CMS Response to the North Dakota and Minnesota Flooding Emergency Public Health Emergency Declaration

Provider Survey and Certification
Questions and Answers

#	Question and Answer
A	**1135 Waiver Authority**
A-1	Question: Do the modifications and flexibilities described in Q&As in response to the existing emergency related to the floods apply only to providers in the States in which the Secretary of Health and Human Services (HHS) has declared a public health emergency and the President has made a declaration under the Stafford Act or National Emergencies Act? Answer: The waivers apply only to providers in the areas in which the Secretary has declared a public health emergency and the President has made a declaration under the Stafford Act or the National Emergencies Act, and only to the extent that the Secretary has invoked his authority under § 1135 of the Social Security Act and then only to the extent that the provider in question has been affected by the emergency. Note, however, that Medicare does allow for certain limited flexibilities outside the scope of the § 1135 waiver authority as discussed in other Qs&As (e.g., see # M-4).
A-2	Question: What is the duration of the waivers granted by the HHS Secretary under § 1135? Answer: In general, the length of the waiver is the duration of the emergency period, unless sooner terminated, as described in § 1135(e). However, requirements are waived only to the extent necessary to achieve the purposes of the statute. For example, if a hospital regains its ability to comply with a waived requirement before the end of the declared emergency period, then the waiver of that requirement would no longer apply to that hospital. Note that if a waiver of Emergency Medical Treatment and Labor Act (EMTALA) or Health Insurance Portability and Accountability Act (HIPAA) sanctions is granted, such a waiver is subject to special limits on duration.
A-3	Question: In addition to those services provided in the emergency area, can the § 1135 waiver authority be used to include waivers regarding benefits and services provided for evacuees from emergency areas who are receiving those services in non-emergency areas? Answer: The § 1135 waiver authority does not extend beyond the "emergency area," which is defined as the area in which there has been both a Stafford Act or National Emergencies Act declaration and a public health emergency declaration. Medicare does allow for certain limited flexibilities outside the scope of the § 1135 waiver authority as discussed in other Q&As. Some of these flexibilities may be extended to areas beyond the declared "emergency area."
A-4	Question: At what point will individuals no longer be treated as "emergency victims?" Is there a set period of time or does it vary by individual? Answer: Emergency policies, including those policies made possible by the § 1135 waiver authority generally do not vary by individual beneficiary. These policies apply to the geographic area(s) in which the emergencies have been declared and may apply to individual health care providers or groups or types of providers. In addition, the § 1135 waiver authority, if invoked, is geared toward requirements upon providers, not individual beneficiaries. However, the effect of a waiver may vary somewhat from individual to individual depending, not upon the waiver authority itself, but rather upon particular circumstances, e.g., whether the person was evacuated to a facility for which requirements were waived (as opposed to a facility to which the waiver did not apply).
A-5	Question: How does a health care provider affected by the North Dakota and Minnesota flooding request and receive approval for an 1135 waiver? Answer: Waiver requests are to be submitted to the health care provider's State Survey Agency (SA). The request must include a justification for the waiver, and include dates and times that the waiver would begin and end. Providers and suppliers will be asked to keep careful records of

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	beneficiaries to whom they provide services, in order to ensure that proper payment may be made. The SA will forward the request to their CMS Regional Office, which will review the provider's request and make appropriate decisions, usually on a case-by-case basis. CMS will approve waivers only to the extent that the provider in question has been affected by the disaster. The only exception to the process of requesting a waiver and justifying the need to the SA and CMS Regional Office relates to waivers of sanctions for hospitals or critical access hospitals (CAHs) located in the emergency area that have activated their disaster plans under the Emergency Medical Treatment and Labor Act (EMTALA) (see Q&A # 35). In all other cases, federally certified/approved providers must operate under normal rules and regulations, unless they have sought and have been granted waivers from specific requirements.
B	**Alternate Care Sites**
B-1	Question: Are there any requirements for North Dakota and Minnesota providers or facilities (e.g., critical access hospitals [CAHs], end stage renal dialysis [ESRD] facilities, intermediate care facilities for persons with mental retardation [ICF/MRs], hospitals, nursing facilities, skilled nursing facilities, etc.) that are located in the public health emergency area, and must evacuate patients or residents to an alternate care site in a safe location (e.g., a different licensed provider type, non-certified provider type, church, school, etc.) and continues to provide care and services? Answer: When health care providers and facilities must evacuate patients and residents to a safe location, the first preference is to evacuate to a facility of the same type. However, if that is not possible, providers and facilities located in the emergency area may request a waiver to evacuate their patients and residents to an alternative care site (or multiple sites, if subsequent sites are necessary) that is in a safe location (e.g., a different certified/licensed provider type, assisted living facility, church, school, etc.), which may be in a geographic location that is outside the emergency area. The provider will be expected to provide safe and quality care to their patients and residents in the alternate setting, and to transfer to an appropriate setting as quickly as possible. The provider must contact their State Survey Agency (SA) for each proposed alternate care site placement, to request a waiver from specific Federal health and safety standards as needed, detail what services they plan to offer at the alternate site, and how they intend to ensure the health and safety of patients or residents at that site. The SA will forward the request to their CMS Regional Office, who will make case-by-case decisions. The SA will monitor the situation closely until the repatriation of the patients and residents occur.
C	**Drugs & Vaccines**
C-1	Question: How can health care facilities determine the appropriate use of contaminated and temperature sensitive drugs? Answer: For information regarding the use of potentially contaminated and temperature sensitive drugs during a disaster, please access the Food and Drug Administration's (FDA) Natural Disaster Response Website at www.fda.gov/cder/emergency. For questions about specific drug products, call the FDA general number: 1-888-INFO-FDA.
C-2	Question: Does the 1135(b) waiver allow the redistribution of drugs marked for destruction in skilled nursing facilities, nursing facilities, hospitals, etc., to aid a declared public health emergency relief effort? Answer: Although Federal regulations do not directly address the issue of redistribution, it does speak about "including procedures that ensure the accurate acquiring, receiving, dispensing and distribution of all medications." Therefore, although the redistribution of drugs is a matter that is regulated by the State Boards of Pharmacy it is also addressed in Federal regulations with respect to the safety of the distribution system in practice. Each respective State Board of Pharmacy should be consulted regarding any proposed variance to State law to aid the relief effort.

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C-3	Question: Information regarding medications that patients and residents were receiving before being evacuated is important for facilities that now serve the evacuees. Can this information be accessed anywhere? Answer: Providers may access the State's Medicaid recipients' clinical drug histories for up to four (4) months. Facilities that receive this information will need to comply with the requirements of the Privacy Act. In addition, Emergency Rx History was launched in April 2007 by the nation's pharmacies to provide individuals who have been displaced by disasters or other kinds of emergencies with faster, safer access to prescription medications. Emergency Rx History allows licensed prescribers and pharmacists anywhere in the country to securely access information containing the prescription history of a patient from the affected area. Emergency Rx History reduces the risk of medication errors by making prescription information available to licensed caregivers when are where they are treating patients and residents. Emergency Rx History is a collaborative, public-service initiative made possible by the nation's community pharmacies and the Pharmacy Health Information Exchange, operated by SureScripts. For more information about Emergency Rx History, please access SureScripts' Website at: http://www.surescripts.com/ Also, health care organizations involved in the manufacturing, distribution and dispensing of pharmaceutical products have come together to announce the creation of Rx Response – a program designed to help support the continued delivery of medicines during a severe public health emergency. The partnership includes the American Hospital Association, American Red Cross, Biotechnology Industry Organization, Healthcare Distribution Management Association, National Association of Chain Drug Stores, National Community Pharmacists Association and the Pharmaceutical Research and Manufacturers of America. For more information regarding Rx Response, please see their website at: http://www.rxresponse.com/.
D	**End Stage Renal Dialysis (ESRD) Facilities**
D-1	Question: How do I find out information about the status of dialysis facilities during a disaster? Answer: The Kidney Community Emergency Response (KCER) group monitors weather-related and other disasters, and maintains information about dialysis services. KCER makes it easy to keep abreast of dialysis services during disasters. To view open / closed status of dialysis facilities please see KCER's link at: www.dialysisunits.com. Providers should notify their local End-Stage Renal Disease Network if there are any changes in status. To access information on ESRD Networks and Coalition activities, and available tools and resources, please see the KCER Website at: www.KCERCoalition.com.
D-2	Question: In an emergency environment, how might capable providers who are not currently certified to provide ESRD outpatient services, become certified to receive Medicare reimbursement for delivered dialysis services? Answer: The Medicare program has a special classification for facilities that provide dialysis treatment services during emergencies. This classification is entitled "special purpose dialysis facilities." The certification for a "special purpose dialysis facility" may last for up to eight months. A special purpose dialysis facility may provide services only to those patients who would otherwise be unable to obtain treatments in the geographical areas served by the facility. A special purpose dialysis facility should consult with a patient's physician to assure that care provided in the special purpose dialysis facility is consistent with the patient's care plan. Certification for a special purpose dialysis facility can be immediate. For this certification, a provider should contact either the State Agency where the facility would be located, or the CMS Regional Office.

