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TO: **Memo Distribution List**

LeadingAge New York

FROM: Hinman Straub P.C.

RE: CMS Final Rule on Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers

DATE: September 23, 2016

NATURE OF THIS INFORMATION: This is information explaining new requirements you need to be aware of or implement.

DATE FOR RESPONSE OR IMPLEMENTATION: The final rule was published in the Federal Register on September 16, 2016 and will become effective on November 16, 2016. Providers will be required to meet the requirements contained in the final rule by November 16, 2017.

HINMAN STRAUB CONTACT PEOPLE: Raymond Kolarsey and Michael Paulsen

THE FOLLOWING INFORMATION IS FOR YOUR FILING OR ELECTRONIC RECORDS:
Category: #9 Medicaid and Medicare Suggested Key Word(s):

The Centers for Medicare and Medicaid Services (CMS) recently adopted a long-awaited final rule establishing enforceable national emergency preparedness requirements for Medicare and Medicaid providers and suppliers to enhance patient safety during emergencies and establish a more coordinated response to natural and man-made disasters. As adopted, the final rule imposes extensive emergency preparedness conditions of participation ("CoPs") that all provider and supplier types must meet to participate in Medicare and Medicaid programs including, but not limited to, hospitals, nursing homes, home care agencies, and hospices. The final rule requires providers to: conduct a risk assessment; establish an emergency preparedness plan, emergency preparedness policies and procedures, and a communication plan; train staff in emergency preparedness; and test the emergency plan annually.

The final rule was published in the Federal Register on September 16, 2016 and will become effective on November 16, 2016. **Given the substantial amount of time and effort that will be required to comply, the final rule provides for an implementation timeline of one (1) year, requiring impacted providers to meet the requirements contained in the final rule by November 16, 2017**.

The final rule establishes generally applicable emergency preparedness requirements ("core elements"), but includes variations for each provider type to meet the differing needs of each provider and the individuals to whom they provide health care services. The final rule maintains the construct and substance of the proposed rule published in December 2014, with limited substantive changes to the core elements applicable to all providers. The requirements for all provider types are based on the requirements applicable to hospitals, with variations taking into account the differing needs of each provider.

CMS has identified four core elements that are central to an effective and comprehensive framework of emergency preparedness requirements for Medicare and Medicaid participating providers. The following core elements will be imposed on all provider and supplier types, with some variations based on provider type:

- **Risk Assessment and Planning**: All providers are required to conduct a comprehensive risk assessment utilizing an ''all-hazards'' approach, focusing on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. All providers are required to develop an emergency preparedness plan that addresses the emergency events identified in the risk assessment, to be reviewed and updated annually.

- **Policies and Procedures**: All providers are required to implement policies and procedures based on the emergency plan and risk assessment, to be reviewed and updated annually.

- **Communication Plans**: All providers are required to develop and maintain an emergency communication plan to ensure coordination of patient care within the facility, across healthcare providers, health departments, and emergency systems. The final rule also requires providers to establish HIPAA-compliant methods of sharing patient

information and keeping medical records readily available during an emergency. The communication plan must be reviewed and updated annually.

- **Training and Testing**: All providers are required to develop and maintain an emergency preparedness training and testing program that includes initial training on all emergency preparedness policies and procedures developed as a result of this rule. All providers are required to conduct drills and exercises to test emergency plans annually.

For all provider types, the final rule has been revised to:

- Clarify that facilities must also coordinate with local emergency preparedness systems in addition to complying with the requirements of the final rule;
- Clarify that facilities must develop and maintain an emergency preparedness communication plan that also complies with local law;
- Revise annual testing requirements to require facilities to conduct one full-scale exercise and an additional exercise of their choice, which could be a second full-scale exercise or a tabletop exercise. The full-scale exercise must be community-based unless a community exercise is not available; and
- Allow a separately certified healthcare facility within a healthcare system to elect to be a part of the healthcare systems unified emergency preparedness program.

