthcare emergency preparedness plans and does not replace existing federal, local, or association guidance. Feedback and recommendations related to the crosswalk should be sent to center@ynhh.org. This tool has been updated to reflect feedback and to provide additional clarifications. (updated April 21, 2017)

The National Fire Protection Association recently developed and released the white paper [Using NFPA 1300 as a Tool to Comply with CMS Requirements for an Emergency Preparedness Program](#) to provide basic information on the new NFPA 1300 standard. This standard provides an all-hazards methodology and process for identifying and prioritizing local risks, developing a community risk reduction plan, and strategies for implementing and evaluating community risk

reduction plans. This white paper outlines how NFPA 1300 closely aligns with the 4 core elements of CMS Emergency Preparedness Rule: conducting a risk assessment, developing policies and procedures, training and testing, and communications plan, and provides a framework for anyone to use to develop a community risk reduction plan. Free access to the full NFPA 1300 code book is available through NFPA's [website](#). (Updated August 26, 2019)

Interpretive Guidelines (updated March 6, 2019)

CMS has published the [original Interpretive Guidance and survey procedures](#) that support the adoption of a standard all-hazards emergency preparedness program for all providers and suppliers. This guidance also addresses the unique differences of other providers and suppliers. The Interpretive Guidance is also available [in Spanish](#). In February 2019, CMS released updates to several "tags" in a [partially revised Interpretive Guidance](#). Both documents should be reviewed together.

Surveyor Training (updated October 11, 2017)

CMS has developed the new Emergency Preparedness Training Online Course which is available online 24/7. This course is required for all State Survey Agency and Regional Office surveyors and reviewers who conduct or review health and safety or LSC surveys for emergency preparedness requirements. Non-survey professionals involved in and responsible for ensuring compliance with regulations are also encouraged to take the course.

Accessing the Course is Simple: When you navigate to the Integrated Surveyor Training Website (<https://surveyortraining.cms.hhs.gov>), click on "I am a Provider." Next, click on the course catalog and search for the "Emergency Preparedness" course. You do not need a username and password when accessing the course through the provider link. If you need technical assistance, please contact the CMS ISTW Help Desk at 1-855-791-8900 or cmstraininghelp@hendall.com. Surveying for the emergency preparedness requirements begins November 15th, 2017.

General Information

The [CMS Emergency Preparedness Survey and Certification Page](#) has information on training and technical assistance available from CMS and includes a number of [templates and checklists](#) for emergency preparedness.

The ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE) dedicated [CMS Rule page](#) contains information and resources on developing plans, policies and procedures, and training and exercises.

Informational Webinars (updated June 8, 2017)

CMS held a Medicare Learning Network National Call on Wednesday, October 5 to discuss the new rule. ASPR staff participated in the call with CMS to answer questions. The slides, audio recording, and transcript are all available for download on the [MLN Emergency Preparedness National Call website](#).

Due to the large number of speaking requests CMS has received regarding the final EP Rule, they offered an additional learning session through the Medicare Learning Network on April 27, 2017. During this session, CMS provided an overview of the final rule and steps facilities can take to meet the training and testing requirements by the implementation date of November 15, 2017. The presentation, audio recording, and transcript can be accessed [here](#).

Frequently Asked Questions (updated September 2017)

CMS has published five rounds of EP Rule Frequently Asked Questions and has published these, along with other technical resource material to the [CMS Survey and Certification Emergency Preparedness website](#).

Healthcare Coalition Information (updated November 15, 2017)

This section has been updated to reflect the relationship between affected provider and supplier types and the Hospital Preparedness Program (HPP) grantees.

Although [healthcare coalitions \(HCCs\)](#) (updated January 5, 2017) themselves are not included in the [17 provider and supplier types](#) covered under the CMS [Emergency Preparedness \(EP\) Rule](#), the rule offers HCCs and newly engaged providers a tremendous opportunity to achieve greater organizational and community effectiveness and sustainability. Together with NHPP, CMS has issued [a letter](#) requesting HCCs to support their members in providing documentation to support verification of training and testing exercise requirements per the CMS Emergency Preparedness Rule.

