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CMS Issues DRAFT Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities

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Earlier this month, the Centers for Medicare & Medicaid Services ("CMS") issued draft "Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities" (the "Draft Guidance") intended to change earlier CMS guidance, which prohibited hospital co-location with other hospitals or healthcare facilities. The Draft Guidance plainly states that "[h]ospitals can be co-located with other hospitals or other healthcare entities"[1] and is designed to clarify how CMS and surveyors "will evaluate a hospital's space sharing or contracted staff arrangements with another hospital or health care entity when assessing the hospital's compliance with"[2] the Medicare Conditions of Participation (the "CoPs") for shared space, contracted services, and emergency services.[3]

Shared Space

To begin, the Draft Guidance distinguishes between distinct space and shared space. A hospital must maintain control over distinct spaces "at all times," making them unsuitable for co-location.[4] These distinct spaces include clinical spaces designated for patient care because sharing such spaces would risk patient safety and heighten concerns over patient management, patient privacy and security, and quality of care.[5]

By contrast, the Draft Guidance generally allows for sharing public spaces and public paths of travel used both by the hospital and by the co-located healthcare entity such as "public lobbies, waiting rooms and reception areas (with separate 'check-in' areas and clear signage), public restrooms, staff lounges, elevators and main corridors through non-clinical areas, and main entrances to a building."[6] This would not, however, included paths that pass through any clinical space.[7]

Contracted Services – Staffing Contracts and Clinical Services Contracts

Noting that services "such as laboratory, dietary, pharmacy, maintenance, housekeeping, and security" are commonly "provided under contract or arrangement with another co-located hospital or healthcare entity,"[8] the Draft Guidance focuses on two specific areas of contracting: staffing and clinical services.

Staff will not be permitted to "float" between the two entities during a single shift, to work at one entity while "on-call" at the other, or to provide services to the two entities simultaneously.[9] Staff contracted from a co-located entity "should receive appropriate education and training in all relevant hospital policies and procedures. The training and education should be the same training that would be provided to individuals who are direct employees of the hospital so that the quality of care and services being

provided is the same."[10]

Notably, a hospital that provides certain clinical services under contract or arrangement from a co-located hospital or other healthcare entity, "is not necessarily required to notify its patients and their representative of all services provided under contract or arrangement, as these services are provided under the oversight of the hospital's governing body and would be treated as any other service provided directly by the hospital."[11]

Emergency Services

As under prior CMS guidance, hospitals that do not have emergency departments need appropriate policies and procedures to address emergency care needs at all times.[12] The Draft Guidance clarifies that such policies and procedures should cover: (1) identifying when a patient is in distress, (2) how to initiate an emergency response, (3) how to initiate treatment, and (4) recognizing when a patient must be transferred to another facility for appropriate treatment.

A hospital may contract with a co-located hospital or healthcare entity to appraise and initially treat patients needing emergency case, but only if the contracted staff are not simultaneously working or on duty at the other entity.[13] CMS also recognizes that, in some instances, "appraisal and initial treatment performed in one hospital requires an appropriate transfer of the patient to the other co-located facility for continuation of care."[14]

A hospital without an emergency department that contracts for emergency services with a co-located hospital's emergency department is considered to provide emergency services and must meet the requirements of the Emergency Medical Treatment and Labor Act ("EMTALA").[15]

What's Next?

CMS is accepting comments on the Draft Guidelines until July 2, 2019, at which point CMS will finalize the policy. It will be important to review the final guidance, and not just the Draft Guidelines, before implementing directions.

[1](Draft Guidance at 1.)
[2](Draft Guidance Cover Memo. at 1; see also Draft Guidance at 5-8 (providing draft guidance to state surveyors).)
[3]The Draft Guidance "is specific to the requirements under general the hospital conditions of participation (CoPs) and does not address the specific location and separateness requirements of any other Medicare-participating entity, such as psychiatric hospitals, ASCs, rural health clinics, Independent Diagnostic Testing Facilities (IDTFs), etc." (Draft Guidance at 1.)
[4](Draft Guidance at 1.)
[5](Draft Guidance at 1-2.)
[6](Draft Guidance at 2.)
[7](Draft Guidance at 2.)
[8](Draft Guidance at 2.)
[9](Draft Guidance at 3.)

[10](Draft Guidance at 3.)
[11](Draft Guidance at 4.)
[12](Draft Guidance at 4.)
[13](Draft Guidance at 4.)
[14](Draft Guidance at 4.)
[15](Draft Guidance at 4.)

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