3. Emergency Generators and Standby Power Systems

Section 9.1.3 of the 2000 LSC requires emergency generators and standby power systems to be installed, tested, and maintained in accordance with 1999 NFPA 110, *Standard for Emergency and Standby Power Systems*. Section 6-4.2.2 of the 1999 NFPA 110 requires diesel-powered generators that do not meet the monthly testing requirements under section 6-4.2 to be run annually with various loads for a total of two (2) continuous hours. Shorter generator run times will reduce undue cost burden and negative environmental impacts. In the 2010 NFPA 110, the NFPA began to allow for total test duration of one hour and 30 minutes (1-1/2 continuous hours). Accordingly, we are permitting a waiver to allow for a reduction in the annual diesel-powered generator exercising requirement from two (2) continuous hours to one hour and 30 minutes (1-1/2 continuous hours), but only if the provider/supplier is in compliance with all other applicable 1999 NFPA 110 operational inspection and testing provisions, as well as with section 8.4.2.3 of the 2010 NFPA 110.

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March 27, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Via Electronic Submission: http://www.regulations.gov

Re: File Code CMS-3178-P Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers (78 Fed. Reg. 79082, December 27, 2013)

The American Health Care Association (AHCA) represents more than 12,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and development disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

General Comments

AHCA appreciates the opportunity to provide comments on the proposed rule ***Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers***. These comments are submitted on behalf of AHCA member nursing centers and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).

1) The regulation for long term care providers (§483.73) and the supporting materials are detailed yet in most instances allow for flexibility in operationalizing these requirements. We appreciate and applaud that flexibility – it is essential to appropriate implementation which will vary based on the patients/residents and location of the provider.

2) AHCA requests the Centers for Medicare & Medicaid Services (CMS) to provide burden hours and cost estimate for all 16,100 nursing centers (number of nursing centers according to CDC, May 30, 2013) to comply with the information collection requirements (ICRs) contained in §483.73 Requirements for States and Long Term Care Facilities, Emergency Preparedness. CMS provides burden hours and cost estimate to comply with ICRs for all provider types affected by these regulations **except** long term care. The reason identified for not including a burden hour and cost estimate for long term care is a waiver of the Paperwork Reduction Act requirements for the regulations that implemented the OBRA '87 requirements. CMS states this waiver is still valid. AHCA rejects this assertion. OBRA '87 occurred nearly 30 years ago. The provisions in OBRA '87 allowing for the waiver to which CMS refers are significantly expanded by this proposed regulation.
3) We believe the burden hours and cost estimates for ICFs/IID do not adequately reflect the costs that will be incurred by ICFs/IID for the staff time required to address the new requirements. For example, no consideration is given for overtime hours that staff might be required to work to care for residents during an emergency. As well, the proposed rule states an ICF/IID with only four patients is likely to have a sufficient number of its own vehicles available during an emergency to evacuate residents and staff, eliminating the need to contract with an outside entity to provide transportation during an emergency situation or disaster. In practice, most four bed ICFs/IID with common ownership, share vehicles depending on the work and other needs of the clients. The financial ability of an independent four bed ICF/IID to procure and maintain a vehicle is extremely unlikely. We request CMS to revise this analysis for ICFs/IID and develop one that realistically reflects the projected burden and costs.
4) Various tools and resources are identified in the proposed rule, for example, Emergency System for Advance Registration of Volunteer Health Professionals; Joint Patient Assessment and Tracking System, and others. CMS must ensure that all Federal tools and resources identified in this proposed rule are easily accessible and relevant to long-term care providers.

Comments Specific to Long Term Care

Responses to questions posed by CMS

We are seeking public comments on when these CoPs should be implemented.

These requirements for participation for long term care should be phased in with full adoption/implementation required four years following the implementation date of the final rule. The basis for the emergency preparedness rules for the identified provider groups are the requirements for hospitals. We strongly recommend that implementation begin with the hospitals, enabling CMS to test the implementation process and determine which approaches work best.

Some states require providers to have a more advanced and comprehensive approach to emergency preparedness, although this is certainly not the case in all states. Nor has it been the case in the expectations of the CMS. As such, it is important to allow adequate time for long term care providers to fully understand and then implement the provisions included in this proposed rule. This is particularly important in certain areas:

Cooperative Efforts – Long term care providers are a very new component of cooperative planning efforts for emergency and disaster situations. And in some instances they have specifically NOT been included in these efforts. It will take a period of time to develop relationships and understanding of the needs and the offerings of long term care centers with the different coalitions across the country. AHCA recommends a 12 - 18 month phase in of these requirements for long-term care providers, following the one-year phase in for hospitals.

