Disease Quality Incentive Program found at *https://www.regulations.gov/docket?D=CMS-2017-0084*.

- CY 2018 Home Health Prospective Payment System Rate Update; Value-Based Purchasing Model; and Quality Reporting Requirements found at *https://www.regulations.gov/docket?D=CMS-2017-0100*.
- FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality found at *https://www.regulations.gov/document?D=CMS-2017-0062-0001*.
- FY 2018 Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System RFI, found at *https://www.regulations.gov/docket?D=CMS-2017-0055*.
- CY 2018 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates found at *https://www.regulations.gov/docket?D=CMS-2017-0091*.
- FY 2018 Inpatient Rehabilitation Facility Prospective Payment System found at *https://www.regulations.gov/document?D=CMS-2017-0059-0002*.
- FY 2018 Inpatient Psychiatric Facilities Prospective Payment System found at *https://www.regulations.gov/document?D=CMS-2017-0105-0002*.
- CY 2018 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B found at *https://www.regulations.gov/docket?D=CMS-2017-0092*.
- FY 2018 Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities found at *https://www.regulations.gov/document?D=CMS-2017-0060-0002*.

Public comments on the RFIs can be found by searching for the terms "RFI" or "request for information" in the aforementioned 2017 payment regulation dockets on *www.regulations.gov*.

The most useful comments will be those that include data or evidence to support the position, offer suggestions to amend specific sections of the existing regulations, or offer particular additions.

Contact: CAPT Jacqueline Leach, USPHS, 410–786–4282.

L. Emergency Preparedness for Providers and Suppliers

On September 16, 2016, we published a final rule entitled, "Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers" (81 FR 63860), which established national emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers (referred to collectively as "facilities" in the subsequent section) to plan adequately for both natural and man-made disasters and coordinate with Federal, State, tribal, regional, and local emergency preparedness systems. In that final rule, we emphasized the need for facilities to maintain access to healthcare services during emergencies, safeguard human resources, and maintain business continuity and protect physical resources. A facility's emergency preparedness program must include the following elements:

- Risk assessment and emergency planning
- Policies and procedures
- Communication plan
- Training and testing

After the publication of that final rule, we continued to review and analyze the final emergency preparedness requirements and pertinent stakeholder feedback. Upon further review, we believe that some emergency preparedness requirements could be modified or eliminated to reduce provider and supplier burden while continuing to maintain essential emergency preparedness requirements that preserve the health and safety of patients in the United States. The following proposals would simplify the emergency preparedness requirements, eliminate duplicative requirements, and/or reduce the frequency with which providers and suppliers would need to perform certain required activities. We note that the current emergency preparedness standards are similar amongst all provider and supplier types, with a few variations to account for differences in health care settings. For clarity in the discussion later in this section of this proposed rule, we often refer to the hospital regulatory citation and we include specific references to other provider or supplier types when necessary.

1. Annual Review of Emergency Preparedness Program (§§ 403.748, 416.54, 418.113, 441.184, 460.84, 482.15, 483.73, 483.475, 484.102, 485.68, 485.625, 485.727, 485.920, 486.360, 491.12, and 494.62 (a), (b), (c), and (d))

Facilities are currently required to annually review their emergency preparedness program, which includes a review of their emergency plan, policies and procedures, communication plan, and training and testing program. However, pertinent stakeholders continue to question whether an annual review of the emergency program is necessary or beneficial to the facility. In response to their comments, we are therefore proposing to change this requirement to require facilities to review their program at least every 2 years. This will increase the facility's flexibility to review their programs as they determine best fits their needs. We expect that facilities would routinely revise and update their policies and operational procedures to ensure that they are operating based on best practices. In addition, facilities should update their emergency preparedness program more frequently than every 2 years as needed (for example, if staff changes occur or lessons-learned are acquired from a real-life event or exercise).

As noted in the Emergency Preparedness final rule (81 FR 63860), ". . . there are various infections and diseases, such as the Ebola outbreak in October, 2014, that required updates in facility assessments, policies and procedures and training of staff beyond the directly affected hospitals. The final rule requires that if a facility experiences an emergency, an analysis of the response and any revisions to the emergency plan will be made and gaps and areas for improvement should be addressed in their plans to improve the response to similar challenges for any future emergencies."

The Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) located at: *https://asprtracie.hhs.gov/*, is an excellent resource for the various CMS providers and suppliers as they seek to implement the emergency preparedness requirements. TRACIE is designed to provide resources and technical assistance to healthcare system preparedness stakeholders in building a resilient healthcare system. There are numerous products and resources located within the TRACIE website that target specific provider types affected by the emergency preparedness aspects of this proposed rule. While TRACIE does not focus specifically on the requirements implemented in this proposed regulation, this is a valuable resource to aid a wide spectrum of partners with their health system emergency preparedness activities. We strongly encourage providers and suppliers to utilize TRACIE and leverage the information provided by ASPR.

