AHLA

July 2018 Volume 22 Issue 6

connections

For the health and life sciences law community

AHLA Top Honors

(page 12)

Managing Care in the Midst of a Natural Disaster (page 26)

Sex Harassment in Health Care in the Wake of the Renewed #MeToo Movement and #TimesUp (page 34)

OFFICIAL MAGAZINE OF AMERICAN HEALTH LAWYERS ASSOCIATION

Managing Care in the Midst of a Natural Disaster:

The Role of Public and Private Health Plans in Response and Recovery

By Melissa Wong, Holland & Knight LLP, and Marla Hadad, Puerto Rico Health Insurance Administration

The management of care is complex even under the best of circumstances, so how do health plans provide and pay for health care under the worst conditions? In the midst of a catastrophic event like a natural disaster, public and private payers must address the urgent needs of their beneficiaries and health care providers while, in many cases, struggling to maintain their own operations despite evacuation orders, inaccessible offices, damaged information and communication systems, or widespread power failures. This article analyzes the critical role that health plans serve in disaster response and recovery, and offers a number of key considerations that may be helpful for plans and other stakeholders as they literally weather the next big storm.

Being Prepared Is Half the Battle

In the aftermath of Hurricane Sandy, the Centers for Medicare and Medicaid Services (CMS) implemented new regulatory and contractual requirements for all Medicare Advantage (MA) organizations and Part D sponsors to implement comprehensive business continuity plans that ensure the maintenance of critical functions in the event of "natural or man-made disasters, system failures, emergencies, and other similar circumstances and the threat of such occurrences."[1] These business continuity plans must include the following elements:

- ***Risk Assessment.*** The organization or sponsor must evaluate the threats and vulnerabilities that might affect business operations and identify the specific events that will activate the business continuity plan.[2]
- ***Maintenance of Communication Systems and Essential Records.*** The organization or sponsor must develop contingency plans to maintain the availability and confidentiality of communication systems and essential records.[3] During any business disruption, information technology systems—including those supporting claims processing, as well as provider and enrollee phone, online and e-mail communication systems—must remain operational or be restored to operational capacity on a timely basis. CMS also specifically incorporates contingency plan requirements set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with respect to electronic protected health information (PHI), including data back-up plans that allows for the retrieval of exact copies of electronic PHI and emergency mode operations to "enable the continuation of critical business processes for the protection of the security of electronic PHI while operating in emergency mode."[4]
- ***Chain of Command.*** The organization or sponsor must establish a chain of command and a communication plan to contact employees as well as first-tier, downstream and related entities, and other third parties, including providers, suppliers, and government and emergency management personnel.[5] The business continuity plan must also provide for the assumption of essential job functions by other employees, or the relocation of operations to alternate sites, as needed.[6]
- ***Testing and Revision.*** Business continuity plans must be tested and updated at least annually to ensure that it can be implemented in emergency situations.[7] Organizations and sponsors must also ensure that employees understand how business continuity plans are to be executed, and to that end, are required to conduct annual training for the relevant employees about the plans and the employees' respective roles.[8]

» ***Restoration of Essential Functions.*** The organization or sponsor must establish a plan to transition back to normal operations following a business disruption.[9] As part of this restoration plan, the organization or sponsor must identify "essential functions" and prioritize the order in which those functions must be restored after a disruption.[10] All essential functions, as well as processes for benefit service authorizations (if not already waived) and call center customer service operations, must be restored within 72 hours after a disruption or failure.[11] Part D sponsors must also ensure the restoration of the administration and tracking of drug benefits in real time, the provision of pharmacy technical assistance, and the operation of an enrollee exceptions and appeals process, including coverage determinations, within 72 hours.[12]

In addition, states may require health insurers to implement disaster recovery or business continuity plans that meet their own regulatory requirements.[13] Many of these state requirements mimic the federal requirements listed above for MA and Part D. For example, Washington's Office of the Insurance Commissioner requires all domestic insurers to create and maintain a written business continuity plan, which similarly must incorporate, among other requirements, data back-up and recovery, prioritization for restoring business functions, alternative methods of communication with insureds, and annual review and testing of the business continuity plan.[14] New York's Department of Financial Services has imposed similar business continuity requirements on health insurers and health maintenance organizations authorized in the state, though the state agency requires submission of a disaster response plan and responses to disaster response plan and business continuity plan questionnaires, while CMS only requires that MA organizations and Part D sponsors be able to produce such written plans upon request.[15]

