CALIFORNIA HOSPITAL ASSOCIATION

June 2018

Preparing Hospitals for Disasters

A Financial Perspective

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by Ron Yaw
California Hospital Association

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California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814
www.calhospital.org

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I. INTRODUCTION

Not if, but when … are you prepared for the next event?

When disasters occur, treating patients is a hospital's first priority. However, health care providers are also a critical element within the disaster medical response system, and must work collaboratively with local government, other health care providers and other agencies to plan, prepare for and respond to victims' needs during natural or man-made disasters, bioterrorism or other public health emergencies.

No one is exempt from disasters. Health care providers must be proactive — preparation is key. It is vital that providers review existing policies and procedures to ensure financial stability and sustainability of critical operations during the disaster itself and, more importantly, the recovery period that follows. Hospitals should try to strengthen themselves by engaging in robust planning, improving their liquidity positions and mitigating the impact of the disaster on their revenue cycles.

To help health care providers plan for and respond to a disaster's financial impacts, CHA has prepared this guide outlining considerations for developing a financial preparedness and response plan. Hospitals should perform a thorough projection and evaluation of the financial challenges any disaster may cause their organization. Among the many elements providers should consider are:

- How to accommodate patients who lack proof of insurance or identification, or whose coverage is out of network
- What backup billing and collections services should be developed prior to a disaster to speed recovery

Also included in this guide are recent historical narratives, as well as accompanying waivers and a one-time declaration of an increase in reimbursement. However, providers should note that such flexibility is dependent on the nature and severity of the disaster, and is not guaranteed in every situation.

For more resources, providers are encouraged to visit CHA's dedicated emergency preparedness website, www.calhospitalprepare.org.

Finance administration resources that can aid in disaster response are also available from the Hospital Incident Command System (HICS), the comprehensive incident management system widely used by hospitals in both non-emergent and emergent situations. CHA encourages providers to communicate with their emergency preparedness coordinators for guidance on finance administration and specific HICS reporting forms.

II. BUSINESS STABILITY AND FINANCIAL HEALTH PLANNING CHECKLIST

The first step hospitals should take in planning for a disaster is to assess their current infrastructure. The following checklist will help providers build, implement and test their plans. Then, health care providers should evaluate areas of improvement and develop a detailed business continuity plan.

- ❑ Develop a comprehensive business continuity plan that includes back-up or alternate plans.
    - Make sure the continuity plan meshes with the organization's disaster plan, as well as those of neighboring health care providers, for coverage of patients in disaster situations.
    - Assign primary and alternate responsibilities for each function.
    - Implement a schedule for updating and re-testing plans.
- ❑ Arrange for appropriate security for the facility and off-site business recovery locations, including after-hours, if needed.
- ❑ Have plans for procuring office space and equipment should current offices become uninhabitable.
    - Review plans with the applicable vendors or managers to ensure a quick relocation.
    - Plan and test set-up of alternative space and equipment with affected business staff.
    - Include a communication action plan to quickly alert business partners to alternative arrangements.
- ❑ Maintain up-to-date important contact information, including:
    - Staff emergency contacts
    - Insurance policy brokers
    - Bonds rating agencies, banks and other investors
    - Medicare contractors and regional offices
      ROSFOSO@cms.hhs.gov – California
    - Medicaid contractors and state offices
    - Other major payers and employers, if utilizing direct service contracting
    - Primary and back-up suppliers and vendors
    - Primary and back-up equipment maintenance contractors

- ❑ Develop and maintain a materials management emergency plan for needed facility supplies. Be sure to:
  - Arrange for obtaining necessary supplies from vendors, with back-up vendors from different geographic locations.
  - Regularly review these arrangements with vendors and verify accurate contact information.
  - Have a process for regularly reviewing emergency supply levels.
  - Develop a quick response process for ensuring adequate inventory if there is advance notice of the impending event.
- ❑ Develop a process for the banking function to be taken over by a remote office of the bank.
  - Ensure your bank is capable and prepared to take such action. If not, develop alternative procedures.
  - Know which bank location will take over and who at that location is responsible for working with you.
  - Regularly verify contact information.
  - Test the transfer of responsibilities as much as practicable.
- ❑ Have a tested and rehearsed methodology for restoring the organization's clinical and operational files.
  - Practice the restoration process.
  - Cross-train staff so they are prepared to take over co-workers' responsibilities.
- ❑ Develop a facility and systems status report to quickly determine repair or replacement needs.
  - Create a support/repairs contact list for necessary repairs or replacement equipment.
  - Identify support services from multiple geographic areas.
  - With the facility's communications team, establish a process to update community leaders on the condition of facility itself and its systems.
- ❑ Create, and have readily available, a resource accounting record for recording resources received, where they are assigned and — if possible — who is assigned responsibility for their use.
  - As much as feasible, make the record compatible with existing facility internal control processes.