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D-3	Question: How will recertification be handled for those Medicare-certified dialysis facilities with CMS Certification Numbers that have to close due to damage? Answer: Medicare-certified dialysis facilities with CMS Certification Numbers (CCN) that need to rebuild or relocate following the disaster, should notify either the State Survey Agency or the Regional Office regarding their intention. Once the dialysis facility is operational and in compliance with Medicare's health and safety requirements, the facility may resume billing under their current CCN. Relocated and rebuilt ESRD facilities will be surveyed to assure compliance with basic health and safety requirements when recovery efforts and resources at the State level permit.
D-4	Question: The CDC states that dialysis centers that are operating in the area need to pay special attention to water treatment and especially carbon tank maintenance because of the assumption that extra chlorine may be dumped into the water system by water treatment plants. More frequent disinfection of the water treatment and dialysis equipment may be needed. Is additional information available about special precautions? Answer: The Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) have set up Websites about infection control and water treatment issues and medical devices during flooding disasters. The CDC has provided multiple sets of guidelines, available at http://www.bt.cdc.gov/disasters/floods/. In addition, a new compilation, Natural Disasters, has been added to the *M Guide Online Knowledge Centers* at the *MMWR* Website (http://www.cdc.gov/mmwr). The *M Guide* provides Internet links to previously published *MMWR* reports regarding assessment of health needs and surveillance of morbidity and mortality after hurricanes, floods, and the December 26, 2004 tsunami. The FDA Website located at http://www.cfsan.fda.gov/~dms/fsdisasm.html provides information about food and water safety during power outages, hurricanes and flooding. The FDA has an all-hazards site for food safety, which is located at: http://www.foodsafety.gov/~fsg/fsgdisas.html
D-5	Question: What considerations need to be taken into account when restoring a dialysis facility to operational status in the recovery phase following a public health emergency? Answer: The CDC, FDA, and the Association for the Advancement of Medical Instumentation (AAMI) have prepared recommendations about reopening dialysis facilities following a disaster. These directions are for use if the building has not been flooded, and after utilities have been restored, the physical facility is in operational condition, and adequate water flow and pressure is available, although source water may be subject to a "boil water alert." If the facility was flooded, please see the CDC guidelines for recovery of a flooded building at http://www.bt.cdc.gov/disasters/floods/ **Water Treatment System** • Flush all pretreatment equipment to drain for at least 30 minutes to remove the stagnant water from the system. • Test the level of free chlorine and chloramine in your source water (expect it to be higher than normal). • Test chlorine and chloramine after the primary carbon tank to verify that the water is <0.5 ppm free chlorine, or <0.1 ppm chloramine. • If chlorine or chloramines after the primary carbon tank ≥0.5 ppm or ≥0.1 ppm, respectively, promptly change the primary carbon tank, or for systems with a secondary carbon tank, test the levels after the secondary carbon tank. • If chlorine and chloramine are below these levels (0.5 ppm or 0.1 ppm), turn on the Reverse Osmosis (RO) machine. • Flush the distribution system (to drain if possible). • Disinfect the RO and the distribution system and rinse. Test for residual disinfectant levels to ensure proper rinsing. • Replace all cartridge filters. • Compare your product water quality readings to your historical data. A significant difference could mean that your RO membranes are damaged, or the quality of the incoming water has drastically decreased. (see note below) If the total dissolved solids (TDS) are greater than 20% higher than your historical readings you may need to use deionization (DI) tanks as a polisher

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	on the product water, followed by an ultrafilter to minimize microbial contamination. • Increase your frequency of monitoring: • Check chlorine/chloramine hourly • Verify hourly that your product water quality is acceptable. • Monitor water cultures and endotoxin at least weekly. If you have the capability to test for endotoxin on site, test daily. • Draw representative water cultures and endotoxin tests as soon as possible. If you have the capability of testing for endotoxin on site, do this before you run patients; report the results to your Medical Director. • Anticipate an increased level of particulate matter in the water. Monitor the pressure drop across pretreatment components and backflush as necessary. • Plan on re-bedding your carbon tanks as soon as possible. • Send a sample of product water for an AAMI analysis as soon as is practical. • Clean the RO membranes as soon as is practical. **Dialysis Machines:** • Chemically disinfect the dialysis machines and rinse. Test for residual disinfectant levels to ensure proper rinsing. • Bring up the conductivity and "self test" the machines to verify proper working condition. If a machine fails the "self test," perform needed repairs prior to using that machine. Note: If the product water TDS is high and the percent rejection is in line with historical performance, then the RO membranes are most likely good, but the feed water may have a higher than usual level of contaminants. DI polishing will help cope with the extra burden in the feed water. If the product water TDS is high and the percent rejection is lower than historical values, then the RO membranes are probably bad and should be replaced promptly. DI polishing may or may not be needed once the RO membranes are replaced. **Hemodialysis Water Treatment References:** Northwest Renal Network document *Monitoring Your Dialysis Water Treatment System* http://www.nwrenalnetwork.org/watermanual.pdf Association for the Advancement of Medical Instrumentation, Recommended Practices for Dialysis Water Treatment Systems (RD 52 and RD 62) http://aami.org/publications/standards/dialysis.html **Other Resources:** *Guidance for Dialysis Care Providers: What to do when your municipal water supplier issues a "boil water advisory"* http://www.cdc.gov/ncidod/dhqp/dpac_dialysis_boilwater.html Water Related Emergencies http://www.bt.cdc.gov/disasters/watersystemrepair.asp Tips about Medical Devices and Hurricane Disasters http://www.fda.gov/cdrh/emergency/hurricane.html Medical Devices that Have Been Exposed to Heat and Humidity http://www.fda.gov/cdrh/emergency/heathumidity.html Medical Devices Requiring Refrigeration http://www.fda.gov/cdrh/emergency/refrigeration.html Fact Sheet: Flood Cleanup - Avoiding Indoor Air Quality Problems http://www.epa.gov/iaq/pubs/flood.html NIOSH Response: Storm and Flood Cleanup http://www.cdc.gov/niosh/topics/flood/