HCCs should be an accessible source of preparedness and response best practices for newly engaged provider types as they adapt to the new requirements. They should also play a role in assisting members with closing planning gaps, as well as assuring integration with core coalition partners. HCCs have an opportunity to enhance their financial sustainability and revenue by

providing contracted technical assistance to HCC members to meet the CMS conditions of participation (CoPs).

HPP grantees and their sub-recipients may provide funding to individual hospitals or other health care entities, as long as the funding is used for activities to advance regional, HCC, or health care system-wide priorities, and are in line with ASPR's four health care preparedness and response capabilities. However, though coalitions should support other preparedness efforts, funding to individual health care entities is **not** permitted to be used to meet CMS CoPs, including for the CMS EP Rule.

HCCs should expect covered health care entities to contact them asking for assistance, including the following examples:

- Obtaining copies of the coalition or regionally conducted hazard vulnerability analysis or risk assessments (or to be included in future assessments).
- Identifying examples of plans, policies, and procedures that are frequently used or accepted by other entities within those coalitions.
- Engaging in training and exercises conducted by coalitions or coalition members.
- Exploring participation in or leveraging of shared services, such as communications systems, patient tracking systems, and other jointly used equipment and supplies.
- Providing basic information on emergency preparedness and healthcare system preparedness.
- Providing technical assistance support to help meet conditions of the CMS EP Rule. Though HPP funding may not be provided to individual health care entities to meet these requirements, HCCs can provide technical assistance such as:
 - Developing emergency plans. HCCs are permitted to use HPP funding to develop the staffing capacity and technical expertise to assist their members with this requirement. An alternative would be to contract or use membership fees from the covered entities to support this capacity and expertise.
 - Developing standard policies and procedures. HCCs are permitted to use HPP funding for the staffing capacity and technical expertise to assist their members with this requirement so long as the HCC can do so and still fulfill the cooperative agreement capabilities.
 - Developing a communication plan that integrates with the HCC's communications policies and procedures. HCCs are permitted to use HPP funding for costs associated with adding new providers and suppliers to their HCC who

are seeking to join coalitions to coordinate patient care across providers, public health departments, and emergency systems (e.g., hiring additional staff to coordinate with the new members, providing communications equipment and platforms to new members, conducting communications exercises, securing meeting spaces, etc.). The HCC should carefully consider whether equipment costs directly support the cooperative agreement capabilities and coordination of patient care. Coalitions should carefully weigh the costs and benefits of including new members in communications systems, as well as the sustainability of these commitments. Information sharing systems used for covered partners that do not provide acute/ emergency care may be different than those used with core partners.

- Plan for and conduct education, trainings, and exercises at the regional or HCC level, but not facility level.

The new CMS EP Rule should prompt HCCs to proactively engage the new provider types and offer assistance. HCCs are encouraged to engage in community activities and provide support to the community response framework. They can serve as a key resource for newly covered providers. However, due to the breadth of the new provider types, coalitions must be deliberate about defining the boundaries of this support under the cooperative agreement. They should also explore opportunities for investment in the coalition by collaborating and working with the newly covered providers (e.g., new membership fees, developing contract agreements for training or exercises).

Emergency Managers and Public Health Preparedness Professionals (Updated January 5, 2017)

Like HCCs, Health Department Preparedness Offices and Emergency Management Agencies are not covered entities under this rule, but should play a role in supporting covered entities.

Emergency Managers should be an accessible source of preparedness and response best practices for newly engaged provider types as they adapt to the new requirements. They should also play a role in assisting facilities with closing planning gaps, accessing training, participating in planned community exercises, as well as assuring integration with other community partners.

Emergency Managers should expect covered health care entities to contact them asking for assistance, including the following examples:

- Obtaining copies of the jurisdiction or regional hazard vulnerability analysis or risk assessments (or to be included in future assessments).

- Identifying examples of plans, policies, and procedures that are frequently used or accepted by other entities within the jurisdiction.
- Engaging in training and exercises conducted by the jurisdiction.
- Exploring participation in or leveraging of shared services, such as communications systems, patient tracking systems, and other jointly used equipment and supplies by partners within the jurisdiction.
- Providing basic information on emergency preparedness and healthcare system preparedness.