- ❑ Establish a system to back up documentation for key contracts and other documents in a secure, off-site location.
  - Establish a process for ensuring back-up documentation is up to date.
- ❑ Identify key websites and other information sources that could help in disaster recovery, and store in backup computers or information management systems.
- ❑ Review all documentation and plans on a regular basis to ensure they reflect changes in staff and responsibilities.
  - Review arrangements annually with back-up vendors.
- ❑ Develop a schedule for regularly testing each component of the business continuity plan and evaluating employee readiness.
  - Regular testing is important to ensure that new staff are prepared and to ensure that emergency procedures are fresh in the minds of all staff.
  - Consider coordinating drills or tests with vendors, key volunteers and community representatives, as appropriate, to ensure clear communication, expectations and action plans.

III. WORKFORCE CONSIDERATIONS

In the event of a disaster, all hospital staff and their families will be affected to various extents. How health care providers plan for that will determine the disruption to ongoing processes and whether operations are continuously maintained. Employers should:

- Expect that some of the staff will not show up, for a variety of reasons. Prepare to cope with the shortage, plan for direct patient care staff, and adapt in the event that some staff leave the area entirely.
- Recognize that overtime and double time expenses will increase, but may be eligible for reimbursement.
- Establish relationships — as well as standard process and procedures in the event of disasters — with neighboring hospitals and nursing home facilities, ambulance and fire-fighting services. Develop plans for resource management, evacuation and transportation.
- Understand that if patients are evacuated to neighboring facilities, your direct patient care staff resources may be required to work at the receiving facility to compensate for the additional patient load.

IV. A GUIDE TO THE DISASTER DECLARATION PROCESS

Local and state governments share responsibility for protecting their citizens from disasters and helping them to recover when a disaster strikes. In some cases, a disaster is beyond state and local government's response capabilities.

In 1988, the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. Sections 5121-5206) was enacted to support state and local government and their citizens when they are overwhelmed by disasters. This law establishes a process for requesting and obtaining a presidential disaster declaration, defines the type and scope of assistance available from the federal government and sets conditions for obtaining that assistance. The Federal Emergency Management Agency (FEMA), now part of the Emergency Preparedness and Response Directorate of the Department of Homeland Security, is tasked with coordinating the response.

A. State Response and Request for Assistance

The Governor of an affected state must respond to the emergency event and execute the state's emergency response plan before requesting a presidential declaration under the Stafford Act. The Governor must certify in writing that the magnitude of the event exceeds the state's capability to respond, and that supplemental federal assistance is necessary. In certain situations — such as those where federal assistance is necessary to save lives or prevent severe damage —the President may provide accelerated federal assistance without a specific request.

B. Presidential Declaration

A presidential declaration under the Stafford Act enables access to disaster relief assistance and funds, as appropriated by Congress, and specifies the types of assistance authorized. One source of funding is the federal Disaster Relief Fund, which has several billion dollars immediately available to address state and local governments' emergency needs. However, the use of these funds is limited to purposes specifically authorized in the Stafford Act. Congress may authorize additional funds as an event dictates.

The President may declare an emergency without first receiving a gubernatorial request if the emergency involves an area of "federal primary responsibility," in which principal responsibility for response rests with the federal government because the emergency area is under the exclusive responsibility and authority of the United States. Such declarations were made during the 2001 Pentagon terrorist attack and the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City.

A Stafford Act declaration can trigger other public health emergency response authorities. However, before the Secretary of Health and Human Services (HHS) can exercise waiver authority under Social Security Act Section 1135, a public health emergency determination under Section 319 of the Public Health Service (PHS) Act and a presidential declaration under the Stafford Act or the National Emergencies Act must be made.

C. Section 1135 of the Social Security Act – 1135 Waivers

Under Section 319 of the PHS Act, the HHS Secretary may declare a public health emergency if — after consulting with public health officials as necessary — he or she determines that a disease or disorder presents an emergency or an emergency otherwise exists, such in cases of significant infectious disease outbreaks or bioterrorist attacks.

Declaring a public health emergency allows the Secretary to take certain actions in response, and can be necessary to authorize a variety of discretionary response actions under the statutes HHS administers.

A public health emergency declaration under Section 319 of the PHS Act and a presidential declaration of an emergency or disaster under the Stafford Act are distinct and separate declarations. Unlike a presidential declaration of a major disaster or emergency under the Stafford Act, there is no requirement that a Governor or other entity make a formal request before the Secretary may declare a public health emergency. Either the President or the HHS Secretary may declare a major disaster or public health emergency absent action by the other party.

When the President declares a major disaster or emergency under the Stafford Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, Section 1135 of the Social Security Act authorizes the Secretary to waive or modify certain federal laws, including:

- Conditions of participation or other certification requirements under Medicare, Medicaid and the Children's Health Program (CHIP)
- Preapproval requirements under Medicare, Medicaid and CHIP
- State licenses for physicians and other health care professionals, for purposes of Medicare, Medicaid and CHIP reimbursement only. The state determines whether a non-federal provider is authorized to provide services in the state without state licensure.
- Emergency Medical Treatment and Labor Act (EMTALA) requirements for redirecting individuals to another location, if the transfer arises out of emergency circumstances. This waiver is effective only if actions under the waiver do not discriminate based on a patient's source of payment or ability to pay.
- Stark self-referral sanctions
- Performance deadlines and timetables
- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers

In addition to this authority, referred to as the 1135 waiver authority, Section 1812(f) of the Social Security Act authorizes the Secretary to provide for skilled-nursing facility coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program payments and does not alter the facility's "acute care nature" (that is, its orientation toward relatively short-term and intensive care).