When Disaster Strikes

Business continuity plans are truly tested when natural disasters strike, and there was no better (or worse) year for testing these plans than in 2017. From hurricanes to droughts to wildfires to floods, the United States experienced a record-setting 16 natural disaster events with damages exceeding $1 billion each.[16] Under the Robert T. Stafford Disaster Relief and Emergency Act, the President of the United States may declare a major disaster or emergency at the request of the governor of the impacted state.[17] This in turn allows the Secretary of the U.S. Department of Health and Human Services (HHS) to declare a public health emergency in the affected areas.[18] Once a public health emergency is declared, the Secretary may temporarily modify or waive requirements otherwise applicable under Medicare, Medicaid and the Children's Health Insurance Program (CHIP).[19] These waivers are authorized by Section 1135 of the Social Security Act, or otherwise can be based on CMS's current authority to adjust the existing policies and procedures of the agency.

In the midst of a catastrophic event like a natural disaster, public and private payers must address the urgent needs of their beneficiaries and health care providers while, in many cases, struggling to maintain their own operations despite evacuation orders, inaccessible offices, damaged information and communication systems, or widespread power failures.

Section 1135 waivers are used during an emergency to ensure "that sufficient health care items and services are available to meet the needs of individuals" enrolled in Medicare, Medicaid, or CHIP.[20] Waivers are also used to ensure that health care providers "furnish[ing] such items and services in good faith . . . may be reimbursed for such items and services and exempted from sanctions for . . . non-compliance, absent

any determination of fraud or abuse" if they are unable to comply with certain requirements that would otherwise apply to the provision of the health care item or service.[21] These requirements include provider conditions of participation, in-state professional licensure requirements, sanctions under the Stark Law for physician self-referral, limitations on payments for health care items and services furnished by non-MA network providers and facilities, deadlines for the performance of required activities (of which the applicable timeframes may be modified but not waived entirely), and restrictions on the transfer of non-stabilized patients and women in labor under the Emergency Medical Treatment and Labor Act (EMTALA).[22] The Secretary also has the authority under Section 1135 to waive certain requirements under HIPAA while the public health emergency exists, such as the imposition of sanctions or penalties on covered entities for failing to provide the required notice of privacy practices to patients, or for the disclosure of PHI to a patient's family and friends without the patient's consent.[23]

CMS tends to issue a set of "blanket" Section 1135 waivers both before and after the emergency. For example, during Hurricanes Harvey, Nate, Irma and Maria last year, CMS granted waivers for the following requirements, among others:[24]

- ***Coverage for Skilled Nursing Facility Stays***. Patients who were evacuated, transferred or otherwise relocated due to the hurricane were not required to show 3 days of prior hospitalization for coverage of a skilled nursing facility stay. In addition, for certain patients who recently exhausted their skilled nursing facility benefits, the waiver also authorized renewed coverage without having to start a new benefit period.
- ***Extension for Reporting Requirements***. CMS waived or extended deadlines for the submission of certain provider data reports including minimum data set assessments and transmissions for skilled nursing facilities under 42 C.F.R. § 483.20, OASIS transmissions for home health agencies under 42 C.F.R. § 484.20(c)(1), and data and cost reports for Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) hospitals.
- ***Replacement of DMEPOS***. Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) were able to replace items that were lost, destroyed, irreparably damaged, or otherwise rendered unusable as a result of the hurricanes without a face-to-face encounter, a new physician's order, or new medical necessity documentation. However, suppliers were required to include with the claim an explanation of why the equipment needed to be replaced.
- ***Part B Prescription Refills***. CMS allowed for replacement prescription fills of covered Medicare Part B prescription drugs for a quantity up to the amount originally dispensed if previously dispensed medication was lost or rendered unusable due to the emergency.

