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 Administration for Strategic 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. In January 2023, CMS added Rural Emergency Hospitals (REH) as a new provider type.

This rule applies to 18 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. Risk Assessment and Emergency Planning (Include but not limited to):
    - Hazards likely in geographic area
    - Care-related emergencies
    - Equipment and Power failures
    - Interruption in Communications, including cyber attacks
    - Loss of all/portion of facility
    - Loss of all/portion of supplies
    - Plan is to be reviewed and updated at least annually
2. Communication Plan
    - Complies with Federal and State laws
    - System to Contact Staff, including patients' physicians, other necessary persons
    - Well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency management agencies.
3. Policies and Procedures
    - Complies with Federal and State laws
4. Training and Testing
    - Complies with Federal and State laws
    - Maintain and at a minimum update annually

The 18 provider and supplier types are listed in Table 1 and categorized based on whether they are inpatient or outpatient; outpatient providers are not required to provide subsistence needs..

Table 1. Affected Provider and Supplier Types (updated May 2023)

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
		Rural Emergency Hospitals (REH)	42 CFR Part 485 (87 FR 72293)

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 18 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 and search for the State Codes and applicable 4 code reserved designations for providers.

4. Compare the CCN and identified provider/supplier type to the 18 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** 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 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 April 16, 2021)

CMS has published the 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 between other providers and suppliers.

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.

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) themselves are not included in the 18 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.

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o 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.

o 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.

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 Quality, Safety, and Oversight Group Emergency Preparedness Program
- ASPR TRACIE CMS Resources
- CMS Interpretive Guidance (updated April 16, 2021)

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]().

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.

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 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
- ASPR TRACIE 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
- Hurricanes & Tropical Storms- Examples of 1135 Waivers during a PHE Declaration

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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](#)

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)

- [ASPR TRACIE Evaluation of Hazard Vulnerability Assessment Tools](#)
- [Communication Systems Topic Collection](#)
- [Continuity of Operations (COOP)/Business Continuity Planning 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](#)
- [Populations with Access and Functional Needs 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](#)

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Hospital-Specific Resources

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