Duration of a Section 1135 Waiver

Waivers under Section 1135 of the Social Security Act typically end with the termination of the emergency period or 60 days from the date the waiver or modification is first published, unless the Secretary extends the waiver by notice for additional periods of up to 60 days.

For public health emergencies that do not involve a pandemic disease, EMTALA and Health Insurance Portability and Accountability Act of 1996 requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. Waiver of EMTALA requirements for emergencies that involve a pandemic disease last until the pandemic-related public health emergency is terminated. The 1135 waiver authority applies only to federal requirements for licensure or conditions of participation, not state.

Trigger Points

In determining whether to invoke an 1135 waiver, the Assistant Secretary for Preparedness and Response (ASPR) — with input from relevant operating divisions — determines the need for and scope of such modifications. Information considered includes requests from Governor's offices, feedback from individual health care providers and associations, requests to regional or field offices for assistance and information obtained from the Secretary's Operation Center. The intent is to determine whether the waivers or modifications allowed under the 1135 waiver authority will assist health care providers in responding to a disaster.

While the start data of hurricanes and other disasters is certain, with a generally known duration, public health emergencies related to diseases or viruses may result in a more diffused and dispersed event. In evaluating trigger points for implementation of an 1135 waiver, it is important to recognize that a state or geographic region may have limited activity as a whole, while a particular city or community may be experiencing a severe outbreak. This geographic variation presents difficulty when quantifying trigger points.

Implementation of 1135 Waiver Authority

Once an 1135 waiver has been authorized, health care providers can submit requests to operate under that authority to the state survey agency or Centers for Medicare & Medicaid Services (CMS) regional office. These requests generally include a justification for the waiver and expected duration of the modification requested. Providers and suppliers have been asked to keep careful records of beneficiaries to whom they provide services to ensure that proper payment is made. The state survey agency and regional office review the provider's request and make appropriate decisions, usually on a case-by-case basis. Providers are expected to return to compliance with any waived requirements prior to the end of the emergency period.

Federally certified or approved providers must operate under normal rules and regulations, unless they have sought and have been granted modifications for specific requirements under the 1135 waiver authority.

Blanket Waiver Modifications

CMS has, in past disasters, implemented specific waivers or modifications under the 1135 authority on a "blanket" basis, when a determination has been made that all similarly situated providers in the emergency area needed such a waiver or modification. Examples include hospitals that have initiated their disaster plans and are operating under the EMTALA waiver, the 25-bed limit and 96-hour annual average per patient length of stay requirement for critical access hospitals and requests for increases in the number of certified beds for providers. While blanket authority for these modifications may be allowed, the provider operating under these modifications should still notify the state survey agency and CMS regional office to ensure proper payment. Similarly, most reporting requirements — such as nursing homes providing Minimum Data Set updates on residents — are suspended for all providers in the impacted areas in accordance with the waiver authority.

The decision to implement a "blanket" waiver or modification of a particular Medicare, Medicaid or CHIP requirement is based on the need and frequency of requests for specific waivers or modifications in response to the disaster or emergency. Factors considered include the scope and severity of the emergency; its expected duration; feedback from the state survey agency and state and federal emergency response officials, who often have personnel able to provide first-hand information; and supporting data gathered by state provider associations.

1135 Waiver Request Format

Though there is no specific form or format required to request a waiver, impacted providers should provide the California Department of Public Health (CDPH) with certain information, including:

- Provider name/type
- Full address (including county/city/town/state)
- CMS Certification Number (Medicare provider number)
- Contact information for follow-up questions, should the regional office need additional clarification
- A brief summary of why the waiver is needed that clearly states the issue's scope and impact. For example: Critical access hospital is sole community provider without reasonable transfer options at this point during the specified emergent event (e.g. flooding, tornado, fires, or flu outbreak). Facility needs a waiver to exceed its bed limit by X number of beds for Y days/weeks (be specific).
- The type of relief or regulatory requirement waiver sought

Providers should send this information to the San Francisco Regional Office at rosfoso@cms.hhs.gov and copy CDPH. This will ensure the waiver request does not conflict with any state requirements and that all concerns are addressed in a timely fashion.

For more information on the 1135 waiver process, visit the CMS website.

V. REIMBURSEMENT ASSISTANCE

A. Business Interruption Insurance Coverage

While all hospitals must have property insurance policies that cover physical damage to the facility, business interruption insurance is often overlooked. This particular type of insurance covers the loss of income that a hospital may suffer after a disaster, based on the net income that would have been generated. This extra policy provision applies to all types of businesses, and is designed to put a business in the same financial position it would have been in if no loss had occurred.