In addition to the Section 1135 blanket waivers, CMS may offer further relief to patients and health care providers during a natural disaster or other public health emergency. It should be noted, however, that while some of the following actions are required by regulation or order, others appear to be optional or merely "expected" of plans:

- ***Special Enrollment Opportunities for Impacted Individuals***. Impacted individuals seeking to enroll or re-enroll in Medicare or in health plans offered through the federal health insurance exchange were given the opportunity to change their plans or apply for coverage during a special enrollment period.[25]
- ***Restrictions on Disenrollment.*** Given widespread relocation after a natural disaster, CMS has installed restrictions on a plan's ability to initiate disenrollment due to an extended absence from a service area of less than 6 months for MA and 12 months for Part D. CMS is also "encouraging" organizations and sponsors from dis-enrolling impacted beneficiaries for failure to pay premiums, and instead permitting plans to increase the grace period before disenrollment.[26] For exchange plans, CMS has allowed issuers to set "more generous deadlines for payments."[27]
- ***Waiver of Provider Enrollment Requirements.*** CMS allowed health care providers helping with response and recovery efforts to enroll as providers in federal health care

programs and receive temporary Medicaid billing privileges without requiring application fees, fingerprint-based criminal background checks, site visits, or in-state licensure.[28]

- ***Waiver of Provider Network Requirements.*** MA organizations and Part D sponsors are obligated to maintain patient access to benefits during a disaster by, for example, allowing the use of non-contracted health care providers, waiving the need for referrals where ordinarily required, and reducing patient cost-sharing amounts for non-network providers to levels that would apply for seeing an in-network provider.[29] In addition, Part D sponsors must ensure adequate access to out-of-network pharmacies when those enrollees cannot reasonably be expected to obtain covered drugs at a network pharmacy, whether in a natural disaster or not.[30] Unlike the other examples included above, these are regulatory requirements that do not require a waiver or order from CMS.
- ***Part D Prescription Refills.*** Part D sponsors are "expected" to lift their "refill too soon" system edits to permit early refills, and to allow an impacted enrollee to obtain the maximum extended day supply if requested and available at the time of refill. CMS does grant sponsors the "operational discretion" to determine how such restrictions would be lifted, as long as enrollees can still obtain access to medication at the point of sale.[31]

Florida, with its high population of residents on prescription medication and long history of hurricanes, has codified into state law more stringent prescription refill requirements during emergencies.[32] During a hurricane warning or other state of emergency, health insurers, managed care organizations, and other entities licensed by the Florida Office of Insurance Regulation that provide prescription medication coverage must waive time restrictions on prescription medication refills, including a mandatory suspension of electronic "refill too soon" edits at pharmacies to enable patients to refill prescriptions in advance if there are authorized refills remaining. Payers must also authorize payment to pharmacies for at least a 30 day supply of any prescription medication, regardless of when the prescription was most recently filled.

Despite the rigorous planning by health plans and time-tested accommodations offered by federal and state regulatory agencies, every catastrophic event exposes the practical challenges of operating in a disaster zone.

The Puerto Rico Office of the Insurance Commissioner imposed even stricter standards for prescription drug access and other allowances after Hurricane Maria. The Commissioner acknowledged in a September 28, 2017 normative letter that the extent of the damage caused by Hurricane Maria rendered insureds simply "unable to meet the requirements of their health care plans when requesting coverage or services."[33] Instead of "encouraging" extended grace periods for premium payments, Puerto Rico prohibited cancellation of an insurance policy or the denial of health care services for an insured's failure to pay premiums, though the agency also emphasized that the directive is not intended to mean forgiveness of the premium itself. The Commissioner also suspended all requirements used to manage prescription drug dispensing or authorization of health care services, such as prior authorization or referral requirements, and encouraged prescription drug refills for up to a 90 day supply.