For purposes of this memorandum, the detailed summary provided of the requirements applicable to hospitals should be reviewed first, with the reader then reviewing the applicable provider type to determine what, if any, changes to the hospital requirements are established for that provider type. Section IV contains implementation guidance to assist your operation with initiating compliance with the final rule.

I. Emergency Preparedness Regulations for Hospitals and All Other Providers

The final rule establishes a new requirement for hospitals and other provider types[1] to have both an emergency preparedness program and an emergency preparedness plan. An emergency preparedness program encompasses an approach to emergency preparedness that allows for continuous building of a comprehensive system of health care response to a natural or man-made emergency.[2] An emergency plan sets forth the actions for emergency response based on a risk

[1] The final rule establishes new CoPs for the following Medicare and Medicaid providers and suppliers: hospitals; Religious Nonmedical Health Care Institutions (RNHCIs); Ambulatory Surgical Centers (ASCs); Hospice; Inpatient Psychiatric Residential Treatment Facilities (PRTFs); Transplant Centers; Long-Term Care (LTC) Facilities; Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID); Home Health Agencies (HHAs); Comprehensive Outpatient Rehabilitation Facilities (CORFs); Critical Access Hospitals (CAHs); Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; Community Mental Health Centers (CMHCs); Organ Procurement Organizations (OPOs); Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs); and End-Stage Renal Disease (ESRD) Facilities.

[2] For the purpose of the final rule, ''emergency'' or ''disaster'' is defined as an event affecting the overall target population or the community at large that precipitates the declaration of a state of emergency at a local, state, regional, or national level.

assessment that addresses an ‘‘all-hazards approach’’ to medical and non-medical emergency events.

A. Risk Assessment

Hospitals and all other providers will be required to perform a risk assessment based on an "all hazards" approach prior to developing an emergency preparedness plan. "All hazards" planning focuses on a broad range of emergencies, rather than planning for every possible threat. The risk assessment is required to be conducted consistent with the concepts outlined in the National Preparedness Guidelines (the "Guidelines"),[3] published by the Department of Homeland Security. CMS has identified additional guidance sources that it recommends providers consult prior to conducting the risk assessment (see Section IV, *"Implementation Strategy"*).

The final rule provides that in order to meet the requirement for a risk assessment, CMS expects hospitals and all other providers to consider, among other things, the following:

- Identification of all business functions essential to the providers' operations that should be continued during an emergency;
- Identification of all risks or emergencies that the provider may reasonable expect to confront, including, but not limited to, natural disasters (hurricane, earthquake, flooding), disease outbreak (pandemic influenza), chemical attacks, biological attacks, explosive attacks, and cyber-attacks;
- Identification of all contingencies for which the provider should plan;
- Consideration of the provider's location, including all locations where the provider delivers patient care/services or has business operations;
- Assessment of the extent to which natural or man-made emergencies may cause the hospital to cease or limit operations; and
- Determination of whether arrangements with other health care providers might be needed to ensure that essential services could be provided during an emergency.

While the final rule does not require providers to conduct a risk assessment on an annual basis, providers are expected to conduct a risk assessment periodically in order to assess and identify potential gaps in its emergency plan.

B. Emergency Preparedness Plan

Hospitals and all other providers will be required to develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must include strategies for addressing emergency events identified by the risk assessment. The comprehensive emergency preparedness plan must include the following elements to satisfy the CoPs:

[3] The Guidelines are available at: http://www.fema.gov/pdf/emergency/nrf/National_Preparedness_Guidelines.pdf

- Be based on and include a documented, facility-based and community-based risk assessment utilizing an all hazards approach, conducted in a manner consistent with the Guidelines;
- Include strategies for addressing emergency events identified by the risk assessment;
- Address specific patient population concerns, including persons who may need additional response assistance ("at-risk populations");
- Address the types of services that the provider would be able to provide in an emergency;
- Address the continuity of operations during an emergency, including delegations of authority and succession plans;
- Ensure that the emergency preparedness plan complies with local law; and
- Include a process for ensuring cooperation and collaboration with local, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation, including documentation of the provider's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.[4]

C. Policies and Procedures

Hospitals and all other providers must develop and implement emergency preparedness policies and procedures, based on the emergency plan and risk assessment. The policies and procedures must be reviewed and updated at least annually.