ASPR TRACIE Technical Assistance Requests (updated July 19, 2018)

Since the rule was released on September 8, 2016, ASPR TRACIE has received more than 750 requests for technical assistance on CMS-related issues. Most of the questions asked have been addressed in this document, but redacted answers to technical assistance (TA) questions are available in this [ASPR TRACIE Summary of TA Requests](#); links to additional resources follow. Redacted answers to technical assistance questions are available in the ASPR TRACIE Information Exchange to for review and additional resources are linked below.

CMS Emergency Preparedness Rule Quick Links

These links provide the most critical information related to the CMS Emergency Preparedness Rule:

- [Federal Register Notice CMS Final Rule](#)
- [CMS Survey and Certification Group Emergency Preparedness Program](#)
- [ASPR TRACIE CMS Resources](#)
- [CMS Interpretive Guidance](#) (updated June 8, 2017)
- [CMS Emergency Preparedness Rule General Briefing Slides](#) (Updated January 5, 2017)
- [CMS At A Glance Chart with High Level Requirements by Provider Type](#)
- [17 Provider and Supplier Type Descriptions](#)
- [CMS Frequently Asked Questions – Round 1](#) (updated November 2, 2016)
- [CMS Frequently Asked Questions – Round 3](#) (updated January 5, 2017)
- [CMS Frequently Asked Questions – Round 4](#) (updated February 3, 2017)
- [CMS Frequently Asked Questions – Round 4 Definitions](#) (updated February 3, 2017)
- [CMS Frequently Asked Question – Round 5](#) (updated September 2017)
- [Yale New Haven CMS EP Rule Accreditation Crosswalk](#) (updated April 21, 2017)
- [CMS Memorandum: Information to Assist Providers and Suppliers in Meeting the New Training and Testing Requirements](#) (updated April 21, 2017)

- [CMS Memorandum: Reminder of Pharmacy and Provider Access during a Federal Disaster or Other State or Public Health Emergency Declarations](#)

CMS Regulatory Issues and Disasters (updated October 11, 2017)

The CMS Emergency Preparedness Rule is only one of many [disaster and emergency related CMS issues](#) facing healthcare providers and suppliers. Below is information pertaining to operating Alternate Care Sites, Reimbursement, and 1135 waivers.

Alternate Care Sites and Disaster Reimbursement

CMS has published a list of [Frequently Asked Questions and Answers on Medicare Fee-For-Service Emergency-Related Policies and Procedures](#). The full list of questions and answers can be [found on the CMS website](#). Based on a number of requests for technical assistance and inquiries into ASPR TRACIE, we have compiled a selection of these Q/A's pertaining to reimbursement for alternate care sites and providers operating outside regular operations that can be found in Appendix A.

ASPR TRACIE also has a Fact Sheet on [Federal Patient Movement: National Disaster Medical System Definitive Care Program](#) for a high level overview of the Definitive Care Reimbursement program.

Waivers of Regulatory Requirements

Waivers to Section 1135 of the Social Security Act

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act AND the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to regular authorities. For example, under section 1135 of the Social Security Act, she may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance

Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). Examples of these 1135 waivers or modifications include:

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements

- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure)
- Emergency Medical Treatment and Labor Act (EMTALA) sanctions for redirection of an individual to receive a medical screening examination in an alternative location pursuant to a state emergency preparedness plan (or in the case of a public health emergency involving pandemic infectious disease, a state pandemic preparedness plan) or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency. A waiver of EMTALA requirements is effective only if actions under the waiver do not discriminate on the basis of a patient’s source of payment or ability to pay
- Stark self-referral sanctions
- Performance deadlines and timetables may be adjusted (but not waived)
- Limitations on payment to permit Medicare enrollees to use out of network providers in an emergency situation

These waivers under section 1135 of the Social Security Act typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period. Waivers for EMTALA (for public health emergencies that do not involve a pandemic disease) and HIPAA requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. Waiver of EMTALA requirements for emergencies that involve a pandemic disease last until the termination of the pandemic-related public health emergency. The 1135 waiver authority applies only to Federal requirements and does not apply to State requirements for licensure or conditions of participation. (From: [1135 Waiver At-A-Glance](#))

Additional Resources

- [1135 Waiver At-A-Glance](#)
- [1135 Waiver Request Communication Method- Best Practice](#)
- [1135 Waivers and The Emergency Preparedness Rule](#)
- [ASPR 1135 Waiver Information](#)
- [ASTHO Emergency Authority and Immunity Toolkit](#)
- [Authority to Waive Requirements During National Emergencies](#)
- [CMS 1135 Waivers](#)
- [EMTALA and Disasters](#)