Key Considerations for the Next Natural Disaster

Despite the rigorous planning by health plans and time-tested accommodations offered by federal and state regulatory agencies, every catastrophic event exposes the practical challenges of operating in a disaster zone. In Puerto Rico, much of the emergency preparation in advance of Hurricane Maria was predicated on the availability of at least some form of mobile communication, whether though cell phones, e-mail or two-way radios. Instead, the entire island lost the ability to

In many ways, payers are uniquely advantaged to participate in the disaster response and recovery process because of their extensive, day-to-day experience in managing care across the health system.

communicate in the days and weeks after the storm. Medical response teams dispatched to more remote areas could take up to 8 hours to make a 2 hour trip due to impassible roads and bridges. By the time these units reached a hospital or emergency shelter to assess the need for medical supplies and made the trip back, those needs could have changed dramatically. Individuals on the ground responsible for coordinating health care access were forced to improvise. Many relied on mobile app devices that could batch and send stored messages as cell signals faded in and out. Physicians would jot down prescription orders for insulin or tetanus shots and entrust the information to a helicopter pilot or volunteer. In fact, emergency response personnel would send critical orders to as many people as possible to increase the likelihood that someone could come through with the needed supply.

As difficult as these scenarios are to witness and experience, it is important for health plans and other stakeholders to learn from the often heroic efforts of those responding in the immediate aftermath of a natural disaster. While each disaster will bring different logistical challenges, health plans and regulating agencies should consider the following actions:

- ***Provide Specific Guidance on Requirements and Waivers During an Emergency.*** Both regulatory agencies and plans should offer practical and clear guidance on applicable requirements and waivers in advance of a natural disaster. After Hurricane Sandy in 2012, the HHS Office of Inspector General noted in its report on hospital emergency preparedness that impacted hospitals may have been confused about whether reimbursement was available for Medicaid patients receiving care in other states, and cites at least one example where a hospital transferred patients greater distances to in-state hospitals accordingly.[34] As another example, payers may permit health care providers additional time to file claims for reimbursement, but may not address scenarios where a provider's medical records may be unavailable or destroyed. Can a provider still file a claim with no supporting documentation? How can providers help reduce concerns of fraud or abuse when submitting such claims? Even though the risk of sanctions or penalties may be low during or immediately after a public health emergency, providers may wish to better understand how HIPAA waivers apply when, for instance, a physician needs to send a patient's prescription order to multiple individuals in order to locate a drug and get it delivered. Does this still comply with HIPAA's minimum necessary standard? While there is no hard and fast guidance that will apply in every situation, the use of real-world examples and practical direction can help focus health care providers on more important access to care issues.
- ***Outreach to High Risk Patients.*** Plans should consider a proactive and targeted outreach program to contact their most vulnerable members and determine the support they need in advance of an approaching emergency event. Such outreach can be conducted through automated calls or ideally, by existing care coordinators, case managers or call center personnel to ask patients about, for example, their current supply of oxygen or prescription medication, or whether they intend to evacuate and seek shelter. Plans may already identify patients with more complex medical needs through utilization reporting or participation in disease management programs and could quickly prioritize those members for outreach. Any accumulated information should be made available to emergency response teams as needed.
- ***Consider Longer Term Impacts.*** As the urgency of the immediate public health emergency subsides, plans must think ahead about longer term impacts caused by the natural disaster. Plans also should engage early with internal and external stakeholders on potential regulatory, operational or financial implications. For example, managed care plans required to lift all prior authorization and out-of-network restrictions for an extended period of time are likely to see impacts on risk and profitability, as will risk-bearing provider groups. If a plan assumes higher expenditures associated with the emergency response, how are those costs calculated for medical loss ratio purposes, and must plans take the hit? CMS has at least addressed impacts to MA and Part D Star Rating measures, and allows organizations and sponsors to contact CMS and auditors to discuss strategies to mitigate issues related to disruptions in business operations and care. For example, CMS will consider alternative sampling approaches, different measurement timeframes and the use of the prior year's score to help offset the impact.[35]
- ***Refine, Refine, Refine.*** While federal and state agencies require an annual review of business continuity or disaster