2. Documentation of Cooperation Efforts (§§ 403.748(a)(4), 416.54(a)(4), 418.113(a)(4), 441.184(a)(4), 460.84(a)(4), 482.15(a)(4), 483.73(a)(4), 483.475(a)(4), 484.102(a)(4), 485.68(a)(4), 485.625(a)(4), 485.920(a)(4), 486.360(a)(4), 491.12(a)(4), and 494.62(a)(4))

Facilities are currently required to develop and maintain an emergency preparedness plan that includes a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facilities' efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. Upon further review of this requirement, we believe that elements of this requirement are unduly burdensome on facilities. Therefore, we propose to eliminate the requirement that facilities document efforts to contact local, tribal, regional, State, and Federal emergency preparedness officials and facilities' participation in collaborative and cooperative planning efforts. Facilities will still be required to include a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. We believe that eliminating this documentation requirement will reduce provider and supplier burden by not requiring facilities to demonstrate that they have contacted local, tribal, regional, State, and Federal emergency preparedness officials or participated in collaborative and cooperative planning in the community, while still requiring facilities to at least include a process for cooperation and collaboration. We continue to encourage facilities to participate, when available, in community cooperative and collaborative planning efforts and execute the training and testing requirements in § 482.15 (d) for hospitals and similar parallel citations for other facilities.

3. Annual Emergency Preparedness Training Program (§§ 403.748(d)(1)(ii), 416.54(d)(1)(ii), 418.113(d)(1)(ii), 441.184(d)(1)(ii), 460.84(d)(1)(ii), 482.15(d)(1)(ii), 483.73(d)(1)(ii), 483.475(d)(1)(ii), 484.102(d)(1)(ii), 485.68(d)(1)(ii), 485.625(d)(1)(ii), 485.727(d)(1)(ii), 485.920(d)(1)(ii), 486.360(d)(1)(ii), 491.12(d)(1)(ii), and 494.62(d)(1)(ii)

Facilities are required to develop and maintain a training program that is based on the facility's emergency plan. This emergency preparedness training must be provided at least annually and a well-organized effective training program must include initial training in emergency preparedness policies and procedures. We revisited the public comments received on the Emergency Preparedness proposed rule (81 FR 63890 through 63891) and determined that requiring facilities to provide annual training may be unduly burdensome. We are therefore proposing to change this requirement to require that facilities provide training biennially or every 2 years, after facilities conduct initial training on their emergency program. In addition, we propose to require additional training when the emergency plan is significantly updated. For example, when a facility makes substantial changes to the procedures or protocols within the emergency plan, we would require additional training on the updated emergency plan. Other non-significant updates, such as revisions to the communication plan regarding contact information for staff, could be sent in company memorandum or provided to the facility's staff through other means. These proposed changes give facilities additional flexibility to determine what is appropriate for their facility's or staff's needs while maintaining adequate readiness.

4. Annual Emergency Preparedness Testing (§§ 403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 460.84(d)(2), 482.15(d)(2), 483.73(d)(2), 483.475(d)(2), 484.102(d)(2), 485.68(d)(2), 485.625(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), and 494.62(d)(2))

Facilities are currently required to conduct exercises to test the emergency plan at least annually. The facility must conduct two emergency preparedness testing exercises every year. Specifically, facilities must:

- Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the facility experiences an actual natural or-man made emergency that requires activation of the emergency plan (including their communication plan) and revision of the plan as needed), the facility is exempt from engaging in a community-based or individual, facility based full-scale exercise for 1 year following the onset of the actual event;
- Conduct an additional exercise that may include either a second full-scale exercise that is community-based or individual, facility-based or a tabletop exercise that includes a group discussion led by a facilitator.

Upon further analysis of this requirement, and taking into account stakeholder feedback, we have determined that there is also a need to clarify and revise some of the requirements included in the Emergency Preparedness final rule (81 FR 63860). We propose to clarify our intent with regard to the types of testing exercises, specifically full-scale exercises and functional exercises. As noted in the Emergency Preparedness proposed rule (78 FR 79101), a full-scale exercise is a multi-agency, multijurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers, etc.) and "boots on the ground" responses (for example, firefighters decontaminating mock victims). We expect facilities to engage in such comprehensive exercises with coordination across the public health system and local geographic area, if possible. Moreover, a functional exercise examines or validates the coordination, command, and control between various multiagency coordination centers (for example, emergency operation center, joint field office, etc.). A functional exercise does not involve any "boots on the ground" (that is, first responders or emergency officials responding to an incident in real time). The term "functional exercise" more accurately reflects our intentions for the testing requirement in the Emergency Preparedness final rule (81 FR 63860). We believe that there are opportunities to reduce the burden for inpatient and outpatient providers to meet the testing requirement.