- [Medicare Fee for Service – Additional Emergency and Disaster-Related Policies and Procedures that may be implemented Only with a § 1135 Waiver](#)
- [Public Health Emergency Declaration Questions and Answers](#)
- [Requesting an 1135 Waiver](#)

Quality Payment Program; Extreme and Uncontrollable Circumstances Natural Disasters Policy

[Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by and Emergency or Disaster](#)

Other Relief Potentially Available

The following Medicare Learning Network (MLN) articles outline the kinds of communications, waivers, and relief that could be available or offered during an emergency. These are actual articles pertaining to areas affected by Hurricanes Harvey, Irma, and Maria during the 2017 Hurricane season, presented below as examples.

Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on [Hurricane Harvey and Medicare Disaster Related Texas Claims](#) has been updated. This article was revised to include information about replacement prescription fills of covered Part B drugs. All other information remains the same.

Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on [Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims](#) has been updated. This article was revised to include information about replacement prescription fills of covered Part B drugs. All other information remains the same.

Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on [Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims](#) has been updated. This article was revised to include information about new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital. Information regarding replacement prescription fills of covered Part B drugs and Facilities Quality Reporting was also added. All other information remains the same.

Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on [Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims](#) has been updated. This article was revised to include information about new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital. Information regarding replacement prescription fills of covered Part B drugs was also added. All other information remains the same.

ASPR TRACIE Resources

ASPR TRACIE has developed a number of general healthcare emergency preparedness and facility-specific resources that can help facilitate compliance with the rule. These resources, along with any new or updated resources, are available on the ASPR TRACIE-dedicated CMS Emergency Preparedness Rule page located at asprtracie.hhs.gov/cmsrule.

General Emergency Management Resources (listed alphabetically)

- [Access and Functional Needs Topic Collection](#)
- [ASPR TRACIE Evaluation of Hazard Vulnerability Assessment Tools](#)
- [CMS Emergency Preparedness Rule General Briefing Slides \(updated January 5, 2017\)](#)
- [Communication Systems Topic Collection](#)
- [Continuity of Operations \(COOP\)/Failure Plan Topic Collection](#)
- [Crisis Standards of Care Topic Collection](#)
- [Durable Medical Equipment in Disasters](#)
- [Emergency Operations Plans/Emergency Management Program Topic Collection](#)
- [Exercise Program Topic Collection](#)
- [Hazard Vulnerability/Risk Assessment Topic Collection](#)
- [Healthcare Coalition Models and Functions Topic Collection](#)
- [Information Sharing Topic Collection](#)
- [Incident Management Topic Collection](#)
- [Recovery Planning Topic Collection](#)

Provider- and Supplier-Specific Resources

- [Ambulatory Care and Federally Qualified Health Centers Topic Collection](#)
- [Dialysis Centers Topic Collection](#)
- [Homecare Topic Collection](#)
- [Long-Term Care Facilities Topic Collection](#)

Hospital-Specific Resources

- [Healthcare Facility Evaluation/Sheltering Topic Collection](#)
- [Hospital Surge Capacity and Immediate Bed Availability Topic Collection](#)
- [Hospital Victim Decontamination Topic Collection](#)

Appendix A: Alternate Care Site and Disaster Reimbursement

The Centers for Medicare and Medicaid Services has published a list of [Frequently Asked Questions and Answers on Medicare Fee-For-Service Emergency-Related Policies and Procedures](#). The full list of questions and answers can be [found on the CMS website](#). Based on a number of requests for technical assistance and inquiries into ASPR TRACIE, we have compiled a selection of these Q/A's pertaining to reimbursement for alternate care sites and providers operating outside regular operations.

ASPR TRACIE also has a Fact Sheet on [Federal Patient Movement: National Disaster Medical System Definitive Care Program](#) for a high level overview of the Definitive Care Reimbursement program.

Select Responses

A-1 Question: In the event of an emergency or disaster, what relief is available to providers, physicians and other suppliers, and/or beneficiaries under the Medicare fee-for service program?