At a minimum, the policies and procedures must address the following:[5]

- The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, including food, water, medical supplies, and pharmaceuticals;
- Alternate sources of energy to maintain: (1) temperatures to protect patient health and safety and for the safe and sanitary storage of provisions; (2) emergency lighting; (3) fire detection, extinguishing, and alarm systems; and (4) sewage and waste disposal;
- A system to track the location of staff and patients in the hospital's care during the emergency;[6]
- Policies to ensure the safe evacuation from a facility, addressing considerations of care and treatment needs of evacuees, staff responsibilities, transportation, evacuation location(s), and means of communication;
- A means to shelter in place for patients, staff, and volunteers who remain in the facility, considering the ability of a facility to survive a disaster and potential proactive steps taken prior to an emergency to facilitate sheltering in place;

[4] In response to comments, CMS recognizes that officials may elect not to collaborate with some providers due to their size and role in the community. In this instance, CMS will accept that such provider provide documentation of its efforts to contact such officials, and when application, its participation.

[5] The minimum requirements listed in this section will not apply to all provider types. Please review the section for specific provider types to identify the full scope of required policies and procedures.

[6] The final rule clarifies that this requirement applies only to on-duty staff and sheltered residents, but provides that if on-duty staff and sheltered residents are relocated during the emergency, the facility must document the specific name and location of the receiving facility or other location.

- A system of medical documentation that preserves patient information, protects confidentiality of patient information, and ensures records are secure and readily available during an emergency;
- A policy to address the use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of designated health care professionals to address surge needs during an emergency; and
- A process for the development of arrangements with other providers in the event of limitations or cessation of operations.

D. Communication Plans

Hospitals and all other providers must develop and maintain an emergency preparedness communication plan that complies with HIPAA Privacy Regulations and must be reviewed and updated at least annually.

Providers would be required to include the following information in a communication plan:

- The names and contact information for staff, entities providing services under arrangement, patients' physicians, hospitals, and volunteers;
- Contact information for federal, state, tribal, regional, or local emergency preparedness staff and other sources of assistance;
- A primary and alternate means for communicating with staff and federal, state, tribal, regional, or local emergency management agencies, in the event the provider's landline telephone system may not be operable in an emergency;
- A method for sharing information and medical documentation for patients under the provider's care with other health care providers to ensure continuity of care;
- A means of providing information about the general condition and location of patients under the facility's care, as permitted under 45 CFR 164.510(b)(4) ("Use and disclosures for disaster relief purposes") of the HIPAA Privacy Regulations;
- A means of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center; and
- Ensure that the emergency preparedness communication plan complies with local law.

E. Training and Testing

Hospitals and all other providers must develop and maintain an emergency preparedness training and testing program, to be reviewed and updated at least annually. Importantly, the final rule requires providers to provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under contract within the facility, and volunteers, consistent with their expected role. After the initial training, providers will be required to conduct emergency preparedness training on an annual basis. Providers will be required to document all training events and maintain such documentation.

In addition to training, the final regulations will also require all providers to conduct drills and exercises to test the emergency plan. The testing requirement contains substantive changes from

the proposed regulation. As a result of the changes, providers will be required to conduct one full-scale exercise[7] and an additional exercise of their choice, which could be a second full-scale exercise or a tabletop exercise[8]. The full-scale exercise must be community-based, or when a community-based exercise is not accessible, an individual, facility-based exercise.

Providers are required to analyze the response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the emergency preparedness plan, as needed.

F. Emergency and Standby Power Systems

Applicable to hospitals and nursing homes only, the final rule requires the implementation of emergency and standby power systems based on the developed emergency preparedness plan. The alternate source of power (generator) and all connected distribution systems and ancillary equipment, must be designed to ensure continuity of electrical power to designated areas and functions the facility.