Policies and Procedures - It is important that CMS consider that some of the emergency systems in place have not been available to long term care previously (e.g., System for Advance Registration of Volunteer Health Professionals) and there must be adequate time for both ESAR-VHP and long term care to become familiar with one another. In addition, there must be sufficient education on how to use these systems and to ensure that Long term care providers have access to these systems. AHCA recommends an 18 – 24 month phase in for use of all emergency systems by long-term care providers, coinciding with the one-year phase in for hospitals.

Training and Testing – A phased-in approach will be essential to ensuring that these provisions are implemented appropriately. We understand from members in some of our states that already have similar requirements that implementation of some of the training and testing requirements took longer than two years. AHCA recommends a 24 – 30 month phase-in for the training and testing requirement, coinciding with the one-year phase in for hospitals.

We request information and comments on the following issues:

• **Targeted approaches to emergency preparedness**—covering one or a subset of provider classes to learn from implementation prior to extending the rule to all groups.

The basis for the emergency preparedness rules for the identified provider groups are the requirements for hospitals. We strongly recommend that implementation begin with the hospitals, enabling CMS to test the implementation process and determine which approaches work best.

• **A phase in approach—implementing the requirements over a longer time horizon, or differential time horizons for the respective provider classes. We**

are proposing to implement all of the requirements 1 year after the final rule is published.

We believe that an expectation of all requirements to be implemented one year after the final rule is published is totally unrealistic. Immediately prior to this section, we provide specific comments and recommendations on phasing in the requirements.

• **Variations of the primary requirements**—for example, we have proposed requiring two annual training exercises—it would be instructive to receive public feedback on whether both should be required annually, semiannually, or if training should be an annual or semiannual requirement.

AHCA recommends training for new employees and annual training for the entire long term care center staff.

We believe that the currently proposed requirements encompass consideration of individual residents' power needs and should be included in LTC facilities' risk assessments and emergency plans. However, we are also soliciting comments on whether there should be a specific requirement for "residents' power needs" in the LTC requirements.

ACHA agrees that the residents' power needs should be included in the emergency plans of long term care centers. During an emergency or a disaster, the residents' power needs must be focused on the power needs for ensuring life sustaining equipment and not be expanded to include those things requiring power that are not essentials (e.g., an electric wheelchair is not life-sustaining if the resident is able to be in a wheelchair that can be pushed by volunteers or staff; a lap-top computer; or a personal television).

We recommend the regulation clearly state that power needs will be managed by the provider based on priority and will address critical equipment and systems – both for individual needs as well as the needs of the entire facility.

Comments on specific provisions of the proposed rule
Emergency Preparedness:

Proposed §483.73 (a) (4) requires a process for ensuring cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation. While this cooperation and collaboration is essential and optimal, there is a great deal out of the control of the nursing center to enable the center to "ensure" this happens. AHCA recommends replacing the word "ensure" with the words "strive for". This provides a more realistic expectation.

Proposed §483.73 (b) (5) requires a system of medical documentation that preserves resident information, protects confidentiality of resident information, and

ensures records are secure and readily available. Again, AHCA recommends replacing the word "ensure" with "strives to make such records secure...". Proposed §483.73(b)(1) addresses policies and procedures related to the provision of subsistence needs for staff and residents. AHCA appreciates the flexibility proposed in the preamble that allows the individual nursing center to determine the subsistence supplies needed based on the location and individual characteristics of the center. AHCA recommends that CMS provide clarification in final regulation clarifying that providers have flexibility to determine the subsistence supplies based on the needs of the staff and residents, and the emergency preparedness plan developed by each long-term care provider.

Proposed §483.73 (b)(1)(i) requires that long-term care providers include food, water, and medical supplies in their plans for subsistence needs. We believe that the term "medical supplies" includes medications. AHCA recommends CMS add the word "medications" (or "pharmaceuticals") to this requirement in the final regulation.

Proposed §483.73(b)(1)(ii) (A) addresses alternate sources of energy to maintain temperatures to protect resident health and safety. AHCA agrees that temperatures to protect health and safety for patients is very important and based on the flexible approach that CMS has used in this rule, we believe that it would be appropriate to identify particular sections of the nursing center that are used as either heating or cooling rooms. This approach is crucial for long-term care providers who must always take into consideration overall costs associated with the care they provide. AHCA recommends CMS clarify this flexibility in the final regulation.