Answer: Currently, there is no authority for the Medicare fee-for service program to make payments for the purpose of emergency or disaster relief. Even in the circumstance of a disaster or emergency, Medicare fee-for-service is limited to making payments only for services covered under Medicare Parts A & B that are furnished to Medicare beneficiaries in accordance with program rules. That said, Medicare can make certain adjustments in response to a disaster or emergency to ease administrative burden on providers and on physicians and other suppliers and to enhance access to services by Medicare beneficiaries.

A-5 Question: How will the healthcare community know what adjustments are available from Medicare fee-for-service in a particular emergency or disaster?

Answer: The contractors that process Medicare fee-for-service claims (Medicare Administrative Contractors (MAC), Durable Medical Equipment (DME) MACs, Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), and Carriers), will implement Medicare fee-for-service adjustments based on instructions from CMS. In the event of an emergency or disaster, providers and physicians and other suppliers should contact their servicing contractor. The DHHS Regional Office(s) for the affected area(s) will generally serve as the point of contact for State officials and industry associations. To raise an issue not addressed within these Q&As, send your query to emergency.ops@cms.hhs.gov.

B-3 Question: Will CMS provide disaster relief funding to hospitals following an emergency or disaster to make up for the lost reimbursement? If so what documentation will be required in patient clinical and financial records?

Answer: There is currently no standing authority for CMS to provide special emergency/disaster relief funding following an emergency or disaster in order to compensate providers for lost reimbursement. Congress had appropriated disaster specific special funding for the Hurricane Katrina disaster; but absent such special appropriation, Medicare does not provide funding for financial losses except as otherwise specified in existing regulations.

C-3 Question: In declared disasters, can CMS make payment for services that are provided by healthcare professionals who, in normal circumstances, would not be permitted by Medicare to bill for their services to beneficiaries (e.g., RNs providing care typically provided by physicians or residents/medical students providing services without the required level of physician supervision)?

Answer: There is no authority under Medicare Part B that permits a Medicare contractor to depart from the statutory provisions that specify to whom Medicare payment is made. Medicare payment cannot be made under the physician fee schedule (PFS) directly to an RN or any other individual without a separately enumerated benefit under Medicare law. The only way that these individuals can receive Medicare Part B payment for their services to Medicare patients is indirectly under the “incident to” provision. The “incident to” provision requires, among other things, that PFS payment is made to the employer of those who furnish services incident to a physician’s (or to certain types of non-physician practitioner’s) professional service and that the services be furnished under direct supervision by a physician (or certain types of non-physician practitioners). Hence, those who provide “incident to” services must be employed, leased, or contracted with the physician or non-physician practitioner, or the entity that bills for their services.

C-4 Question: What are the definitions of healthcare facility that must be met to qualify for reimbursement?

Answer: Many different types of health care facilities qualify to participate in the Medicare program, and are considered to be either a “provider” or a “supplier.” Section 1861(u) of the Social Security Act defines a “provider of services” for Medicare as a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program. Section 1861(d) defines a “supplier” as a physician or other practitioner, a facility or other entity, with the exception of a provider of services, that furnishes Medicare items or services. The required characteristics of specific categories of providers and suppliers that are facilities (e.g., an ambulatory surgical center or a rural health clinic) are further defined by statute and regulation. Information on the Medicare certification

requirements for various types of providers and institutional suppliers may be found on the Survey and Certification portion of CMS' website:

http://www.cms.hhs.gov/CertificationandCompliance/01_Overview.asp#TopOfPage

C-7 Question: If a provider affected by a disaster has facility damage or destruction which results in the loss of documentation used to support payment, what flexibility is available?

Answer: Instructions for how to handle situations where documentation to support payment has been lost or destroyed can be found in CMS' Program Integrity Internet Only Manual in Publication 100-08, Chapter 3, § 3.8 entitled "Administrative Relief from MR During a Disaster" at the following link: <http://www.cms.gov/manuals/downloads/pim83c03.pdf>.

D-9 Question: In the event of a declared emergency or disaster that results the provider's loss of the **means to submit claims electronically may the provider submit paper claims?**

Answer: If such a disruption is expected to last more than 2 business days, affected providers are automatically waived from the electronic submission requirement for the duration of the disruption. If duration is expected to be 2 business days or less, a provider should simply hold claims for submission when power and/or communication are restored. A provider is to self-assess when this circumstance applies, rather than apply for contractor or CMS waiver approval. A provider may submit claims to Medicare on paper or via other non-electronic means when this circumstance applies. A provider is not expected to pre-notify its Medicare claims administration contractor that this circumstance applies as a condition of submission of non-electronic claims.