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	OSHA Fact Sheet http://www.osha.gov/OshDoc/data_Hurricane_Facts/Bulletin3.pdf American Institute of Architects: Procedures for Cleaning Out a House or Building Following a Flood http://www.aia.org/about/initiatives/AIAS075276
E	**Home Health Services**
E-1	Question: What adjustments or flexibility is allowed related to Medicare requirements for completion of the OASIS assessment process? Answer: In the time period indicated in the statutory waiver invoked by the HHS Secretary under § 1135 of the Social Security Act, CMS may modify certain timeframe and completion requirements for Outcome and Assessment Information Set (OASIS). In this emergency situation, an abbreviated assessment can be completed to assure the patient is receiving proper treatment and to facilitate appropriate payment. For those Medicare approved home health agencies (HHAs) serving qualified home health patients in the public health emergency areas determined by the Secretary, the following modifications to the comprehensive assessment regulation at 42 CFR § 484.55 may be made. These minimal requirements will support reimbursement when billing is resumed and help ensure appropriate care is provided. • The Start of Care assessment (RFA 1) may be abbreviated to include the Patient Tracking Sheet and the payment items. HHA should maintain adequate documentation to support provision of care and payment. • The Resumption of Care assessment (RFA 3) and the Recertification assessment (RFA 4) may be abbreviated to the payment items. HHA should maintain adequate documentation to support provision of care and payment. • The OASIS transmission requirements at 42 CFR 484.20 are suspended for those Medicare approved HHAs that are serving qualified home health patients in the affected areas. • The Discharge assessment (RFA 8 or RFA 9) and the Transfer assessment (RFA 6, RFA 7) are suspended during the waiver period. HHAs should maintain adequate documentation to support provision of care and payment.
E-2	Question: Can the "residence" component of the homebound requirements be suspended by allowing the delivery of home health services at any site of temporary residence during the crisis? Can this include a residence that is a nursing facility or hospital provided the patient is otherwise not at such level of care when the patient is using the facility as a medical shelter? Answer: The Social Security Act stipulates that beneficiaries must be confined to the home in order to be eligible to receive home health services. A beneficiary's home is any place in which a beneficiary resides that is not a hospital, skilled nursing facility (SNF), or nursing facility as defined in § 1861(e)(1), § 1819(a)(1), or § 1919(a)(1) of the Social Security Act, respectively. Under these temporary extraordinary circumstances, place of residence can include services provided at temporary locations like a family member's home, a shelter, a community facility, a church, or a hotel. A hospital, SNF, or nursing facility as defined above would not be considered a temporary residence.
E-3	Question: Will home health agencies be given any special consideration for OASIS if their vendor is located in a public health emergency area and has been impacted by the disaster? Answer: HHAs do have other options as far as software to use. We suggest they use HAVEN for the interim. If they need assistance with importing their vendor's data into HAVEN, they should contact the HAVEN Help Desk at 1-877-201-4721.

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E-4	Question: Several of my home health agency physical locations have been destroyed by the disaster. May I relocate and continue furnishing services? Answer: Contact your SA, who will forward your request to the CMS Regional Office. The RO will review requests on a case-by-case basis, and limited exceptions to the physical location requirements may be allowed. In addition, please refer to the State's specific licensure and certification requirements during a public health emergency. If the facility will not be operating in the original location for several months (approximately four months after the disaster), CMS will revisit the situation and determine if voluntary deactivation is best. The original certification was for services to a designated service area and may not be used to expand or relocate services, but is for temporary emergency service delivery.
F	**Hospice**
F-1	Question: What is a hospice agency's responsibility in the event of a disaster? Answer: A hospice agency, as indicated in 42 CFR § 418.100(b), "Disaster Preparedness," must have an acceptable written plan to be followed in the event of an internal or external disaster, including care of casualties arising from such a disaster. We note that this provision does not necessarily address all public health emergencies.
F-2	Question: If a hospice provider cannot provide care for its patients, can these patients transfer to another hospice provider? Answer: Under the Social Security Act at § 1812(d)(2)(C) and CMS regulations at 42 C.F.R. § 418.30(a), a Medicare beneficiary may transfer from one hospice agency to another hospice for any reason once per election period. If a Medicare beneficiary has already utilized this one-time right to transfer but needs to move again because of the public health emergency, § 1861(dd)(5)(D) of the Act provides for a hospice agency to arrange with another hospice for the delivery of services in extraordinary circumstances. We would not deem a change in hospice under these circumstances to be a voluntary transfer under 42 C.F.R. § 418.30 (i.e., a beneficiary would still be entitled to transfer voluntarily after a transfer for "extraordinary circumstances").
F-3	Question: In the event that the originating hospice is able to resume provision of services to their patients, may patients be transferred back to the originating hospice? Answer: CMS believes that patients should be provided with the choice of resuming care from the originating hospice or continuing with the existing hospice provider. If the beneficiary remains with the "host"/replacement hospice at the end of the emergency period, we would consider this a transfer under our regulations at 42 CFR § 418.30. If a beneficiary uses the services of an alternate hospice agency for a short period of time due to extraordinary circumstances such as a natural disaster, neither the departure from nor return to the original hospice agency would be considered a "transfer" within the meaning of 42 CFR § 418.30.
F-4	Question: How should a hospice that temporarily receives a patient from another hospice handle administration of that patient's care plan if the patient arrives with no alternate caregiver information, and/or the admissions officer believes that the patient may be legally incompetent to make health care decisions for him/herself? Answer: Under CMS rules, the health and safety of the patient always comes first. The receiving hospice should complete an assessment of the patient to identify immediate needs and establish a plan of care with the interdisciplinary group (IDG). The receiving hospice should make every effort to contact the original hospice and/or attending physician to discuss the previously implemented plan of care and, if necessary, to determine if the patient is legally competent. If the receiving hospice has access to the plan of care established by the original hospice every attempt should be made to

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	follow the plan if the needs of the patient are such that the original plan will provide the appropriate interventions.
F-5	Question: Who can speak/sign paperwork on behalf of the patient (including discharge and transfer decisions)? Answer: A person's legal authority to make healthcare decisions on behalf of another is a matter of state law; hospices should confer with their counsel to determine whether their state law has provisions which address health care decision-making in emergency/extraordinary circumstances. If the hospice patient cannot speak or sign paperwork the receiving hospice should make arrangements to get permission for treatment and care pursuant to state requirements.
G	**Hospital Services – General**
G-1	Question: Could the State Survey Agency certify a hospital to provide skilled nursing services? Answer: A hospital could apply for certification of portions of its facility as a Nursing Facility. A hospital with less than 100 beds and located in a nonurbanized area may apply for swing bed status and receive payment for skilled nursing facility services by applying with the CMS RO. A survey by the State Survey Agency (SA) would be required.
G-2	Question: I was scheduled for surgery at my hospital next week, but my hospital is unable to get to me. I already had all my tests done. Can I have the surgery at another hospital? Will I need to have the tests done again? Answer: If your physician has re-established his practice near you, you can contact him/her at the new location. However, if you cannot locate your physician, you will need to see another physician who will want to perform his/her own evaluation. If the test results are available, repeat tests may not be necessary. If the test results are not available, they will need to be repeated. A new physician may also have differing criteria as to who is eligible for surgery. Those criteria do vary among health care providers.
H	**Hospital Services – Acute Care**
H-1	Question: During an emergency situation, if acute care beds are all in use, can a hospital use its hospital-based SNF beds to provide acute care? Answer: Under the 1812(f) waiver that is in effect, a hospital can discharge more stable patients to a skilled nursing facility (SNF). In this situation, the 3-day prior hospital stay requirement and benefit period requirements will be relaxed, and the beneficiary's care will be reimbursed at the appropriate SNF PPS rate. If it would be impractical or clinically inappropriate to discharge hospital patients to SNF-level care, a hospital may expand its inpatient bed capacity by obtaining a CMS waiver and placing some hospital patients into its hospital-based SNF. The hospital should submit their waiver request to the State Survey Agency, who will forward it to their CMS Regional Office for approval. If approved, the hospital must inform its FI/MAC. The hospital will be responsible for documenting that those patients admitted to the hospital-based SNF need a hospital level of care. The hospital will need to provide adequate RN staffing in the SNF to make sure that every patient needing a hospital level of care has immediate RN availability at the bedside. High acuity hospital patients or patients who need special equipment or special treatments should not be placed in the SNF. Care must also be taken not to place hospital patients into the SNF, if those patients place the SNF patients at risk (behavior problems, communicable infections).
H-2	Question: Can a hospital that does not have either a hospital-based SNF or a swing bed unit use its acute care beds to provide SNF level care? Answer: No. Both hospital-based SNFs and swing beds have different conditions of participation, and, even when an 1135 waiver is in effect, it can only be established after an on-site survey. During an emergency, CMS has very limited survey capability, and could not conduct surveys quickly