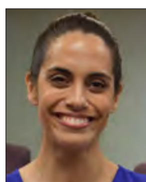
Thanks go out to the leaders of the Payers Plans and Managed Care Practice Group for sponsoring this feature: **Leah B. Stewart**, Dell Medical School at UT Austin, Austin, TX (Chair); **Xavier Baker**, Crowell & Moring LLP, Washington, DC (Vice Chair—Research & Website); **Ardith M. Bronson**, DLA Piper LLP (US), Miami, FL (Vice Chair—Publications); **Karen R. Palmersheim**, Cigna, Pasadena, CA (Vice Chair—Membership); **Melissa Wong**, Holland & Knight LLP, Boston, MA (Vice Chair—Educational Programs); **Janice H. Ziegler**, Dentons US LLP, Washington, DC (Vice Chair—Strategic Planning and Special Projects); **Kate McDonald**, McDermott Will & Emery LLP, Washington, DC (Social Media Coordinator). For more information about the Payers Plans and Managed Care Practice Group, visit www.healthlawyers.org/PGs. Follow them on Twitter @AHLA_PPMC.

response plans, plans should attempt to incorporate their lessons learned as early as possible after the event. Plans should solicit a wide range of opinions from employees and other stakeholders who played different roles in the emergency response, and encourage thoughtful and candid feedback about which safeguards worked and which did not.

» ***Work Your Connections.*** Plans may be expected to work with each other to exchange information on members or to coordinate logistics. As witnessed in Puerto Rico after Hurricane Maria, plan and agency attorneys played an important role in coordinating care and leveraged existing relationships and connections to help their communities. As just one of the many examples in which these individuals rose to the occasion, attorneys across a wide range of specialties banded together to help establish a warehouse distribution network for donated drug supplies. Within a matter of weeks, the team hashed out drug storage requirements, developed flow charts and requisition forms, drafted vendor contracts, and implemented an inventory management system to coordinate distribution of badly needed prescription drugs.

In many ways, payers are uniquely advantaged to participate in the disaster response and recovery process because of their extensive, day-to-day experience in managing care across the health system. Public and private health plans can and should seek to share these strengths when they are most needed. C

Melissa Wong is an associate in the health care and life sciences practice group in the Boston office of Holland & Knight LLP. She advises a wide range of clients on health care regulatory and transactional matters, with particular expertise in Medicare and Medicaid reimbursement and other regulatory compliance areas specific to managed care.



Marla Hadad is the director of legal affairs at the Puerto Rico Health Insurance Administration (PRHIA). She oversees all legal and compliance-related matters for Puerto Rico's Government Health Plan program, which insures nearly half of the island's population. Prior to joining the agency, Ms. Hadad worked as a litigator in private practice representing the PRHIA, among other clients.