The final rule contains significant changes to the requirements for maintaining an emergency power system. Specifically, the final rule removes the proposed requirement that hospitals and nursing homes maintain emergency fuel quantities onsite. Rather, the final rule provides that for those facilities that maintain an onsite fuel source to power emergency generators, the facility must have a plan for how it will keep emergency systems operational during the emergency, unless it evacuates. The final rule also removes the requirement to test emergency and stand-by-power systems for a minimum of 4 continuous hours every 12 months at 100 percent of the anticipated power load during an emergency, with the expectation that facilities will continue to test their generators and equipment based on NFPA codes in current general use and manufacturer requirements. The final rule clarifies that hospitals and nursing homes must have a plan to maintain operations unless the facility evacuates.

II. Changes to Emergency Preparedness Regulations by Provider Type

The following section identifies the variations from the emergency preparedness regulations applicable to hospitals based on provider type.

A. Nursing Homes

The emergency preparedness requirements for skilled nursing and nursing facilities (also referred to as long term care, or LTC facilities) are identical to the requirements for hospitals, with two exceptions. Specifically, the final rule requires LTC facilities, in utilizing an ‘‘all-hazards’’ approach for risk assessment and emergency preparedness planning, to include a requirement for facilities to have a plan to account for missing residents.

[7] The final regulation contains a 1 year exemption from this requirement if the provider experienced an emergency that required activation of the emergency plan.

[8] A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

The final rule also adds a requirement to the communication plan requirements (Section I, Subsection D), to require facilities to determine what information in their emergency plan is appropriate to share with its residents and their families or representatives and that the facility develop a means by which that information is disseminated to those individuals. This is due to the long term nature of resident stays, in which the facility essentially becomes the residents' residences or homes.

B. Certified Home Health Agencies

Currently, there are no existing emergency preparedness requirements contained under the Home Health Agency (HHA) Medicare CoPs contained in part 484, Subparts B and C. The final rule adds emergency preparedness requirements at § 484.22 applicable to HHAs. The final rule requires HHAs to comply with some of the requirements that are imposed on hospitals; however, it also contains additional policies and procedures requirements applicable to HHAs, but not to hospitals, to address the unique circumstances under which HHAs provide services.

Risk Assessment and Planning

HHAs will be required to conduct a risk assessment, using the same approach and criteria established for hospitals (Section I, Subsection A). In addition to developing an emergency preparedness plan from the risk assessment (Section II, Subsection B) , HHAs will be required to *develop and include individual emergency preparedness plans for each patient as part of the comprehensive patient assessment*.

In response to comments, CMS provided clarification on this requirement imposed on HHAs, noting that the provision is not intended to require HHAs to develop extensive emergency preparedness plans with their patients. CMS states that HHAs are already conducting and developing patient specific assessments and during these assessments, CMS expects HHAs to instruct their staff to assess the patient's needs in the event of an emergency. CMS expects that HHAs already discusses with their patients on what to do in the event of an emergency and the possibility that they may need to provide self-care if agency personnel are not available. The individualized plan required under the final rule would be written answers and solutions as a result of these discussions and could be as simple as a detailed emergency card developed with the patient.

Policies and Procedures

While HHAs will be required to develop and implement policies and procedures, they will not be required meet all of the same requirements that applicable to hospitals. HHAs will be required to develop and implement policies and procedures required for hospitals identified above (Section I, Subsection C), *except for the following*:

- The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, including food, water, medical supplies, and pharmaceuticals;

- Policies to ensure the safe evacuation from a facility, addressing considerations of care and treatment needs of evacuees, staff responsibilities, transportation, evacuation location(s), and means of communication;
- A means to shelter in place for patients, staff, and volunteers who remain in the facility, considering the ability of a facility to survive a disaster and potential proactive steps taken prior to an emergency to facilitate sheltering in place; and
- Providing care and treatment at alternate care sites identified by emergency management officials.