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	enough to be useful. The hospital should make every effort to place patients in free-standing SNFs during the waiver of the 3-day prior hospital stay requirement.
H-3	Question: Can exempt beds in the declared emergency area be converted to acute beds if a shortage of acute beds occurs due to victims of the disaster? In the past, such requests were handled on a case-by-case basis. Should we continue to send such requests to the State Survey Agency for conversion? Answer: CMS will handle each request to convert exempt beds to acute care beds to accommodate the needs of disaster victims on a case-by-case basis. The State's input in reviewing the provider's request and determining whether there is a need for the proposed beds is critical to ensure that beneficiaries receive the high quality care they need. It is important to realize that any change in bed type would be approved only if there was an established need for the care to be provided, if the care can be provided safely and only for a very short period of time. Basically the change in bed type would only be approved for a brief emergency situation. Beneficiaries must be transferred to the appropriate provider type as soon as their condition permits.
H-4	Question: Can a hospital's emergency plan include co-locating with another existing hospital? Can the plan include co-locating at two different hospitals so that the adult and pediatric population is separated? Does a psych hospital have to co-locate with another psych hospital? Answer: No. We feel a higher level of assurance of compliance with Medicare health and safety standards is achieved when hospitals utilize a simple transfer of patients to a receiving hospital upon evacuation, rather than co-locating with that hospital, since the newly "co-located hospital" would have to be evaluated for the degree to which it is able to comply separately with the Medicare standards in the new location, and the necessity of waivers in areas of noncompliance.
I	**Hospital Services – Critical Access Hospital (CAH)**
I-1	Question: Critical access hospitals are normally limited to 25 inpatient beds, but may need to press additional beds into service or extend lengths of stay to respond to the crisis. Will CMS enforce this limit? Answer: During the public health emergency period, CMS will waive the limit of 25 inpatient beds, specified in section 1820(c)(2)(B)(iii) of the Social Security Act, for Critical Access Hospitals (CAHs) located in the declared emergency areas of North Dakota or Minnesota. This means that evacuees that CAHs treat will not be counted toward the determination of the 25-bed limit. CAHs located in North Dakota and Minnesota must notify their State Survey Agency (SA) when evacuees received and admitted would result in the facility exceeding its 25-bed limit. The CAH must provide information regarding the name and location of the CAH; the reason for exceeding the 25-bed limit; the estimated number of anticipated admissions exceeding the 25-bed limit; and the date that the 25-bed limit was first exceeded. CAHs will be asked to keep careful records of patients admitted, to ensure that proper payment may be made. They should also describe measures that they are taking to ensure that there are adequate, qualified personnel to provide care for the expanded number of CAH inpatients. The SA will forward the providers notification to the CMS Regional Office, for record-keeping purposes.
I-2	Question: Will critical access hospitals in the declared emergency areas remain subject to the 96-hour rule? Answer: CMS will not count any bed use that exceeds the 96-hour average annual length of stay limit if this result is clearly identified as relating to the emergency. The 96 hour average annual length of stay (LOS)/patient is calculated annually. Depending on the length of the emergency period in North Dakota or Minnesota, there may be no adverse impact on a CAH's ability to achieve this annual average. However, if a CAH located in the public health emergency area is found to have exceeded the 96-hour average in its next annual calculation, CMS will determine whether this resulted from the CAH's provision of services to evacuees during the public health emergency.

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	CAHs should notify their State Survey Agency (SA) if they find that their patients are averaging a longer than 96 hour LOS during the public health emergency. They should also describe the measures that they are taking to ensure that there are adequate, qualified personnel, equipment and supplies to provide safe care for those patients who require a longer LOS. Generally CAHs are expected to transfer out patients who require longer admissions, to hospitals that are better equipped to provide specialized or complex services to patients who are more acutely ill.
J	**Hospital Services – Emergency Medical Treatment and Labor Act (EMTALA)**
J-1	Questions: What is HHS's process for approving and issuing Emergency Medical Treatment and Labor Act (EMTALA) waivers in response to an emergency (aside from both a public health emergency (PHE) being declared by the HHS Secretary and an emergency/disaster being declared by the President)? Answer: There are 4 prerequisites to a waiver of EMTALA sanctions under HHS's authority under Section 1135 of the Social Security Act. They are as follows: (1) The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act, (2) The Secretary of HHS has declared a Public Health Emergency (PHE) under Section 319 of the Public Health Service Act, (3) The Secretary of HHS has invoked his authority under Section 1135 of the Social Security act and authorized CMS to waive sanctions for certain EMTALA violations that arise as a result of the circumstances of the emergency, and (4) The hospital has implemented its hospital disaster protocol.
J-2	Question: What is the time frame for the EMTALA waiver of sanctions? Answer: Waivers of sanctions under the Emergency Medical Treatment and Labor Act (EMTALA) in the emergency area end 72 hours after implementation of the hospitals disaster plan. (If a public health emergency involves pandemic infectious disease, the waiver of sanctions under EMTALA is extended until the termination of the applicable declaration of a public health emergency. However, that is not the current situation in North Dakota or Minnesota.)
J-3	Question: Can the 72-hour EMTALA waiver be extended for a non-pandemic related emergency? Answer: No. Section 1135 does not authorize an extension of the EMTALA waiver beyond 72-hours after the implementation of a hospital disaster protocol, for public health emergencies that do not involve pandemic infectious diseases.
J-4	Question: Are hospitals required to comply with all of the requirements of EMTALA during the public health emergency period in the emergency area? Answer: Generally, yes. However, the Secretary has the authority not to impose sanctions on a hospital located in the emergency area during the emergency period if the hospital redirects or relocates an individual to another location to receive a medical screening examination pursuant to either a state emergency preparedness plan or a state pandemic preparedness plan or transfers an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency. These waivers shall be limited to a 72-hour period beginning upon implementation of a hospital's emergency or disaster protocol and are not effective with respect to any action taken that discriminates among individuals on the basis of their source of payment or their ability to pay.
J-5	Question: If a hospital remains open during the emergency period and is operating at or in excess of its normal operating capacity and cannot get sufficient staff, may the hospital shut down its emergency department (ED) without violating EMTALA? Answer: Under these circumstances, EMTALA would not prohibit the hospital from closing its ED to new patients if it no longer had the staff or facilities to screen and treat individuals (in effect, going on diversion). The hospital should follow any applicable State and local notice requirements and its

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	own previously established plan for public notification when it goes on diversionary status. The hospital would continue to have an EMTALA obligation to individuals undergoing examination or treatment in its ED at the time it stops accepting new emergency patients. In addition, in spite of the "closure," if an individual comes to such a hospital and requests examination or treatment for an emergency medical condition, the hospital would be obligated under EMTALA to act within its capabilities to provide an appropriate screening and, if necessary, stabilizing treatment.
J-6	Question: Does a hospital need to submit a request to the State Survey Agency for the general EMTALA waiver? Answer: Requests for waiver of sanctions under the Emergency Medical Treatment and Labor Act (EMTALA) are not required for hospitals or CAHs located in the emergency area during an emergency period that have activated their disaster plans pursuant to a declared waiver of EMTALA sanctions of section 1135. Such waivers are limited to a 72 hour period beginning with the hospital's activation of its hospital disaster protocol and are not effective for actions that discriminate among individuals on the basis of their source of payment or ability to pay. Hospitals that activate their hospitals disaster plan and are invoking the permitted EMTALA waiver of sanctions must provide notice to their State Survey Agency, who will forward the information to their CMS Regional Office.
J-7	Question: Would it be considered an EMTALA violation if the hospital did not have any medical records available because of the disaster? Answer: The waiver of EMTALA sanctions in section 1135 only pertains to sanctions for either failing to conduct an appropriate medical screening examination or failing to provide an individual with an appropriate transfer to another medical facility. Section 1135 does not address the treatment of medical records. During a declared public health emergency, CMS would consider the circumstances as part of any medical record compliance determination.
J-8	Question: Evacuees from states affected by the public health emergency may arrive at hospital emergency departments merely to obtain refills of prescriptions that they lost when they evacuated during a disaster or public health emergency. Must these individuals be given an EMTALA medical screening examination when they come to the emergency department? Answer: Even under non-emergency circumstances, the Emergency Medical Treatment and Labor Act (EMTALA) regulations make it clear that individuals seeking only prescription refills need not be given a complete medical screening examination, but rather, one that is appropriate for the request that they make. Hospitals may wish to develop specific protocols that include a streamlined screening examination for individuals seeking prescription refills, consistent with the regulation cited above.
J-9	Question: Would it be possible for the HHS Secretary to waive all of EMTALA's provisions, or only some of them? Answer: There are only two EMTALA provisions for which the sanctions can be waived under a section 1135 waiver. Under the section 1135 authority, CMS can be authorized to waive the following sanctions: (1) For an inappropriate transfer (if the transfer arises out of the circumstances of the emergency), and (2) For the relocation or redirection of an individual to receive an appropriate medical screening examination pursuant to an appropriate State emergency preparedness plan or State pandemic preparedness plan. However, the Secretary must first expressly authorize CMS to waive both sanctions and then each hospital must implement its disaster protocol in order for either of the waivers to apply to that hospital. Moreover, the statute provides that the waiver is only applicable if the hospital's actions do not discriminate among individuals based on their source of payment or ability to pay.