E-1 Question: If a physician leaves his/her location to provide services to beneficiaries in a jurisdiction/locality outside of his/her usual jurisdiction/locality, must the physician bill based upon the new location or may he/she bill based upon his/her usual jurisdiction/locality?

Answer: Physicians must bill and be paid for the service based upon the actual location/locality in which the service is rendered.

E-3 Question: If a practitioner is temporarily working out of another doctor's office (within the same State) due to damage from the emergency, would they need to file a Change of Address for this temporary site? **Answer:** Yes. In most cases, the physician or non-physician can reassign his or her benefits to the other group by completing the CMS-855R. However, if the physician or non-physician practitioner has not updated their enrollment record in more than 5 years, then the individual practitioner would need to also submit the CMS-855I. Further questions may be referred to the provider's Medicare contractor.

M-13 Question: During an emergency, will Medicare fee-for-service allow payment for care provided at a site not considered part of the facility (which are informally termed “alternative care sites” (ACSs)) for patients who are not critically ill? For example, if local hospitals are almost at capacity during an emergency and the few beds remaining must be reserved for patients needing ventilators and critical care, will Medicare fee-for-service pay for non-critical care provided at an ACS, such as a school gymnasium?

Answer: In the absence of an 1135 waiver, a hospital may add a remote location that provides inpatient services to the hospital’s Medicare certified beds under its existing provider agreement, provided that the remote location satisfies the requirements to be provider-based to the hospital’s main campus (including being located within 35 miles pursuant to 42 CFR 413.65(e)(3)). The remote location must satisfy all provider-based requirements including being compliant with the hospital Conditions of Participation (CoPs). The hospital would be expected to file an amended Form CMS 855A with its Medicare Administrative Contractor or legacy Fiscal Intermediary as soon as possible adding an additional location. CMS generally requires a survey of compliance with all CoPs at all new inpatient locations, but also has discretion to waive the onsite survey in this area.

N-2 Question: Is it permissible for a hospital to triage individuals with suspected cases of an infectious disease (including particularly an H1N1 flu virus infection) to an alternative site for evaluation under EMTALA? If so, how do we bill for these services?

Answer: Under current Emergency Medical Treatment and Labor Act (EMTALA) law and regulations, hospitals are permitted to move individuals out of their dedicated emergency departments to another part of the hospital (on the hospital’s same campus) in order to provide the required medical screening examination (MSE) and then, if an emergency medical condition is found to exist, to provide stabilizing treatment or arrange for an appropriate transfer. Sometimes hospitals refer to these as “fast-track clinics” and use them either all year round or during surge in demand for emergency department services during the seasonal cold and flu season. The medical screening examination provided in the “clinic” must be performed consistent with the requirements of the EMTALA provision, by qualified medical personnel who can perform an MSE that is appropriate to the individual’s presenting signs and symptoms. If, prior to directing the individual elsewhere in the hospital, qualified medical personnel in the emergency department completed an appropriate MSE and determined that the individual does not have an emergency medical condition, then the hospital has no further EMTALA obligation to that individual and the issue of moving the individual to an alternate site, either on or off the hospital’s campus, would be moot from an EMTALA perspective. For services rendered to Medicare fee-for-service (FFS) beneficiaries, standard Medicare FFS billing rules apply. Hospitals should work with their other payers to determine if special billing rules may apply.

S-1 Question: Some States are considering utilizing mobile hospitals, based on military field hospital model as a means of meeting their emergency preparedness needs. Under what scenario could these mobile units be eligible for Medicare funding?

Answer: It may be possible for a Medicare participating hospital to operate a mobile facility as a part of the hospital, as long as the mobile unit complies with all the hospital conditions of participation (including the Life Safety Code) and the provider-based rules (including remaining within 35 miles of the main provider). If the mobile unit meets the provider based regulations at 42 C.F.R. § 413.65, then they use the main hospital's provider number. If not, then the mobile unit will be treated as a freestanding clinic. CMS will gladly work with any State wishing to develop mobile capacity. Situations involving use of mobile units will be evaluated on a case-by case basis.