This type of coverage is not sold as a standalone policy, but can be added to the hospital's property insurance policy or comprehensive package policy. Since business interruption is included as part of the business' primary policy, it only pays out if the cause of the loss is covered by the overarching policy. However, in the event the disaster does not affect the physical plant directly — such as a mandatory evacuation — business interruption insurance would cover losses due to closure or the absence of patients.

The following scenarios are typically covered under a business interruption insurance policy:

- Net income: Net income that would have been earned during the closure period
- Fixed costs: Operating expenses and other costs still being incurred by the facility (e.g., lease payments)
- Temporary relocation: Extra expenses for moving to, and operating from, a temporary location
- Commission and training costs: Costs of providing training to replacement employees following the insured event
- Extra expenses: Reimbursement for reasonable expenses beyond fixed costs, like overtime and double time, that allow the business to continue operation while the property is being repaired or rebuilt
- Civil authority ingress and egress: Government-mandated closure of business premises that directly causes loss of revenue, like a forced business closure because of government-issued curfews or street closures related to an insured event

This coverage extends until the end of the business interruption period, as determined by the insurer; most define this period as starting on the date of the covered event and extending until the damaged property is returned to the functional state that existed prior to the disaster.

Business interruption insurance cannot cover:

- Undocumented income: Business interruption coverage can be very technical when determining the benefits to be paid under lost income. Providers should use historical financial statements to develop scenarios with documented data including admissions, daily census, payer mix, surgical cases, estimated reimbursement and net revenues.
- Utilities: In most cases, utilities are not covered because utility service typically shuts off when the facility is closed or evacuated.

- Losses from closures caused by non-covered damages: Because business interruption coverage only pays out if the cause of the loss is covered by the primary policy, it would not apply to events — like floods or earthquakes — that are not covered by the primary policy.
- Closures from downed power lines: If a storm or accident results in downed power lines, most closures are not covered. Power outages are a common occurrence, making it a difficult risk to insure because it affects so many people. Moreover, power is typically restored fairly quickly.
- Waiting period: Most business interruption policies require a facility to be shut down for at least 72 hours before benefits kick in.

B. Federal Public Assistance

Federal law limits eligibility for FEMA funds to public and private nonprofit hospitals. Investor-owned hospitals are eligible only for low-interest loans through the U.S. Small Business Administration. FEMA funding is considered last resort funding, meaning that any insurance policies and other funding mechanisms must be exhausted first. FEMA pays only the non-insured portion of any eligible damages. In addition, only those nonprofit hospitals in FEMA-designated disaster areas are eligible for assistance.

Application Process

The first step in the public assistance claims process is to submit a Request for Public Assistance to FEMA within 30 days of the emergency area being designated in the declaration; private hospitals also must submit the Private Nonprofit Facility Questionnaire. These requests are not binding and are considered only a notice of intent to apply for reimbursement for costs sustained during a disaster event. Submission of the request triggers assignment of a FEMA case manager, who then schedules a kickoff meeting with the hospital and works with hospital staff to identify eligible costs and categories of available funding, complete the full application for assistance and document the claims.

Categories of costs potentially eligible for reimbursement are detailed in a FEMA guide. In general, costs related to business interruption are ineligible. However, one could argue that hospitals represent a unique situation in claims management and adjudication because of the challenge in determining whether a cost is incurred as part of normal business, despite the disaster, or is directly attributable to and a result of the disaster. **Documenting the claim thoroughly and comprehensively is vital, as is working closely with the designated FEMA case manager.** Hospitals are advised to keep detailed inventories with documented costs and record the roles of all employees and contractors related to the disaster. Mitigation activities are crucial. When selecting vendors, hospitals must strictly follow all federal laws related to procurement to be eligible for FEMA funding.

In addition, if a hospital received FEMA reimbursement in the past and was required to maintain a certain level of insurance as a condition of reimbursement, eligibility for future funding will depend on documenting that it obtained and maintained that required level of insurance. Once FEMA approves a scope of work for reimbursement, hospitals may not deviate from it.

C. Other Programs

Loan Programs for Nonprofit Small or Rural Health Facilities

The California Health Facilities Financing Authority (CHFFA) recognizes the difficulty small and rural health facilities have in obtaining adequate financing for their capital needs. The HELP II Loan Program provides low-interest rate loans to California's nonprofit small or rural health facilities in an efficient, timely and cost-effective manner. HELP II loans may be used to purchase or construct new facilities, remodel or renovate existing facilities, purchase equipment or furnishings and refinance existing debt.

Facilities with gross annual revenues of up to $30 million are eligible for loans under this program. District hospitals and rural health facilities are eligible without any revenue limitations. Applications are accepted on a monthly basis.