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K	**Inpatient Rehabilitation Facilities (IRF)**
K-1	Question: The disruption to the hospital system caused by the emergency and its aftermath may require some hospitals to use any available bed to care for patients that have been transferred from the affected areas, or to treat the large number of people requiring hospital care. If an inpatient rehabilitation facility (IRF) admits a patient solely in order to meet the demands of this emergency, will the patient be included in the hospital's or unit's inpatient population for purposes of calculating the applicable compliance thresholds in 42 Code of Federal Regulations (CFR) § 412.23(b)(2) ("the 60 percent rule")? Answer: In order to meet the demands of the emergency, CMS will modify enforcement of the requirements specified in 42 CFR § 412.23(b)(2), which is the regulation commonly referred to as the "60 percent rule." If an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such, the patient will not be included in the hospital's or unit's inpatient population for purposes of calculating the applicable compliance thresholds outlined in § 412.23(b)(2). In the case of an admission that is made solely to meet the demands of the emergency, a facility should clearly identify in the inpatient's medical record by describing why the patient is being admitted solely to meet the demands of the emergency. In addition, during the applicable waiver time period, the exception described in this answer would also apply to facilities not yet classified as IRFs, but that are attempting to attain classification as an IRF. An institutional provider would use the "CR" (catastrophic/disaster related) modifier to designate any service line item on the claim that is disaster related. If all of the services on the claim is disaster related, the institutional provider should use the "DR" (disaster related) condition code to indicate that the entire claim is disaster related.
L	**Hospital Services – Long Term Care Hospitals (LTCH)**
L-1	Question: Generally, a hospital must have an average Medicare inpatient length of stay of greater than 25 days in order to be classified as a long-term care hospital (LTCH). If a long-term care hospital (LTCH) admits a patient solely to meet the demands of the emergency, will the patient's stay be counted towards the greater than 25-day average Medicare inpatient length of stay calculation in 42 CFR 412.23(e)(3)(i)? Answer: If a long-term care hospital (LTCH) admits a patient solely in order to meet the demands of the emergency, the patient's stay will not be included for purposes of the average length of stay calculation in 412.23 (e)(3)(i). LTCHs must clearly indicate in the medical record where an admission is made to meet the demands of the emergency.
M	**Skilled Nursing Facility (SNF) / Nursing Facility (NF)**
M-1	Question: Will skilled nursing facilities (SNFs) in the declared public health emergency area still be requiring residents to have a 3-day hospital stay prior to their admission? Answer: Section 18 12(f) of the Social Security Act allows Medicare to pay for SNF services without a 3-day qualifying stay if the Secretary of HHS finds that doing so will not increase costs or change the essential acute-care nature of the SNF benefit. During the emergency period, CMS will temporarily provide SNF benefits in the absence of the 3-day prior hospital qualifying stay for those SNF residents affected by the declared public health emergency to facilitate a smooth transition for residents that will fit their individual care needs. This policy applies to any Medicare beneficiary who: • Was evacuated from a nursing home provider in the emergency area; • Was discharged from a hospital (in the emergency or receiving locations) in order to provide care to more seriously ill patients; or • Needs SNF care as a result of the emergency, regardless of whether that individual was in a hospital or SNF prior to the disaster.

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M-2	Question: Can a skilled nursing facility (SNF) in an emergency area exceed their licensed and certified bed capacity to accommodate additional patients? Answer: The SNF should contact their SA, who will forward their request to the CMS Regional Office (RO), who will review the request and make a case-by-case determination. While providers may exceed their census to meet a short-term need, continued housing of residents over a facility's capacity will require review and evaluation by the State Survey Agency, to ensure that staffing levels are sufficient, as well as the ability to safeguard residents.
M-3	Question: If a skilled nursing facility (SNF) has sustained moderate to severe damage and physical plant assessments indicate re-occupancy may be delayed for several months, what are the particulars of assigning voluntary deactivation status to those facilities? Answer: Providers in the emergency area will be reviewed on a case-by-case basis. If the facility will not be back in business for several months (approximately four months after the disaster), CMS may ask for their voluntary termination of their provider agreement and will be flexible about bringing them back into the program.
M-4	Question: Can skilled nursing facilities located in a state not affected by the emergency exceed their licensed and Medicare certified bed capacity in order to accept residents from another facility (e.g., corporate sister facility) in an affected area? The nursing home provider should contact their SA, who will forward their request to the CMS Regional Office. The RO will review the request and make a case-by-case decision. While providers may exceed their resident census to meet a short-term need, continued housing of residents over a facility's capacity will require review and evaluation by the State Survey Agency. In making case-by-case determinations regarding a receiving provider's acceptance of residents that places it over its licensed and certified capacity, CMS will not make it a priority to place displaced/evacuated residents from one facility into another facility by the same owner.
M-5	Question: What are the requirements for filling out an MDS assessment during an emergency? Answer: Under normal circumstances, a provider is required to complete a Minimum Data Set (MDS) assessment of a resident within 14 days of admission to the facility or when there has been a significant change in the resident's condition. In order to facilitate nursing home responses during a declared emergency, the guidance below will apply during the 1135(b) waiver period. In the case of evacuations, the evacuating facility should determine by day 15 whether or not residents will be able to return to the evacuating facility within 30 days from the date of the evacuation. In the case that the evacuating facility is unavailable to make this determination, the receiving facility makes this determination. If and when the residents return to the evacuating facility within 30 days, the MDS cycle will continue as though the residents were never transferred. This decision places minimal disruption on the staffs' daily routine in caring for all residents. The evacuating facility would then complete the MDSs according to the Long-Term Care Facility Resident Assessment Instrument User's Manual once the residents return to its facility. When the evacuating and/or receiving facility determines that the residents will not return to the evacuating facility within the 30-day time frame, the evacuating facility should discharge the resident by completing a discharge tracking form whenever possible. The receiving facility will admit the residents and complete an admission MDS (and/or a 5-day MDS) as per the federal participation requirements. The MDS cycle will begin as of the admission date. The discharge/admission date must occur within the previously mentioned 30-day time frame. If and when the resident returns to the evacuating facility after the 30-day time frame, the receiving facility will discharge the resident and complete a discharge tracking form. The evacuating facility

