March 28, 2014

Marilyn B. Tavenner
Administrator
Center for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Re: CMS Medicare and Medicaid Programs: Emergency Preparedness Requirements for Participating Providers; Proposed Rule, December 27, 2013

Dear Ms. Tavenner:

The Kansas Hospital Association appreciates the opportunity to provide comments on the proposed Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers on behalf of our members. As an organization we are deeply involved in the role Kansas hospitals play in emergency preparedness. We believe hospitals should be prepared for disasters which could reasonably occur in our state and the region.

In working closely with Kansas hospitals, we see the commitment our members are making to emergency preparedness and believe they are well prepared to respond to disaster situations. During the last two years Kansas hospitals have been leading the expansion of regional health care coalitions – bringing in public health, emergency management, emergency medical services, behavioral health, long term care as well as other health and medical service partners working together in emergency preparedness. The Kansas Hospital Association feels this level of preparedness comes from hospitals and their partners’ participation in the National Hospital Preparedness Program.

We strongly encourage alignment between the National Hospital Preparedness Program grant guidance and the requirements contained in the emergency preparedness conditions of participation to ensure efforts in the hospital preparedness program are directly related to compliance with the conditions of participation. During a time of unprecedented financial pressures on hospitals, the resources simply do not exist to comply with two disparate emergency preparedness program requirements.

The Kansas Hospital Association respectfully requests the Centers for Medicare & Medicaid Services also consider the following comments before developing the final rule related to emergency preparedness for participating providers and suppliers.

- **All-Hazards Approach.** CMS indicates a facility should utilize an all-hazards approach to assessing risk. We would appreciate clarification on whether events which have been assessed as zero (a hurricane in Kansas) would need to be addressed in the emergency plan. We recommend, in the interest of best use of limited resources, to identify and focus on the top internal and external threats that have the highest probability and highest risk of impacting a community and region.

- **Patient Tracking Systems.** Patient tracking systems have proven over time to be difficult to implement and expensive to maintain. The requirement to provide a method to track both patients and staff during and after an event will present
challenges in today’s environment and when working across state lines. We suggest CMS recommend the federal government (DHS, DOD, HHS) develop a national system which could be expanded to the states for implementation. A national system would create a consistent approach to patient tracking and alleviate issues when patients cross state lines for treatment or are transferred to tertiary facilities in larger cities. In Kansas this happens quite frequently where Kansas City, a major metropolitan area actually encompasses a large area in two states, or when critical access hospital patients require a higher level of care.

- **Subsistence Needs.** The proposed requirement that hospitals develop the provision for subsistence needs for patients, staff, volunteers, and visitors that may need to be transported to an alternate care site for the duration of a disaster is unrealistic to meet and maintain. Kansas hospitals have neither the space, staff nor money to maintain a supply expressly for the purpose of supplying subsistence needs during a disaster. The question would also arise regarding how and who allocates those supplies provided by a hospital in the shelter or care site. We believe this a role more suited for emergency management or an organization such as the Red Cross.

- **Communications Plan.** The proposed emergency preparedness requirements also state hospitals must develop a communications plan which complies with both federal and state law. We would appreciate CMS’ clarification on which federal law(s) are referenced in the proposed rule to ensure providers are aware of, and comply with, all federal regulations.

- **Emergency Generators.** CMS has proposed that facilities test their emergency generators and stand-by power systems at least annually for a minimum of 4 continuous hours at 100% load the hospital anticipates it will require during an emergency. We strongly encourage CMS review this recommendation. This recommendation far exceeds the current recommendation by the Joint Commission, NFPA, as well as manufacturers’ recommendations. The proposed recommendation would certainly result in higher fuel and equipment maintenance costs, shortened life expectancy for an emergency generator and contribute to increased noise and air pollution. We recommend that CMS follow existing NFPA and manufacturer recommendations.

The proposed conditions of participation, especially without the interpretative guidelines, require further clarification and are open to a great deal of interpretation regarding what is the intent for compliance. We would recommend, especially for our rural facilities in Kansas not surveyed by the Joint Commission, the initial survey be considered a technical advisory visit without citations for deficiencies. This collaborative approach would ensure both the hospitals and the surveyors have a common understanding of the conditions of participation and what is required for compliance.

Thank you for your time and consideration of our comments. We look forward to working with all parties involved to ensure our hospitals and communities in Kansas are prepared for any emergencies.

Sincerely,

Tom Bell
President and CEO