D. Billing Medicare FFS and Medi-Cal FFS

Medicare FFS

As part of its response to the 2005 Katrina hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed the "DR" condition code and the "CR" modifier to facilitate the processing of claims affected by that emergency. The DR condition code and CR modifier were also authorized for use on claims for items and services affected by subsequent emergencies.

The use of the "CR" modifier and "DR" condition code indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all of the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.

The official instruction, CR 6451, regarding this change may be viewed here.

Medi-Cal FFS

Original or initial Medi-Cal claims must be received by the Department of Health Care Services (DHCS) Fiscal Intermediary within six months following the month in which services were rendered. Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations. Please note that delay reasons also have time limits.

The delay reason code for Natural disasters is 15. For further late billing instructions and the full list of delay reason codes and required documentation needed, please see UB-04 Submission and Timeliness Instructions.

VI. RECENT DISASTER DECLARATIONS

A. 2017 Hurricanes

Hurricane Harvey 2017

CMS approved the state's request to waive CHIP co-payments for members with a permanent address in one of the Hurricane Harvey FEMA-declared disaster counties.

Co-payments were waived for services provided August 25, 2017, through November 30, 2017. Therefore, providers were not to required to collect co-payments for CHIP members living in or displaced from a Hurricane Harvey FEMA-declared disaster county.

HHS intends to develop a process to seek federal emergency funds to compensate providers.

Hurricane Irma 2017

As part of the Trump Administration's government-wide efforts to provide relief to those affected by Hurricane Irma in Puerto Rico, HHS activated a program to help hospitals and medical facilities providing care to people affected by Irma. HHS previously activated the program in response to a devastating earthquake that hit Haiti in 2010.

The program, called the National Disaster Medical System (NDMS) Definitive Care Reimbursement Program, reimburses medical facilities and hospitals for the definitive medical care costs of patients medically evacuated following disasters. These patients are directed to NDMS-designated hospitals and medical facilities and tracked through federal coordinating centers managed by the departments of Veterans Affairs and Defense.

The program, overseen by the HHS ASPR, covers medical care provided to people who are injured or become ill as a result of natural disasters if, following the disaster, medical care is no longer available in their area. Covered services include medically necessary hospital care, which can extend beyond the typical 30-day stay, as well as home care, rehabilitation, physical therapy and primary care.

Approximately 85 patients will be covered under the NDMS Definitive Care Reimbursement Program in eligible medical facilities in Puerto Rico. These patients were medically evacuated to Puerto Rico from the U.S. Virgin Islands, utilizing resources available through the U.S. Department of Defense and FEMA's national ambulance contract.

Facilities participating in the program must make up to 25 beds available for NDMS patients, and receive reimbursement up to 110 percent of the Medicare rate, or a comparable rate if the Medicare rate is unavailable. More than 1,900 hospitals across the country participate in NDMS' Definitive Care Reimbursement Program.

Department of Health Care Services (DHCS) Hurricane Response

DHCS issued a letter providing guidance to counties on processing applications from individuals affected by disasters, including hurricanes Harvey, Irma and Maria. Counties shall process such applications from individuals affected by disasters according to the instructions in the All County Welfare Directors Letter 15-36.

DHCS collaborated with federal partners and other states' Medicaid programs to develop a frequently asked questions document providing special instructions, guidance and resources to the affected population. It includes information for applicants and beneficiaries about requirements on how to apply for and access services. There is also information for providers in areas affected by natural disasters, which is particularly germane as some of the impacted population may relocate from one city or state to another.

B. California Wildfires 2017

Firefighters began battling multiple wildfires on October 8, 2017, in numerous counties across California, prompting mass evacuations. Thousands of acres burned and threatened infrastructure as strong winds fueled the fast-moving fires.

FEMA announced on October 10, 2017, that federal disaster assistance was made available to supplement state, tribal and local recovery efforts in the areas affected by wildfires from October 8, 2017, onward.

Following the presidential major disaster declaration, on October 15, 2017, Acting HHS Secretary Eric D. Hargan declared that a public health emergency exists, and has existed since October 8, 2017, as a consequence of the California wildfires.

Medicare Fee–for-Service Response to the 2017 Southern California Wildfires

CMS issued information for providers and suppliers that were affected by the December 2017 California and were required to submit claims to Medicare administrative contractors for services provided to Medicare beneficiaries.

VII. APPENDICES

A. Request for Public Assistance Form

DEPARTMENT OF HOMELAND SECURITY
Federal Emergency Management Agency
REQUEST FOR PUBLIC ASSISTANCE

OMB Control Number 1660-0017
Expires December 31, 2019

Paperwork Burden Disclosure Notice

Public reporting burden for this data collection is estimated to average 15 minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and submitting this form. This collection of information is required to obtain or retain benefits. You are not required to respond to this collection of information unless a valid OMB control number is displayed in the upper right corner of this form. Send comments regarding the accuracy of the burden estimate and any suggestions for reducing the burden to: Information Collections Management, Department of Homeland Security, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, Paperwork Reduction Project (1660-0017) **NOTE: Do not send your completed form to this address.**

Privacy Act Statement

Authority: FEMA is authorized to collect the information requested pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, §§ 402-403, 406-407. 417, 423, and 427, 42 U.S.C. 5170a-b, 5172-73, 5184, 5189a, 5189e; The American Recovery and Reinvestment Act of 2009, Public Law No. 111-5, § 601; and "Public Assistance Project Administration," 44 C.F.R. §§ 206.202, and 206.209.