The final rule removes the proposed requirement that HHAs develop arrangements with other HHAs and other providers to receive patients in the event of limitations or cessation of operations to ensure the continuity of services to HHA patients. In responding to comments on this provision, CMS stated that, during an emergency, if a patient requires care that is beyond the capabilities of the HHA, CMS expects that care of the patient would be rearranged or suspended for a period of time; however, HHAs will be responsible to have procedures to inform State and local emergency preparedness officials about HHA patients in need of evacuation from their residences at any time due to an emergency situation.

The final rule also removes the requirement for HHAs to track their staff and patients. The tracking requirement has been replaced with a requirement for HHAs to have policies and procedures that address the follow up procedures the HHA will exercise in the event that their services are interrupted during or due to an emergency event. In addition, the HHA must inform state and local officials of any on-duty staff or patients that they are unable to contact.

Communication Plans

The final rule does not significantly alter the communication plan requirements imposed on hospitals for HHAs. HHAs are required to comply with all requirements identified above (Section I, Subsection D), *except for developing a means, in the event of an evacuation, to release patient information*. In addition, the final rule modifies the requirement to provide information regarding the facility's occupancy to require HHAs to provide information about the agency's needs and its ability to provide assistance to the authority having jurisdiction.

Training and Testing

The final rule does not alter the training and testing requirements imposed on hospitals for HHAs. As a result, HHAs are required to meet the requirements identified above (Section I, Subsection E). HHAs are not required to comply with the emergency power system requirements discussed in Section I, Subsection F.

C. Hospices

The final rule mostly applies the requirements that are imposed on hospitals on all hospice providers, including hospice inpatient care facilities.

Risk Assessment and Planning

Hospice providers are required to conduct a risk assessment, using the same approach and criteria established for hospitals (Section I, Subsection A) and develop an emergency preparedness plan from the risk assessment (Section I, Subsection B). In developing the emergency preparedness plan, the final rule includes a requirement applicable only to hospice providers that the plan addresses managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

Policies and Procedures

It is important to note that the final rule removes the requirement for home based hospices to track their staff and patients. The tracking requirement has been replaced with a requirement for home based hospices to have policies and procedures for following up with on-duty staff and patients to determine services that are still needed in the event that their services are interrupted during an emergency event. In addition, the hospice must inform state and local officials of any on-duty staff or patients that they are unable to contact.

While hospice providers are required to develop and implement policies and procedures, they will not be required meet all of the same requirements that applicable to hospitals. Hospice providers are *only* required to develop and implement the following policies and procedures:

- Procedures to inform State and local officials about hospice patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment;
- A system of medical documentation that preserves patient information, protects confidentiality of patient information, and ensures records are secure and readily available;
- The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency; and
- The development of arrangements with other hospices and other providers to receive patients in the event of limitations or cessation of operations to ensure the continuity of services to hospice patients.

The final rule includes additional requirements for hospice inpatient care facilities to develop policies for:

- A means to shelter in place for patients, hospice employees who remain in the hospice;
- Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance;
- The provision of subsistence needs for hospice employees and patients, including food, medical, and pharmaceutical supplies;
- Alternate sources of energy; and

- A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency, and, in the event staff or patients are relocated, inpatient hospices must document the specific name and location of the receiving facility or other location to which on-duty staff and patients were relocated to during the emergency.

Communication Plans

The final rule does not alter the communication plan requirements imposed on hospitals for hospice providers and requires compliance with all requirements identified in Section I, Subsection D.

Training and Testing

The final rule does not alter the training and testing requirements imposed on hospitals for hospice providers in Section I, Subsection E. However, the final rule contains an additional requirement for hospice providers to periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff, i.e. volunteers and contractors) with special emphasis placed on carrying out the procedures necessary to protect patients and others. Hospices are not required to comply with the emergency power system requirements discussed in Section I, Subsection F.