Proposed §483.73 (b) (2) addresses the need for a long term care provider to have a system to track the location of staff and residents in the provider's care both during and after the emergency. We believe that it is important to have a communication system in place to contact staff through email, telephone, twitter, or some other method as determined by the nursing center in order to deliver needed information so staff is aware of the status of the center, any staffing needs, etc. AHCA recommends that CMS state the requirement regarding tracking location applies to staff that evacuate with and are in an alternate location with and caring for residents. Further, communication with other staff should be to have an effective communication system in place to reach staff who are essential and to communicate with all staff through a means identified in the provider's emergency plan.

Proposed §483.73 (b) (5) addresses the need for a system of medical documentation that preserves resident information, protects confidentiality of resident information, and ensures records are secure and readily available. AHCA recommends the final rule include the following documentation: resident demographics, allergies, diagnosis, list of medications and contact information (commonly referred to as the "face sheet").

Proposed §483.73 (b) (6) addresses the use of volunteers in an emergency or other emergency staffing strategies. As mentioned earlier, CMS must ensure that all Federal tools and resources identified in this proposed rule are easily accessible and relevant to long-term care providers, including the Emergency System for Advance Registration of Volunteer Health Professionals.

Proposed §483.73 (d)(2)(iii) addresses a paper-based, table top exercise with a group discussion that is to be led by a facilitator. AHCA recommends including language in the final rule clarifying that facility staff can be the facilitator that leads the training as described.

Proposed §483.73 (e)(2)(i) requires the provider to at least once every 12 months test each emergency generator for a minimum of 4 continuous hours. Further, the generator test load must be 1—percent of the load the center anticipates requiring during an emergency.

CMS provides no data or justification for the need for this increased testing requirement. Furthermore, the increased testing will result in additional and unnecessary wear and tear on the equipment resulting in a reduction of the useful life of the generator: a cost that CMS has not considered in its fiscal analysis.

NFPA codes and standards are developed using the approved procedures of the American National Standards Institute (ANSI). Codes, standards and similar regulatory documents developed under the ANSI procedures satisfy the provisions of OMB Circular A119 and the National Technology Transfer and Advancement Act (NTTAA-Public Law 104-113). Among other things, the NTTAA works to increase "... utilization of consensus technical standards by federal agencies." As written, the proposed rule will result in CMS developing overlapping-and conflicting criteria when compared to the expert private sector documents that govern these topics.

AHCA believes that NFPA requirements for inspection, testing, and maintenance of generators are appropriate and should not be increased without data and evidence to support this change. AHCA recommends CMS defer to NFPA codes and standards related to installation and maintenance and testing of generators.

Comments Specific to Intermediate Care Facilities for Individuals with Intellectual Disabilities

There seems to be a simplistic and inaccurate assumption that *"small facilities might find it easier than large facilities to develop an emergency preparedness plan and emergency preparedness policies and procedures. As an example, an ICF/IID with only four patients is likely to have a sufficient number of its own vehicles available during an emergency to evacuate residents and staff, eliminating the need to contract with an outside entity to provide transportation during an emergency situation or disaster."* This assumes that every four bed ICF/IID has a vehicle dedicated to that

facility, whereas in practice, most four bed ICFs/IID with common ownership, share vehicles depending on the work and other needs of the clients. The financial ability of an independent four bed ICF/IID to procure and maintain a vehicle is extremely unlikely. Further, an independent four bed ICF/IID would not, necessarily, *"find it easier to develop an emergency preparedness plan."* This assumption ignores the economies of scale that allow a larger facility or group of facilities to do risk analyses, policy development, staff training, etc., as required in this proposed rule. We are concerned that 483.475(a)(3) does not take into account the fact that ICFs/IID are already in a position where they *"address the special needs of its client population"* through normal person-centered care planning. Emergency planning is already based on the "special needs" of the ICF/IID client population.
Finally, we believe that there will be a significant cost to ICFs/IID to comply with these rules as currently proposed, both in the initial compliance phase (risk analyses, development of policies and procedures, development of communications plans) and in the ongoing compliance (training and testing, community drills). Without additional funding, in particular for smaller ICFs/IID, these proposals could draw funds away from important and necessary staffing, client care and/or facility maintenance.

Thank you for the opportunity to provide comments on this proposed rule.

Sincerely,

Margaret Connorton

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