For providers of inpatient services, we propose to expand the testing requirement options such that one of the two annually required testing exercises may be an exercise of their choice, which may include one community-based full-scale exercise (if available), an individual facility-based functional exercise, a drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator. As indicated in the Emergency

Preparedness proposed rule, "A workshop resembles a seminar, but is employed to build specific products, such as a draft plan or policy (for example, a Training and Exercise Plan Workshop is used to develop a Multiyear Training and Exercise Plan)" (78 FR 79101). Providers of inpatient services include RNHCIs, inpatient hospice facilities, Psychiatric Residential Treatment Facilities (PRTFs), hospitals, long-term care facilities (LTCFs), ICFs/IIDs, and CAHs. We believe this will allow greater flexibility for inpatient providers to meet this requirement. We note that although RNHCIs provide inpatient services, we have determined that changing their existing requirements to make them consistent with this proposed provision will be unduly burdensome as they are currently required to conduct a paper-based, tabletop exercise at least annually.

For providers of outpatient services, we believe that conducting two testing exercises per year is overly burdensome as these providers do not provide the same level of acuity or inpatient services for their patients. Therefore, we propose to require that providers of outpatient services conduct only one testing exercise per year. Furthermore, we propose to require that these providers participate in either a community-based full-scale exercise (if available) or conduct an individual facility-based functional exercise every other year. In the opposite years, we propose to allow these providers to conduct the testing exercise of their choice, which may include either a community-based full-scale exercise (if available), an individual, facility-based functional exercise, a drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator. Providers of outpatient services include ASCs, freestanding/home-based hospice, Program for the All-Inclusive Care for the Elderly (PACE), HHAs, CORFs, Organizations (which include Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services), CMHCs, Organ Procurement Organizations (OPOs), RHCs, FQHCs, and ESRD facilities. Due to the nature of services provided by OPOs we propose to require that they have the option of providing either a tabletop exercise or workshop every year.

Lastly, we propose to clarify the testing requirement exemption by noting that if a provider experiences an actual natural or man-made emergency that requires activation of their emergency plan, inpatient and outpatient providers will be exempt from their next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of the actual event. A facility's communication plan is part of their emergency plan, as is coordination with other community emergency preparedness officials (for example, emergency management and public health), and we expect that these elements, along with the completion of a corrective action plan, are part of the activation of their emergency plan.

We seek to reduce burdens for health care providers and patients, improve the quality of care, decrease costs, and ensure that patients and their providers and physicians are making the best health care choices possible. Therefore, we are soliciting public comments on additional regulatory reforms for burden reduction in future rulemaking. Specifically, we are seeking public comment on additional proposals or modifications to the proposals set forth in this rule that would further reduce burden on all Medicare and Medicaid participating providers and suppliers mentioned in this section and create cost savings, while also preserving quality of care and patient health and safety. Consistent with our "Patients Over Paperwork" Initiative, we are particularly interested in any suggestions to improve existing requirements, within our statutory authority, where they make providing quality care difficult or less effective. We also note that such suggestions could include or expand upon comments submitted in response to RFIs that were included in the following 2017 payment regulations:

- End-Stage Renal Disease Prospective Payment System and Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, and End-Stage Renal Disease Quality Incentive Program found at *https://www.regulations.gov/docket?D=CMS-2017-0084*.
- CY 2018 Home Health Prospective Payment System Rate Update; Value-Based Purchasing Model; and Quality Reporting Requirements found at *https://www.regulations.gov/docket?D=CMS-2017-0100*.
- FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality found at *https://www.regulations.gov/document?D=CMS-2017-0062-000*.
- FY 2018 Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System RFI, found at *https://www.regulations.gov/docket?D=CMS-2017-0055*.
- CY 2018 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates found at *https://www.regulations.gov/docket?D=CMS-2017-0091*.
- FY 2018 Inpatient Rehabilitation Facility Prospective Payment System found at *https://www.regulations.gov/document?D=CMS-2017-0059-0002*.
- FY 2018 Inpatient Psychiatric Facilities Prospective Payment System found at *https://www.regulations.gov/document?D=CMS-2017-0105-0002*.
- CY 2018 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B found at *https://www.regulations.gov/docket?D=CMS-2017-0092*.
- FY 2018 Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities found at *https://www.regulations.gov/document?D=CMS-2017-0060-0002*.

Public comments on the RFIs can be found by searching for the terms "RFI" or "request for information" in the aforementioned 2017 payment regulation dockets on *www.regulations.gov*. The most useful comments will be those that include data or evidence to support the position, offer suggestions to amend specific sections of the existing regulations, or offer particular additions.