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	will re-admit the resident. The MDS cycle will be established based on the reentry tracking form. When residents are transferred to a receiving facility with an anticipated return to the evacuating facility within the 30-day time frame, the evacuating facility may bill Medicare for the services provided at the receiving facility using the evacuating facility's provider number. The evacuating facility is responsible for payment to the receiving facility for the services that facility provides to the evacuated residents. In these cases, the fiscal intermediary will process these claims using the evacuating facility's provider number as if the patients had not been transferred. When a facility is having a problem meeting these requirements, they should contact their State Survey Agency to discuss the situation and receive guidance about any extensions in meeting the required MDS assessment time frames.
M-6	Question: What will be the requirements for MDS completion if a resident is discharged from an evacuating facility within the 30 days? Will another admission MDS be required? Answer: The receiving facility should determine by day 15 whether or not residents will be able to return to the evacuating facility within 30 days or not. If the resident returns to the evacuating facility within the 30-day time limit, the MDS cycle will continue as though the resident was never transferred. If the resident does not return to the evacuating facility within the 30-day time limit, the evacuating facility should discharge the resident by completing a discharge tracking form and the receiving facility should admit the resident and complete an admission MDS (and/or a 5-day MDS) as per the federal participation requirements. The MDS cycle will begin as of the admission date. The discharge/admission date must occur within the previously mentioned 30-day time frame.
M-7	Question: During an emergency, the electronic MDS submission may not be possible from the evacuating facilities (e.g., server is down or equipment has water damage). Answer: If the local MDS database is unavailable (destroyed or lost), CMS can help the evacuating facility restore previously submitted MDS data once a working computer is obtained. They should call the MDS Help Desk at 1-888-477-7876. Note: CMS can not help restore data unless the provider had previously submitted the data to the Federal data submission system.
M-8	Question: What should a Medicaid-certified nursing facility do if an individual is transferred without record of PASRR Level I Screen? Answer: Transfers are not subject to the requirement for Preadmission Screening and Resident Review (PASRR) Level I prior to admission, but are subject to Resident Review (RR) upon a change of condition. Therefore, payment will not be denied based on the absence of a Level I screen. Nevertheless, Medicaid nursing facilities (NFs), and State Medicaid agencies are responsible to identify possible mental illness/mental retardation (MI/MR) in NF residents. CMS suggests that the NF, or other entity specified by the state, accomplish this requirement by performing a Level I Screen as part of the intake procedure. The NF is responsible to see that the screen is performed, to complete the resident's record, and to ensure that the resident receives a Level II evaluation if needed. If there is insufficient data to do so, document the situation, then be alert with these residents for any signs of MI/MR, which will trigger a change in condition and if needed a Resident Review (RR). To access additional guidance on PASRR requirements, see http://www.cms.hhs.gov/katrina/pasrrguidelines.pdf
M-9	Question: What should a Medicaid-certified NF do if they receive a transfer of an individual with indication that PASRR Level II Evaluation and Determination is needed, but no record is available? Answer: Inter-facility transfers are subject to Resident Review (RR), not preadmission screening (PAS) pursuant to 42 CFR 483.106(b)(4). Therefore, there is no risk to the NF that federal financial participation (FFP) will be denied for lack of a PAS. Nursing facilities may admit residents, under emergency Categorical Determination if possible, and begin the Level II evaluation process. CMS will not consider the NF or the state out of compliance if documentation shows that due to

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	evacuation, a resident's possible need for RR is known at admission, is initiated not later than the initial resident assessment and MDS process, and the evaluation/determination is performed as soon thereafter as resources are available.
M-10	Question: What should a Medicaid-certified NF do if they receive a displaced person/evacuee for admission who is not a transfer from a Medicaid-certified NF, or the person's previous status is not clear? Answer: The NF, or other entity specified by the State, should perform a Level I Screen. CMS will not consider the NF or the State out of compliance or withhold FFP if documentation shows that due to the evacuation from declared public health emergency, a Level I Screen was performed upon admission, or within 2 days of admission, and Level II Evaluation is initiated per state procedures if indicated.
M-11	Question: What should a Medicaid-certified NF do if they receive displaced residents/evacuees from an ICF/MR, hospital, or other specialized facility? Level of care (LOC) determinations are State medical necessity requirements and CMS has no authority to suspend such requirements. Emergency guidance from the State and from CMS Regional Office should control admitting practices regarding LOC. However, because PASRR determination of need for NF is connected to LOC, the following information may be useful: a) To the extent that a NF admits evacuees from a higher LOC, the NF would be required to provide all needed services until the individual can be discharged to a facility that would provide the appropriate LOC. MI/MR needs at the hospital or the ICF/MR LOC are unlikely to be met at a NF. b) CMS is aware that some evacuees will lack records, and that pre-evacuation LOC may be inaccurate due to the effects of the emergency on the individual. c) To the extent that a NF admits individuals who do not meet the paying state's LOC requirements, the state may deny Medicaid payment for those individuals. CMS would not consider this a Medicaid-reimbursable admission. A receiving state should make available appropriate facilities for direct admission of displaced persons, rather than compromise the well-being of the person, other residents, and staff by admitting individuals the facility is not equipped to serve.
M-12	Question: What will happen when there is no inter-state PASRR agreement between the evacuating and receiving States? Answer: The State of residence normally has responsibility to pay for PASRR functions, or have a reciprocal agreement with the receiving State. Depending on the number of evacuated Medicaid NF residents, and the length of stay, States may wish to make retroactive inter-state PASRR agreements. CMS will not require inter-state agreements unless States are adjacent (and should already have agreements) or PASRR requirements are not being met due to lack of inter-state cooperation.
M-13	Question: What will happen when a resident is transferred from another state and has PASRR Level II documentation in their record that is sufficient for planning care? Answer: The Medicaid NF should determine whether the evacuee's PASRR documentation would be sufficient under the receiving State's PASRR's rules. The receiving State may allow NFs to accept the existing Level II data on a case-by case basis. CMS will not expect a new evaluation if the documentation shows that for a resident evacuated due to declared public health emergency, the PASRR data received with the out-of-state resident can be used by a care planning team as sufficient and in lieu of an in-state PASRR Evaluation and Determination.
M-14	Question: What will happen when a resident is transferred from another state that has PASRR Level II documentation in their record, but the information is not meaningful in the receiving state (e.g., differing terminology, level of detail, or definitions of Specialized Services)?

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	Answer: If the NF decides to admit the evacuated as a transfer, proceed as with a resident requiring RR and ensure the individual receives a Level II screening that can be used in care planning. CMS will not consider the NF or the state out of compliance or withhold FFP if documentation shows that due to the evacuation from the declared public health emergency, a transferred resident lacked a valid Level II Determination that NF is appropriate, and RR is initiated not later than the initial resident assessment and MDS process, and the evaluation/determination is performed as soon thereafter as resources are available to do so.
M-15	Question: What will happen if a resident transferred from another state, with MI/MR, is considered appropriate for Medicaid NF placement in the state of origin, but documentation or examination shows the individual is not appropriate according to the PASRR criteria in the receiving state? Answer: The decision is up to the receiving State and the NF's prerogative to admit only residents whose needs it can meet. CMS suggests admitting under emergency Categorical Determination, while seeking appropriate alternative placement. But if the well-being of the transferred resident and/or other residents are compromised, the transferred resident should be immediately placed in another facility per the standards of the receiving State. CMS will not consider the NF or the State out of compliance or withhold FFP if documentation shows that due to the evacuation, an individual is admitted to a NF under the sending state's PASRR Determination, and the receiving state's emergency Categorical Determination for a period no longer than the period normally specified by the state for this category.
M-16	Question: What will happen if the evacuating State defines Specialized Services as services provided in the Medicaid NF to augment NF services, while the receiving state defines Specialized Services as hospitalization or other placement not in a NF? Answer: If this circumstance exists, contact your CMS Regional Office for guidance.
M-17	Question: Skilled nursing facility residents in the public health emergency area may be evacuated to other nursing homes without their medical history. The national Minimum Data Set (MDS) may be the primary source of medical record information for many of these residents. What can nursing homes that accept residents do to obtain information available on the residents' MDS record to assure appropriate care of those residents? In some cases the States affected by the disaster are unable to provide this information. Answer: CMS will compile a list of all certified nursing home providers that are reported as being evacuated, and will compile a file of critical clinical information obtained from the MDS records of the residents in those nursing homes in an Excel spreadsheet. Any nursing home provider that has received evacuees may request access to this file(s). To receive this information, the receiving nursing home provider should contact the CMS contractor Iowa Foundation for Medical Care's (IFMC) Help Desk at 1-888-477-7876. When the request is received, IFMC will place the file in the receiving nursing home provider's shared MDS folder. The report will stay in the receiving nursing home provider's file for about 30 days.
M-18	Question: How will nursing home residents be tracked so they can get in touch with their families, especially residents with Alzheimer's Disease or other forms of dementia who may not be able to identify themselves or provide much other information? Answer: CMS recommends that State Agencies collaborate with health care facilities and their public and private partners to develop a method for tracking patients and residents in the event of a public health emergency.
M-19	Question: Several of our nursing home residents have been evacuated to other facilities, and are to have their scheduled physician visit, but the residents' physician is unable to travel to the town where the residents are now located. Can another professional, such as a nurse practitioner, clinical nurse specialist, or physician assistant, be utilized to make those visits during the public health emergency, or must they be seen by a physician?

