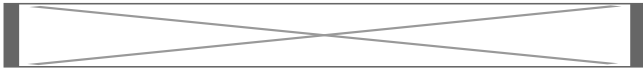

Insights

Should Co-Located Hospitals Hate Those Blurred Lines?

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At long last, the Centers for Medicare & Medicaid Services ("CMS") issued **final guidance** on hospital co-location with other hospitals and health care facilities ("Final Guidance"). Hospital co-location has been a compliance challenge for many due to CMS's piecemeal approach, which included a regional office letter issued in 2011, a PowerPoint presentation and, most recently, **draft guidance** issued in May 2019 ("Draft Guidance"). This piecemeal approach signaled CMS's preference for clear distinctions between co-located entities, but until CMS issued its final guidance, it was unclear whether CMS would make this preference its official position. Regulated entities thus had to make calculated decisions when determining how to structure any co-location to comply with the guidance.

The Final Guidance takes a more flexible approach to hospital co-location than the Draft Guidance, again blurring the lines between acceptable and prohibited hospital co-location arrangements. Where the Draft Guidance once drew a clear line regarding the expectations for separation and distinction of clinical space, allowing the sharing of public space, the Final Guidance blurs that line with added flexibility. Thus, entities can determine whether any shared space meets the Conditions of Participation ("CoPs"), particularly regarding patient safety and privacy.

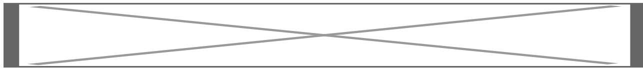
The flexibility may come with a downside. For instance, it is unclear how CMS and surveyors will interpret and apply flexibility to co-location arrangements. On the one hand, hospitals could utilize the flexibility to determine, for its organization, how to best co-locate with another hospital or healthcare provider in compliance with the CoPs; whereas on the other, the agency and surveyors could utilize the flexibility to limit such co-location, finding even common co-location situations to be "non-compliant."

Below is a list of areas characterized by flexibility and clarity in the Final Guidance.

Blurred Lines

The following identifies some of the areas that CMS loosened up in the Final Guidance, giving entities flexibility to interpret and apply.

- **Co-Located Entities.** Clarifies that references to "healthcare provider," for purposes of a hospital co-locating with a healthcare provider, does not include:
  - Critical access hospitals (CAHs) due to specific distance and location requirements.
  - Private physician offices, including those that may be participating in a timesharing or leasing agreement. This change could mean that a hospital co-locating with a physician office is outside the



scope of this Guidance or, alternatively, limit a hospital's ability to co-locate with a private physician office, although due to the lack of commentary on this provision, CMS's intent is unclear. Further insight will likely come when CMS Regional Offices and surveyors implement this Final Guidance.

- **Space.** Eliminates the discussion of separate and distinct clinical spaces (versus shared public spaces) and instead requires the hospital to have "spaces of operation consistent with the CoPs at 42 CFR Part 482".
    - Recommends that the hospital consider whether the hospital's spaces that are used by another co-located provider risk their compliance with the CoPs.
    - Requires demonstration of compliance regarding right to personal privacy, right to receive care in a safe environment, and right to confidentiality of patient records.
    - Provides an example of co-located hospitals sharing a supply room, within which each hospital identifies their supplies separately within the same space.
- **Staff.** Eliminates the interpretation that, in order for staff to be "immediately available," the staff cannot "float" or be concurrently "on call," between co-located entities during the same shift.
    - Removes the clarification that medical staff that are governing body approved, privileged and credentialed at each hospital, can be shared or "float" between co-located hospitals.
- **Clinical Services.** Eliminates the clarification regarding a hospital's notification to patients regarding providing certain clinical services under contract or arrangement.
- **Emergency Services.** Removes the discussion about a hospital contracting with a co-located hospital to provide emergency services during designated shifts.

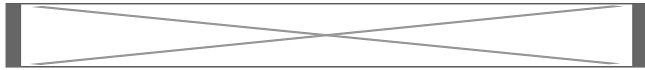
Clear Lines

While the Final Guidance eliminates much of the detailed discussion regarding co-located space, staffing, and emergency services, the Final Guidance retains some elements from the Draft Guidance. The Final Guidance continues to permit a co-located hospital to provide services, directly or under contract or arrangement, specifically including:

- Laboratory
- Dietary
- Pharmacy
- Maintenance
- Housekeeping
- Security
- Food preparation and delivery services
- Utilities such as fire detection and suppression, medical gases, suction, compressed air and alarm systems (such as oxygen alarms).

The Final Guidance also retains a hospital's ability to obtain staff under arrangement or contract from a co-located entity and confirms that a hospital can refer or transfer a patient with an emergency condition to the co-located hospital, for care beyond initial emergency treatment.

The Final Guidance and added flexibility may be welcome news for some and concerning for others. Regulated entities should closely monitor future communications, such as from CMS to state surveyors, to better understand CMS's intent and meaning behind some of its blurred lines. For questions regarding hospital co-



location and the impact of this Final Guidance, please contact **Meghan M. Linvill McNab** or **Brandon W. Shirley**.

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