Contact: Kianna Banks, 410–786–3498.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of the section 3506(c)(2)(A)-

required issues for the following information collection requirements (ICRs).

A. Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates for all salary estimates (*https://www.bls.gov/oes/2016/may/oes_nat.htm*). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits and overhead costs (calculated at 100 percent of salary), and the adjusted hourly wage.

NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hour)	Fringe benefit ($/hour)	Adjusted hourly wage ($/hour)
Healthcare Support Worker	31–9099	$18.13	$18.13	$36
Physicians and Surgeons	29–1060	101.04	101.04	202
Physicians and Surgeons, All Other	29–1069	98.83	98.83	198
Physicians, Psychiatrists	29–1066	94.26	94.26	189
Surgeons	29–1067	121.59	121.59	243
Registered Nurse (RN—Quality Improvement, Home Care Coordinator, HealthCare Trainer, Quality Assurance Nurse, QAPI Nurse Coordinator, Infection Control Nurse Coordinator, Psychiatric RN)	29–1141	34.70	34.70	69
Medical Secretary (Clerical, Administrative Assistant)	43–6013	16.85	16.85	34
Administrative Services Manager (Facility Director)	11–3011	47.56	47.56	96
Management Occupations (Director, Community Relations Manager, Administrator)	11–0000	56.74	56.74	114
Pharmacist	29–1051	57.82	57.82	115
Medical and Health Services Manager (Administrator, Transplant Program Senior Administrator/Hospital Administrator/Medical and Health Services Managers, Program Director, Risk Management Director. QAPI Director, Organ Procurement Coordinator, Nurse manager, Director of Nursing, Nursing care facilities/skilled nursing facilities)	11–9111	52.58	52.58	105
Managers, All Others(Administrator)	11–9199	53.92	53.92	108
*Activities Specialist (Recreational Therapists, Nursing Care Facilities/SNFs)	29–1125	19.92	19.92	40
Internists (Medical Director, General Physician	29–1063	97.04	97.04	194
Family and General Practitioner (Medical Director)	29–1062	96.54	96.54	194
Physical Therapist (Director of Rehab)	29–1123	41.93	41.93	84
Healthcare Social Worker (Social Worker)	21–1022	26.69	26.69	53
Mental Health and Substance Abuse Social Worker (Social Worker)	21–1023	23.02	23.02	46
Nurse Practitioner (Clinician, Nurse Practitioner Outpatient Care Center)	29–1171	50.30	50.30	101
Mental Health Counselor	21–1014	22.14	22.14	44
Physician Assistant	29–1071	49.08	49.08	98
Licensed Practical and Licensed Vocational Nurses (Director of Nursing)	29–2061	21.56	21.56	44
First Line Supervisors of Office and Administrative Support Workers (Office Manager)	43–1011	27.83	27.83	56
Office Clerks, General (Clerical staff)	43–9061	15.87	15.87	32
Secretaries and Administrative Assistants (Clerical staff)	43–6010	19.39	19.39	38
Chief Executive	11–1011	93.44	93.44	186

*Salary information used is for Nursing Care Facility/SNF industry. As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

B. ICRs Regarding RNHCI Discharge Planning (§ 403.736(a) and (b))

Section 403.736 will reduce the extensive requirements for an RNHCI to coordinate with other medical providers for post-RNHCI care. The discharge evaluation must include an assessment of a patient's capacity for self-care and information regarding the care once the patient leaves the facility. The nursing staff would need to prepare the patient and/or their caregiver for discharge. Most patients are discharged to home or to another facility that adheres to the same religious tenets. Although all patients must have a discharge planning evaluation, not all patients require a discharge plan. Based on recent claims data, there was a combined annual total of 619 beneficiaries that stayed in the 18 facilities.

We estimate that the time currently required to develop and document discharge plans and activities is 1,238 burden hours (2 hours for each of the 619 beneficiaries discharged) and that it would be reduced by half. Of the approximately 619 annual discharges, we estimate that a RNHCIs burden would be reduced to one hour for each discharged individual. A RNHCI would not need to develop a discharge plan that includes medical care once a patient leaves the RNHCI because doing so would not be in keeping with the religious tenets of the patients they serve. We estimate that the healthcare support worker responsible for a patients discharge plan is paid at mean wage of $36, including 100 percent for fringe and overhead costs. Based on our experience with RNHCIs, we estimate that it would take 1 hour to develop the proposed discharge instructions and discuss them with the patient and/or caregiver. We estimate a total of 619 annual discharges from RNHCIs at a savings of $36 per discharge for a total savings of $22,284 ($36 × 619 hours).