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	Response: During a public health emergency, CMS would permit any required NF or SNF physician task (including tasks which the regulations specify must be performed personally by the physician) to be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. However, State regulations may differ, and the 1135 waiver may not supersede State law.
N	**Staffing**
N-1	Question: I would like to volunteer my medical services, but do not have a license to practice in the State of North Dakota and Minnesota, which is affected by the declared public health emergency. Can I still treat patients in this State? Answer: Check with your State Agency and the appropriate health care professional board. Each State should be making plans to address potential staffing shortages and licensing procedures, such as establishing reciprocity with other states and recruiting volunteers during nonemergency and/or emergency periods. In addition, the U.S. Department of Health and Human Services requires every State that receives Hospital and Healthcare Facilities Partnership Preparedness Program grant funds to develop an Emergency System for Advance Registration of Volunteer Health Professions (ESAR-VHP) system that allows advance registration and credentialing of clinicians and health volunteers to effectively respond to surge capacity needs. The State ESAR-VHP System will: • Register health professional volunteers • Apply emergency credentialing standards to registered volunteers • Allow verification of the identity, credentials, and qualifications of registered volunteers during an emergency By registering in ESAR-VHP, the volunteer agrees to provide health services during an emergency and authorizes the State to collect the necessary information to determine the individual's credential status and emergency credentialing level.
N-2	Question: Nurse aides may relocate from a State in a public health emergency area, into another state, as some corporate nursing homes transfer residents and staff to sister facilities in other states during an emergency. Some nursing homes in the affected States may be unable to conduct criminal background checks, check references, or search the status of the State's Nurse Aide Registry. What should these facilities do to ensure that they do not employ nurse aides with a conviction and/or substantiated finding of abuse, neglect or misappropriation of resident property? Answer: During the declared public health emergency, nursing homes must do the best they can to ensure that only nurse aides in good standing who have relocated from an affected area, are hired to work in the nursing home. At a minimum, CMS expects that when a nursing home employs nurse aides relocating from an affected State, the nursing home will search any nurse aide registry that it believes might contain information on the nurse aide. The Office of Inspector General (OIG) Exclusion List is also a useful tool for nursing homes and other health providers to obtain information about nurse aides and other health care workers with relevant convictions, such as offenses of abuse and neglect. The OIG Exclusion List may be located at: http://oig.hhs.gov/fraud/exclusions/listofexcluded.html (Federal regulations currently do not require that skilled nursing facilities conduct a criminal background check before hiring a nurse aide; the criminal background check may be a state requirement.)
N-3	Question: Additional nurse aides may be needed by skilled nursing facilities (SNFs) that have admitted residents displaced by a disaster. May those SNFs use persons who are currently not included on the State's nurse aide registry to help with duties normally performed by nurse aides?

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	Answer: Under current law, skilled nursing facilities may employ individuals who are enrolled in an approved nurse aide training program, who have demonstrated proficiency, but have not yet passed the competency evaluation program. These persons must be under the supervision of a registered nurse. There is a 4-month period that facilities may employ persons enrolled in a nurse aide training program, but whose names are not yet included on the state nurse aide registry. SNFs must employ individuals who are competent to function as nurse aides to provide direct care to residents, as determined by regulation. If a SNF wishes to use volunteers to provide services, they are free to do so. However, volunteers are not employees of the facility and generally will be limited in the types of duties they can perform. For more information about the declared public health emergency volunteer efforts, please see the following Website: https://volunteer.ccrf.hhs.gov/
N-4	Question: We have had several questions related to licensure verification of health professional including physicians, nurses, and social workers. What should a prospective employer do if he/she cannot verify licensure with the appropriate professional board during a declared public health emergency? Answer: We would expect providers to exercise due diligence, access whatever information is available through alternate resources, and ensure that the individual properly attests to their qualifications. The employer may contact past employers that may have verified the license, request verification, and document the efforts. Also, the employer may obtain a signed affidavit from the prospective employee attesting that he or she is licensed. The affidavit should be maintained while awaiting the professional board to resume operations.
N-5	Question: Skilled nursing facilities in the declared public health emergency areas may be having problems with delivering medication to residents. Some states will only allow a nurse to administer medications. Can nurse aides administer medication in this emergency? Are there any Federal statutes or regulations that would affect these issues, or are they only affected by state laws and regulations? Answer: With regard to the administration of medications by anyone other than a nurse in a declared public health emergency area, SNFs would need to seek guidance from the State, as this is an issue of State law.
O	**Monitoring & Enforcement Activities**
O-1	Question: Will the North Dakota or Minnesota State Survey Agency change their activities during a declared public health emergency? What is the potential impact to survey activities? Answer: Based on a variety of factors, including the State Survey Agency's (SA) operational status, scope of the emergency, and impact on normal operations of providers, SAs may, at CMS Regional Office or Central Office direction, modify or suspend certain survey activities. Each pending action will be reviewed on a case-by-case basis to determine if there are activities that may need to be completed by the CMS Regional Office during the emergency period.
O-2	Question: What happens when a skilled nursing facility (SNF) or nursing facility (NF) (either an evacuated facility or one that has accepted evacuees) is on an enforcement track and its operations have been disturbed by a declared public health emergency? For example, a denial of payment for new admissions sanction may be in effect for the "accepting" or receiving facility. Answer: For a facility that is located in an emergency area, enforcement actions such as denial of payments for new admissions (DPNAs) and termination actions may be deferred during the effective period of the 1135(b) waiver. Each pending enforcement action will be reviewed on a case-by-case basis. For facilities accepting evacuated residents, DPNA deferment will be based on a recommendation by the State Survey Agency and a review of vacancies in other facilities in the area. Further, deferral of DPNA for accepting facilities will only apply to new admissions that are evacuees from the affected states.