APPLICANT (Political subdivision or eligible applicant)	DATE SUBMITTED

COUNTY (Location of Damages. If located in multiple counties, please indicate)

APPLICANT PHYSICAL LOCATION

STREET ADDRESS			
CITY	COUNTY	STATE	ZIP CODE

MAILING ADDRESS (If different from Physical Location)

STREET ADDRESS			
POST OFFICE BOX	CITY	STATE	ZIP CODE

Primary Contact/Applicant's Authorized Agent	**Alternate Contact**
NAME	NAME
TITLE	TITLE
BUSINESS PHONE	BUSINESS PHONE
FAX NUMBER	FAX NUMBER
HOME PHONE (Optional)	HOME PHONE (Optional)
CELL PHONE	CELL PHONE
E-MAIL ADDRESS	E-MAIL ADDRESS
PAGER & PIN NUMBER	PAGER & PIN NUMBER

Did you participate in the Federal/State Preliminary Damage Assessment (PDA)? ☐ YES ☐ NO

Private Non-Profit Organization? ☐ YES ☐ NO

If yes, which of the facilities identified below best describe your organization? _____

Title 44 CFR, part 206.221(e) defines an eligible private non-profit facility as: "... any private non-profit educational, utility, emergency, medical or custodial care facility, including a facility for the aged or disabled, and other facility providing essential governmental type services to the general public, and such facilities on Indian reservations." "Other essential governmental service facility means museums, zoos, community centers, libraries, homeless shelters, senior citizen centers, rehabilitation facilities, shelter workshops and facilities which provide health and safety safety services of a governmental nature. All such facilities must be open to the general public."

Private Non-Profit Organizations must attach copies of their Tax Exemption Certificate and Organization Charter or By-Laws. If your organization is a school or educational facility, please attach information on accreditation or certification.

OFFICIAL USE ONLY: FEMA - _____ **-DR-** _____ **-** _____ **FIPS#** _____ **DATE RECEIVED** _____

FEMA Form 009-0-49 9/16 PREVIOUS EDITION OBSOLETE

B. PNP Facility Questionnaire

DEPARTMENT OF HOMELAND SECURITY
FEDERAL EMERGENCY MANAGEMENT AGENCY
PNP FACILITY QUESTIONNAIRE

O.M.B. NO. 1660-0017
Expires December 31, 2011

PAPERWORK BURDEN DISCLOSURE NOTICE

Public reporting burden for this form is estimated to average 30 minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the needed data, and completing, reviewing, and submitting the form. You are not required to respond to this collection of information unless it displays a valid OMB control number. Send comments regarding the accuracy of the burden estimate and any suggestions for reducing this burden to: Information Collections Management, Department of Homeland Security, Federal Emergency Management Agency, 500 C Street, SW, Washington, DC, 20472, Paperwork Reduction Project (1660-0017). **Please do not send your completed survey to the above address.**

FEMA and State personnel will use this questionnaire to determine the eligibility of specific facilities of an approved Private Non-Profit (PNP) organization (See 44 CFR 206.221). Owners of critical facilities (i.e., power, water (including providing by an irrigation organization or facility, if it is not provided solely for irrigation purposes), sewer, wastewater treatment, communications and emergency medical care) can apply directly to FEMA for assistance for emergency work (debris removal and emergency protective measures) and permanent work (repair, restore or replace a damaged facility). Owners of non-critical facilities can apply directly to FEMA for assistance for emergency work, but must first apply to the U. S. Small Business Administration (SBA) for assistance for permanent work. If the owner of a non-critical facility does not qualify for an SBA loan or the cost to repair the damaged facility exceeds the SBA loan amount, the owner may apply to FEMA for assistance.

1. Name of PNP Organization _____

2. Name of the damaged facility and location _____

3. What was the primary purpose of the damaged facility _____

4. Is the facility a critical facility as described above? ☐ Yes ☐ No

5. Who may use the faciltiy _____

6. What fee, if any, is charged for the use of the faciltiy _____

7. Was the facility in use at the time of the disaster? ☐ Yes ☐ No

8. Did the facility sustain damage as a direct result of the disaster? ☐ Yes ☐ No

9. What type of assistance is being requested? _____

10. Does the PNP organization own the facility? ☐ Yes ☐ No

11. If "Yes" obtain proof of ownership; check here if attached. ☐

12. Does the PNP organization have the legal responsibility to repair the facility? ☐ Yes ☐ No

13. If "Yes", provide proof of legal responsibility; check here if attached. ☐ Yes ☐ No

14. Is the facility insured? ☐ Yes ☐ No

15. If "Yes", obtain a copy of the insurance policy; check here if attached. ☐

Additional information or comments:

CONTACT PERSON	DATE

FEMA Form 90-121, FEB 09

C. CMS Responses to CHA

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, California 94103-6708

DIVISION OF FINANCIAL MANAGEMENT & FEE FOR SERVICE OPERATIONS

October 13, 2017

Cheri Hummel
Vice President, Emergency Management & Facilities
California Hospital Association
1215 K Street, Suite 800
Sacramento, California 95814

Dear Ms. Hummel:

We are writing in response to your October 12, 2017 inquiry regarding the Medicare program. You indicated that the California Hospital Association has been working closely with hospitals adversely affected by the fires in northern California. You asked the Centers for Medicare & Medicaid Services (CMS) to respond to the following questions.

Question 1: Since this is a natural disaster, has the 1135 waiver been invoked or do we have to apply for the 1135 waiver?

Response: We confirmed with CMS Region IX's Division of Survey & Certification that no 319 Secretarial declarations have been made. The U.S. Department of Health and Human Services and CMS are closely monitoring the situation. Currently, the 1135 waiver has not been invoked.

Question 2: You asked about skilled nursing facility (SNF) patients being evacuated to an acute care hospital when the SNF residents do not have a medical condition necessary for an inpatient hospital admission. Would the receiving hospital be permitted to bill Medicare for the SNF patients who are evacuated to the acute care hospital?

Response: Please see the following information:

What is the process for evacuation of SNF residents to hospitals? In situations where the SNF makes arrangements to temporarily evacuate Medicare Part A residents to a hospital, the transferring SNF is responsible for paying the receiving facility. Thus, the transferring SNF is still considered the provider and would be providing services to its residents "under arrangement" in this situation. If the resident/patient does not meet the hospital level of care, there is no mechanism to pay the hospital directly. We have defined "temporary" as 30 days or less. During this period, the transferring SNF continues to bill Medicare. The transferring SNF is responsible for completing the necessary Minimum Data Set (MDS) assessments. The transferring SNF may transmit the updated MDS at a later date, once the emergency is resolved as long as the MDS was completed timely and within the appropriate observation period. This process does not require the issuance of the 1135(b) waiver.

Question 3: If the SNF evacuates its residents to another SNF for 30 days, can the originating SNF bill Medicare for the SNF residents care furnished at the receiving SNF?

Response: With respect to a SNF evacuating its residents to another SNF or hospital as part of an emergency plan, a SNF can temporarily transfer its residents to another facility as long as the evacuation is for less than 30 days, and thus be providing its services "under arrangements." The transferring SNF need not issue a formal discharge in this situation, as it is still considered the provider and should normally bill Medicare for each day of care. The transferring SNF is then responsible for reimbursing the other provider that accepted its residents during the emergency period. We have defined "temporary" as 30 days or less. During this period, the transferring SNF continues to bill Medicare. The transferring SNF is responsible for completing the necessary MDS assessments (either directly or by delegating the function to the receiving facility). The receiving SNF need only complete the clinical assessment portion of the MDS for each evacuated resident, and may do this on a paper MDS form if the electronic MDS is not available. The receiving SNF may then send the paper MDS assessment back to the transferring/evacuating facility. The original transferring/evacuating SNF may transmit the updated MDS at a later date, once the emergency is resolved as long as the MDS was completed timely and within the appropriate observation period.

Alternatively, if there is a "missed MDS assessment" during the emergency, the facilities may agree to accept the default PPS rate for the resident during that time period.

Question 4: Can a critical access hospital (CAH) receive evacuees which results in the CAH exceeding its 25-bed limit?

Response: We confirmed with CMS Region IX's Division of Survey & Certification that a CAH is not permitted to exceed their 25-bed limit without issuance of the 1135 waiver authority.

We contacted Noridian Healthcare Solutions which currently serves as the Medicare Administrative Contractor (MAC) in Jurisdiction E. Medicare's policy provides contractors with leeway to determine Medicare reimbursement for services provided under unusual circumstances. While CMS recognizes it is in the patients' best interest to be evacuated as soon as possible during an emergency, contractors have the responsibility to determine if Medicare expenditures should be made for the evacuation.

Lastly, you may wish to review the following question and answer regarding Medicare's coverage policy pertaining to an emergency evacuation due to a natural disaster.

Question 1: During an emergency, will Medicare fee-for-service allow payment for care provided at a site not considered part of the facility (which are informally termed "alternative care sites" (ACSs)) for patients who are not critically ill? For example, if local hospitals are almost at capacity, during an emergency and the few beds remaining must be reserved for patients needing ventilators and critical care, will Medicare fee-for-service pay for non-critical care provided at an ACS, such as a school gymnasium?