Endnotes

1 80 Fed. Reg. 7912 (Feb. 12, 2015), implementing 42 C.F.R. § 422.504(o) and 42 C.F.R. § 423.505(p).
2 42 C.F.R. § 422.504(o)(1)(i),(ii)(A) and 42 C.F.R. § 423.505(p)(1)(i),(ii)(A).
3 42 C.F.R. § 422.504(o)(1)(ii)(B) and 42 C.F.R. § 423.505(p)(1)(ii)(B).
4 42 C.F.R. §422.504(o)(1)(ii)(B)(2) and 42 C.F.R. § 423.505(p)(1)(ii)(B)(2), incorporating 45 C.F.R. § 164.308(a)(7)(ii)(A),(C).
5 42 C.F.R. § 422.504(o)(1)(ii)(C),(D) and 42 C.F.R. § 423.505(p)(1)(ii)(C),(D).
6 42 C.F.R. § 422.504(o)(1)(ii)(E) and 42 C.F.R. § 423.505(p)(1)(ii)(E).
7 42 C.F.R. § 422.504(o)(1)(iii) and 42 C.F.R. § 423.505(p)(1)(iii).
8 42 C.F.R. § 422.504(o)(1)(iii)(B),(iv) and 42 C.F.R. § 423.505(p)(1)(iii)(B),(iv).
9 42 C.F.R. § 422.504(o)(1)(ii)(E) and 42 C.F.R. § 423.505(p)(1)(ii)(E).
10 42 C.F.R. § 422.504(o)(1)(ii) and 42 C.F.R. § 423.505(p)(1)(ii).
11 42 C.F.R. § 422.504(o)(2) and 42 C.F.R. § 423.505(p)(2).
12 42 C.F.R. § 423.505(p)(2).
13 CMS expressly incorporated compliance with all applicable federal, state, and local laws at 42 C.F.R. § 422.504(o)(1)(ii)(G) and 42 C.F.R. § 423.505(p)(1)(ii)(G).
14 Wash Rev. Code § 48.07.205 and Wash. Admin. Code § 284-16-710.
15 New York Dept. of Fin. Servs., Insurance Circular Letter No. 4 (Mar. 28, 2017), *available at* https://www.dfs.ny.gov/insurance/circltr/2017/cl2017_04.htm.
16 Nat'l Ctrs. for Environmental Info., Nat'l Oceanic and Atmospheric Admin., Billion-Dollar Weather and Climate Disasters: Overview (2018), *available at* www.ncdc.noaa.gov/billions/overview.
17 42 U.S.C. § 5121 et seq.
18 Public Health Service Act, P.L. No. 104-321, codified at 42 U.S.C. § 247d.
19 Social Security Act, § 1135, codified at 42 U.S.C. § 1320b-5.
20 42 U.S.C. § 1320b-5(a)(1).
21 42 U.S.C. § 1320b-5(a)(2).
22 42 U.S.C. § 1320b-5(b).
23 42 U.S.C. § 1320b-5(b)(7).
24 Section 1135 blanket waivers from 2017 are currently listed on the CMS website, *available at* https://www.cms.gov/about-cms/agency-information/emergency/hurricanes.html.
25 Letter from James Mulcahy et al., CMS, to All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations and Demonstrations (Sept. 28, 2017), *available at* https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Disaster-Memo-Medicare-SEP.pdf. *See also* Letter from Randy Pate, Director, Ctr. for Consumer Info. and Ins. Oversight, CMS, to All Federally-facilitated Exchange (FFE) Qualified Health Plan (QHP) and Stand-alone Dental Plan Issuers (Sept. 28, 2017), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2017-Hurricane-Disasters-Guidance.pdf.
26 Letter from James Mulcahy et al., CMS, to All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations and Demonstrations (Sept. 28, 2017), *available at* https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Disaster-Memo-Medicare-SEP.pdf.
27 Letter from Randy Pate, Director, Ctr. for Consumer Info. and Ins. Oversight, CMS, to All Federally-facilitated Exchange (FFE) Qualified Health Plan (QHP) and Stand-alone Dental Plan Issuers (Sept. 28, 2017), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2017-Hurricane-Disasters-Guidance.pdf.
28 *See, e.g.* CMS Announces Ongoing Efforts to Support Hurricane Irma Emergency Recovery, CMS (Sept. 13, 2017), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-09-13-2.html. *See also* Letter from Henrietta Sam-Louie, Assoc. Reg'l Administrator, Div. of Medicaid and Children's Health Operations, CMS, to Mari Cantwell, Cal. Dep't of Health Care Svcs. (Oct. 20, 2017), *available at* https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Medicaid-Provider-Enrollment-Section-1135.pdf.
29 42 C.F.R. § 422.100(m).
30 42 C.F.R. § 423.124(a).
31 Letter from Kathryn A. Coleman, Dir., Medicare Drug & Health Plan Contract Admin. Group and Amy Larrick Chavez-Valdez, Dir., Medicare Drug Benefit and C & D Data, CMS, to All Medicare Advantage Organizations and Part D Sponsors (Aug. 29, 2017), *available at* https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Reminder-Pharmacy-Provider-Federal-Disaster.pdf.
32 Fla. Stat. § 252.348.
33 Office of the Ins. Comm'r, Gov't of Puerto Rico, Normative Letter CN-2017-221-D (Sept. 28, 2017), *available at* http://ocs.gobierno.pr/enocspr/files/CN-2017-221-D-%20(ingles).pdf.
34 Office of Inspector Gen., Dep't of Health and Humans Svcs., Hospital Emergency Preparedness and Response during Superstorm Sandy, pgs. 22-23 (Sept. 2014), *available at* https://oig.hhs.gov/oei/reports/oei-06-13-00260.pdf.
35 Letter from Jerry Mulcahy et al., CMS, to All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations and Demonstrations (Sept. 28, 2017), *available at* https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Disaster-Memo-Medicare-SEP.pdf.