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O-3	Question: How should the collection and accrual of civil money penalties imposed by CMS be handled for affected facilities? Answer: State Survey Agencies can make recommendations regarding this issue to the Regional Office (RO). ROs have discretion in this regard after considering the specifics of any given situation. Facilities may be facing different challenges and CMS will take those differences into account, such as the following: a. For facilities directly impacted by the emergency, generally, civil money penalties (CMPs) will not be collected during the emergency period, and accrual of penalty amounts will temporarily cease, during the effective period of the section 1135(b) waiver. b. For all facilities that have admitted evacuees where CMPs have also been imposed, the ROs will handle CMP issues on a case-by-case basis. c. For other facilities that may be affected by the inability of the SAs to conduct revisit surveys which affects the accrual of CMPs, the ROs should be contacted for a case-by-case determination.
O-4	Question: Will CMS consider suspending the collection of a CMP for a skilled nursing facility in a declared public health emergency area while they care for additional evacuees they have taken into their facility? Answer: Based on the 1135(b) waiver, CMS will generally suspend collection of a CMP for skilled nursing facilities (SNFs) located in the emergency area that are providing care for evacuees. The suspension will remain in effect during the time period of the 1135(b) waiver. Subsequently, CMS will request a financial impact statement from the specific facilities where CMPs are due and payable, and will conduct a case-by-case review to determine if any adjustments should be made. Suspension of a CMP collection for any other skilled nursing facility admitting evacuees will be handled on a case-by-case basis.
O-5	Question: Is a plan of correction still required from affected skilled nursing facilities (SNFs) that would otherwise have needed to submit one? Answer: The State Survey Agency and the CMS Regional Office will address this issue on a case-by-case basis, since the answer depends on the extent to which the provider is affected. For seriously affected SNFs in the emergency area, a plan of correction will generally be deferred during the effective period of the section 1135(b) waiver.
O-6	Question: If a provider who has been adversely impacted by a declared public health emergency is unable to restart full operations, can they maintain their existing Medicare or Medicaid provider agreement while the facility is closed? Can a provider relocate, and what are the procedures for program certification if relocation is necessary? Answer: Each Medicare or Medicaid certified provider in the declared emergency area(s) should contact their State Survey Agency (SA) regarding their status and future plans. CMS recognizes that there are times when a public health emergency may result in consequences beyond the provider's control. Therefore, some providers may never be able to reopen at their original location and others may reopen at their original location after some period of time. Some providers may not be able to reopen unless they relocate to a new site. Participation as a Medicare and/or Medicaid certified provider is based on the ability of the provider to demonstrate they can furnish services in a manner that protects the health and safety of beneficiaries according to the specific regulations for each provider type. However, CMS will exercise discretion and flexibility on a case-by-case basis when determining to deactivate a provider's Medicare or Medicaid provider agreement and number, when the cessation of business is due to a declared public health emergency. If the provider plans to reopen in a new location, CMS will need to determine if this will be a

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	relocation of the current provider under its existing Medicare certification or a cessation of business at the original location and subsequent establishment of a new business at another location, which would require a new certification. For a Critical Access Hospital (CAH) with a necessary provider designation that relocates, the rules at 42 CFR 485.610(d) govern the determination of whether the CAH can continue to meet the necessary regulatory requirements and still retain CAH status. With the exception of CAHS with a necessary provider designation, a certified provider that plans to reopen a new location and wishes to retain its current provider agreement must demonstrate to the RO that it is functioning as essentially the same provider serving the same community. CMS will consider each request for relocation on a case-by-case basis and will typically use the following type of criteria: • The provider remains in the same State and complies with the same State licensure requirements. • The provider remains the same type of Medicare provider after relocation. • The provider maintains at least 75 percent of the same medical staff, nursing staff and other employees, and contracted personnel (contracted personnel who regularly work 20 or more hours a week at the provider). • The provider retains the same governing body or person(s) legally responsible for the provider after the relocation. • The provider maintains essentially the same Medical Staff bylaws, policies and procedures, as applicable. • At least 75 percent of the services offered by the provider during the last year at the original location continue to be offered at the new location. • The distance the provider moves from the original site. • The provider continues to serve at least 75 percent of the original community at its new location. • The provider complies with all Federal requirements, including CMS requirements and regulations at the new location. • The provider maintains essentially the same policies and procedures such as nursing, infection control, pharmacy, patient care, etc. • Provider types for which specific location criteria apply must continue to satisfy those criteria in the new location. For example, for CAHs that are not designated as necessary providers, retention of CAH designation requires that the CAH in its new location satisfy the criteria at 42 CFR 485.610 (b) and (c). CMS may use any other necessary information to determine if a provider continues to be essentially the same provider, under the same provider agreement, after relocation.
P	**Emergency Preparedness Planning Resources**
Q-1	Question: Where can I get additional resource information about emergency preparedness? Answer: A variety of Federal emergency preparedness resources are listed below: • HHS Disasters & Emergencies: Requests for Information on Aspects of Emergency Preparedness, Response, and Recovery: http://www.hhs.gov/emergency/rfi/ • U.S. Government - Avian and Pandemic Flu Website (managed by HHS): http://pandemicflu.gov/ • Centers for Disease Control & Prevention: Healthcare Preparation & Planning: http://www.bt.cdc.gov/planning/#healthcare • Centers for Disease Control & Prevention: Emergency Preparedness & Response: http://www.bt.cdc.gov/ • Centers for Disease Control & Prevention: Emergency Preparedness—Training & Education: http://www.bt.cdc.gov/training/ • Agency for Healthcare Research & Quality (AHRQ): Resources for Pandemic Flu and Other Public

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	Health Emergencies: http://www.ahrq.gov/path/biotrspn.htm • Department of Homeland Security: http://www.ready.gov/ • Department of Homeland Security Interagency Coordinating Council on Emergency Preparedness and Individuals with Disabilities: http://www.disabilitypreparedness.gov/ • Federal Emergency Management Administration (FEMA): Emergency Preparedness: http://www.fema.gov/plan/index.shtm • FEMA: Continuity of Operations (COOP) Programs: http://www.fema.gov/government/coop/index.shtm • DHS Homeland Security Exercise and Evaluation Program (HSEEP): https://hseep.dhs.gov/pages/1001_HSEEP7.aspx • U.S. Fire Administration (USFA): http://www.usfa.dhs.gov/index.shtm • National Disaster Medical System (NDMS): http://ndms.dhhs.gov/ • National Fire Protection Association: http://www.nfpa.org/index.asp?cookie%5Ftest=1 • Veterans Affairs Emergency Management Strategic Healthcare Group: http://www1.va.gov/emshg/ • National Renal Administrators Association, Kidney Community Emergency Response Coalition: http://www.nraa.org/Disaster_Prep.php • U.S. Department of Labor, Occupational Safety & Health Administration, Emergency Preparedness & Response: http://www.osha.gov/SLTC/emergencypreparedness/osha_support.html • Centers for Medicare & Medicaid (CMS) Survey and Certification Emergency Preparedness Website: http://www.cms.hhs.gov/SurveyCertEmergPrep/ • Rx Response Preparedness Plan – Getting Medicines to Patients During a Crisis: http://www.rxresponse.com/web/guest/home2 • Joint Commission – Standing Together: An Emergency Planning Guide for America's Communities: http://www.jointcommission.org/NewsRoom/PressKits/PlanningGuide/ • Florida Health Care Association: Emergency Preparedness for Nursing Homes http://www.fhca.org/emerprep/index.php • National Association for Home Care and Hospice: Emergency Preparedness Packet for Home Health Agencies: http://www.nahc.org/regulatory/home.html **Hemodialysis Water Treatment References:** • Northwest Renal Network document Monitoring Your Dialysis Water Treatment System: http://www.nwrenalnetwork.org/watermanual.pdf • Association for the Advancement of Medical Instrumentation, Recommended Practices for Dialysis Water Treatment Systems (RD 52 and RD 62) • http://aami.org/publications/standards/dialysis.html **Other Resources:** • Guidelines for Dialysis Care Providers on Boil Water Advisories: http://www.cdc.gov/ncidod/hip/dialysis/boilwater_advisory.htm • Water Related Emergencies: http://www.bt.cdc.gov/disasters/watersystemrepair.asp • Tips about Medical Devices and Hurricane Disasters: http://www.fda.gov/cdrh/emergency/hurricane.html • Medical Devices that Have Been Exposed to Heat and Humidity: http://www.fda.gov/cdrh/emergency/heathumidity.html • Medical Devices Requiring Refrigeration http://www.fda.gov/cdrh/emergency/refrigeration.html • Fact Sheet: Flood Cleanup - Avoiding Indoor Air Quality Problems: http://www.epa.gov/iaq/pubs/flood.html • NIOSH Declared public health emergency Response: Storm and Flood Cleanup: http://www.cdc.gov/niosh/topics/flood/ • OSHA Fact Sheet: http://www.osha.gov/OshDoc/data_Hurricane_Facts/Bulletin3.pdf

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	• American Institute of Architects: Procedures for Cleaning Out a House or Building Following a Flood: http://www.aia.org/liv_disaster_floodproc • American Red Cross: http://www.redcross.org/ • Salvation Army: http://www.salvationarmyusa.org/usn/www_usn.nsf