Response: In the absence of an 1135 waiver, a hospital may add a remote location that provides inpatient services to the hospital's Medicare certified beds under its existing provider agreement, provided that the remote location satisfies the requirements to be provider-based to the hospital's main campus (including being located within 35 miles pursuant to 42 CFR 413.65 (e)(3)). The

remote location must satisfy all provider-based requirements including being compliant with the hospital Conditions of Participation (CoPs). The hospital would be expected to file an amended Form CMS 855A with its MAC or legacy Fiscal Intermediary as soon as possible adding an additional location. The CMS generally requires a survey of compliance with all CoPs at all new inpatient locations, but also has discretion to waive the onsite survey in this area.

If Medicare providers have further billing or coverage concerns, they may contact the J-E MAC's provider contact center at (855) 609-9960.

We hope this is of assistance to you. If you need any additional information, you may contact me at (415) 744-3551.

Sincerely,

Neal E. Logue
Health Insurance Specialist
Division of Financial Management and
Fee for Service Operations

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, California 94103-6708

DIVISION OF FINANCIAL MANAGEMENT & FEE FOR SERVICE OPERATIONS

October 18, 2017

Cheri Hummel
Vice President, Emergency Management & Facilities
California Hospital Association
1215 K Street, Suite 800
Sacramento, California 95814

Dear Ms. Hummel:

This is a follow-up response to our letter to you dated October 13, 2017, regarding the California wildfires. You indicated that the California Hospital Association has been working closely with hospitals adversely affected by the wildfires in northern California.

On October 15, 2017, Acting Secretary Eric D. Hargan declared that a public health emergency exists and has existed since October 8, 2017, in the State of California, as a consequence of the California wildfires. You may review the following CMS webpage which includes information regarding the emergency declaration for the 2017 California wildfires. https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html.

With respect to section 1135 of the Social Security Act, you may review the following CMS webpage which includes detailed information about 1135 waivers and how request an 1135 waiver. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers.html.

With respect to Medicare Part A coverage for post-acute skilled nursing facility (SNF) care, CMS has approved a blanket waiver of the Social Security Act, Section 1812(f). This waiver of the requirement for a 3-day prior hospitalization for coverage of a SNF Part A stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires in California in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. Individual facilities do not need to apply for this blanket waiver.

We hope this is of assistance to you. If you need any additional information, you may contact me at (415) 744-3551.

Sincerely,

Neal E. Logue
Health Insurance Specialist
Division of Financial Management and
Fee for Service Operations

D. CMS San Francisco Regional Office Contacts

Major Subject/Topic	Division Name	Telephone Number	Email Address
Medicare FFS Coverage	Division of Financial Management & Fee-for-Service Operations	(415) 744-3658	rosfofm@cms.hhs.gov
Medicare Claims	Division of Financial Management & Fee-for-Service Operations	(415) 744-3658	rosfofm@cms.hhs.gov
Medicare Enrollment	Division of Medicare Health Plans Operations	(415) 744-3617	rosfodhpp@cms.hhs.gov
Medicare Managed Care (Medicare Advantage)	Division of Medicare Health Plans Operations	(415) 744-3617	rosfodhpp@cms.hhs.gov
Medicare Prescription Drug Coverage	Division of Medicare Health Plans Operations	(415) 744-3617	rosfodhpp@cms.hhs.gov
Medicaid	Division of Medicaid and Children's Health Operations	(415) 744-3658	rosfomcd@cms.hhs.gov
State Children's Health Insurance Program	Division of Medicaid and Children's Health Operations	(415) 744-3658	rosfomcd@cms.hhs.gov
Medicare Contractor (Carrier or Fiscal Intermediary)	Western Consortium Contractor Management Staff	(415) 744-3643	wccms@cms.hhs.gov
Medicare Fraud	Division of Financial Management & Fee-for-Service Operations	(415) 744-3658	rosfofm@cms.hhs.gov
Medicaid Fraud	Division of Medicaid and Children's Health Operations	(415) 744-3658	rosfomcd@cms.hhs.gov
Quality Improvement Organizations (QIO) and Quality of Care Complaints	Seattle Regional Office	(206) 615-2310	roseacsq@cms.hhs.gov
Medicare Provider (Hospital, Home Health Agency, etc.)	Division of Survey and Certification	(415) 744-3679	rosfoso@cms.hhs.gov
Medicare Certification	Division of Survey and Certification	(415) 744-3679	rosfoso@cms.hhs.gov
Freedom of Information Act (FOIA) Requests	Division of Survey and Certification	(415) 744-3679	rosfoso@cms.hhs.gov
Medicare Financial Issues	Division of Financial Management & Fee-for-Service Operations	(415) 744-3658	rosfofm@cms.hhs.gov
Medicare Secondary Payer	Division of Financial Management & Fee-for-Service Operations	(415) 744-3658	rosfofm@cms.hhs.gov
Media / Press Inquiries or Interviews	Office of the Regional Administrator	(415) 744-3501	rosfoora@cms.hhs.gov
Inviting CMS to Participate in an Event	Office of the Regional Administrator	(415) 744-3501	rosfoora@cms.hhs.gov

VIII. REFERENCES

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