D. Federally Qualified Health Centers (FQHCs)

Currently, FQHCs are required to provide emergency care either on site or through clearly defined arrangements for access to health care for medical emergencies during and after the FQHC's regularly scheduled hours. Therefore, FQHCs must provide for access to emergency care at all times. Although FQHCs currently do not have specific requirements for emergency preparedness, they have requirements for ''Emergency Procedures'' found at § 491.6 (''Physical plant and environment''), requiring staff training for non-medical emergencies and the use of exit signs in appropriate locations. The current requirements have been incorporated into the final rule.

Risk Assessment and Planning

FQHCs will be required to conduct a risk assessment, using the same approach and criteria established for hospitals (Section I, Subsection A). In developing an emergency preparedness plan from the risk assessment (Section I, Subsection B), the plan must address the type of services the facility has the capacity to provide in an emergency, based on, but not limited to, the facility's size, available human and material resources, geographic location, and ability to coordinate with community resources.

Policies and Procedures

While FQHCs will be required to develop and implement policies and procedures, they will not be required meet all of the same requirements adopted for hospitals. FQHCs will be required to

develop and implement policies and procedures required for hospitals identified above (Section I, Subsection C), *except for the following*:

- The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, including food, water, and medical supplies;
- A system to track the location of staff and patients in the hospital's care both during and after the emergency;
- A process for the development of arrangements with other providers in the event of limitations or cessation of operations; and
- Providing care and treatment at alternate care sites identified by emergency management officials.

The final rule modifies the hospital requirement to develop policies to ensure the safe evacuation from a facility applicable to FQHCs. FQHCs will only be required to develop policies and procedures for the evacuation from the facility, including appropriate placement of exit signs, staff responsibilities, and needs of the patients.

Communication Plans

The final rule does not significantly alter the communication plan requirements imposed on hospitals, requiring FQHCs to comply with all requirements identified above (Section I, Subsection D), *except for developing a means, in the event of an evacuation, to release patient information*. The final rule modifies the requirement to provide information regarding the facility's occupancy to require FQHCs to provide information about the center's needs and its ability to provide assistance to the authority having jurisdiction.

Training and Testing

The final rule does not alter the training and testing requirements applicable to hospitals for FQHCs, requiring FQHCs to meet the requirements identified above (Section I, Subsection E). FQHCs are not required to comply with the emergency power system requirements discussed in Section I, Subsection F.

III. Integrated Health Care Systems

The final rule includes a new provision that will allow providers that are part of healthcare system consisting of multiple separately certified healthcare facilities to elect to develop a unified an integrated emergency preparedness program. Participation in the integrated emergency preparedness program will satisfy the provider's responsibilities under the final rule. In order to qualify, the integrated emergency preparedness program must:

- Demonstrate that each separately certified provider within the system actively participated in the development of the program;
- Be developed and maintained in a manner that takes into account each separately certified provider's unique circumstances, patient populations, and services offered;

- Demonstrate that each separately certified provider is capable of actively using the program and is in compliance with the program;
- Include an emergency plan that meets the requirements applicable to hospitals and other provider types; and
- Contain a documented individual provider-based risk assessment for each separately certified provider.

IV. Implementation Strategy and CMS Guidance Materials

The final rule will significantly impact the operations of all Medicare providers. While most providers are required by either state or federal law to develop and maintain an emergency preparedness plan, the final rule imposes a continuing obligation to assess, plan, develop, and implement a comprehensive response to a wide-range of potential emergencies, with continual training and testing requirements. As these requirements are imposed through CoPs, the ramifications for the failure to maintain compliance with the CoPs for emergency preparedness will have a substantial impact on provider business operations.

In order to assist providers with compliance with the final rule, CMS has established a web page containing information and tools for developing effective and robust emergency plans and responses. The website contains provider guidance for emergency planning, including an emergency preparedness checklist recommended for effective healthcare facility planning. It also contains disaster-specific information to assist providers in their planning and preparedness. Further guidance, resources and information will be regularly posted to the website.

We recommend that impacted providers initiate compliance with the final rule through a comprehensive review of existing emergency preparedness efforts. We then recommend that providers review the guidance material and CMS-issued emergency preparedness checklist to identify tasks that must be initiated and assigned.

Please contact us with any questions that you may have.

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