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CMS proposes long-awaited draft guidance on co-located hospitals

May 17, 2019

On May 3, 2019, the Centers for Medicare & Medicaid Services (CMS) issued draft manual guidance[1] for surveyors evaluating whether hospitals that are co-located with other hospitals (or with other health care entities) meet the Medicare Conditions of Participation (CoPs). The draft co-location guidance is a long-awaited clarification of CMS's views regarding co-located hospitals' sharing of space and services – which has been an area of growing scrutiny as CMS has increasingly emphasized the need for co-located hospitals to "independently" comply with CoPs. In issuing the new proposed guidance, CMS stated that its objective is to allow some flexibility for co-located hospitals to share common areas and certain services, so long as patient safety and quality of care are adequately protected.

Although the draft guidance proposes to clarify when space, staff, contracted services, and emergency services may be shared, the draft guidance is far from comprehensive. Many questions remain. In a somewhat unusual step, CMS has provided an opportunity for stakeholders to comment on the draft guidance.

Although the draft guidance is most relevant to co-located hospitals, it may affect *all* hospitals (especially in the area of contracted services and contracted staff) because it interprets the CoPs, which are applicable to all Medicare-participating hospitals. The draft guidance may also carry implications for hospital provider-based spaces, which are more likely to be co-located with other health care entities (or otherwise organized in a manner that implicates sharing of space or staff). Hospitals may wish to seek further clarification from the agency and suggest ways in which the draft guidance could be refined or expanded.

Because guidance documents generally are not subject to rule-making requirements, CMS is not required to respond to comments or even publish final co-location guidance. As a result, it is not clear when, if ever, final guidance will be published.

Comments on the draft co-location guidance must be submitted by **July 2, 2019**. A summary of select significant provisions of the draft guidance follows.

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[1] CMS, Draft Guidance for Hospital Co-Location with Other Hospitals or Healthcare Facilities (May 3, 2019).

Shared and distinct space

CMS draws a distinction between "clinical spaces" and "shared spaces":

- Clinical space *cannot* be shared. CMS defines clinical spaces as "non-public spaces in which patient care occurs."
- Shared spaces *can* be shared, so long as both hospitals are individually responsible for CoP compliance in the shared spaces. CMS defines shared spaces to mean public spaces (e.g., lobbies, reception areas with clear and separate signage, public restrooms, staff lounges) and public paths of travel (that do not cross through clinical space).

Ambiguities remain, however. For example, although CMS suggests that at least some nonclinical, employee-only spaces (such as staff lounges) are considered "public spaces" that can be shared, the agency does not clarify whether this is true for all such nonclinical, employee-only spaces, such as conference rooms, and it also is not clear whether certain nonemployee (but nonclinical) spaces such as utility rooms and storage closets (containing supplies) can be shared.

Contracted staffing

The draft guidance states that co-located hospitals generally may share staff, so long as hospitals ensure that staff do not simultaneously serve the co-located entities and do not "float" by working for both entities during the same shift. This restriction on "floating" applies to most contracted staff, including supervising directors (e.g., lab, pharmacy, or nursing directors), but would not extend to medical staff (e.g., physicians), if they are privileged and credentialed at each hospital.

When using staffing contracts, CMS also proposes to require the hospital governing body to ensure:

- Adequacy of staff levels;
- Adequate oversight and periodic evaluation of contracted staff;
- Proper training and education of contracted staff, equal to the training provided to direct employees of the hospital;
- Contracted staff have knowledge of and adhere to the quality and performance improvement standards of the individual hospital; and
- Accountability of contracted staff related to clinical practice requirements.

Contracted services

CMS proposes that services may be provided under contract or arrangement with a co-located hospital (or other health care entity), such as laboratory, dietary, pharmacy, maintenance, housekeeping, and security services. Sharing is also permitted for food preparation and delivery services and for utilities (e.g., fire detection and suppression, medical gases, suction). It is not clear whether this is an exhaustive list of permissible contracted services, although it likely is not. It also is not clear whether there are certain services that might logically fall within this category, but that CMS would not permit to be shared.

CMS also does not fully explain how the requirements for contracted services interact with the requirements for contracted staff. For example, it is unclear in what situations (if any) contracted services are not considered to be furnished by contracted staff (and vice versa). This ambiguity is notable because of the extensive training requirements that CMS proposes when using contracted staff. It may be that CMS draws some distinction between contracts with a vendor entity for

certain services (e.g., housekeeping), where the vendor, rather than any specific individual, is the contract party and responsible for the service, versus contracts with individuals (e.g., direct arrangements with licensed practical nurses for independent contractor nursing services), but again this is not clear from the draft guidance. It may also be that Medicare draws a distinction between patient-care versus non-patient care activities. More likely, CMS's view is that any person providing contract services at a hospital must receive training and oversight relative to his or her function, regardless of whether the individual personally or a vendor company is the contract party.

Emergency services

The draft guidance also suggests that CMS will evaluate emergency services at co-located hospitals with heightened scrutiny. The guidance indicates that, if a co-located hospital has its own emergency department, the hospital *may* contract with its host hospital (or another entity) for the appraisal and initial treatment of patients experiencing an emergency – so long as the arrangement is properly structured and contracted staff are not working (or "on duty") simultaneously at two different entities.

CMS's proposed guidance for co-located hospitals that do *not* have their own emergency department is less clear. CMS proposes that if a co-located hospital does not have a distinct emergency department, CMS will require surveyors to evaluate closely whether the co-located hospital responds to its own emergencies (using appropriate staff) and has its own adequate and properly maintained emergency equipment. Further, CMS states that if a co-located hospital does not have an emergency department but contracts for emergency services through the emergency department of its host hospital, then the co-located hospital is subject to Emergency Medical Treatment and Labor Act (EMTALA) requirements.

That said, it appears that it would be permissible to use contracted staff to provide emergency-related services at co-located hospitals that do not have emergency departments – if the arrangement is operationalized in a manner that does not permit floating (e.g., the contracted staff being on duty at, or responding to emergencies at, two entities during the same shift). But the guidance is not clear on this point, and CMS may intend an alternative interpretation.

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The CMS draft guidance of course relates only to the Medicare CoPs (and one specific EMTALA consideration). As with all Medicare requirements – and particularly in this instance – providers should be aware of state licensure, certificate of need, building/life safety, and other potentially applicable state and local statutes and regulations that may impose requirements relating to shared space that are more stringent than those reflected in the draft guidance.

If you have any questions about the draft co-location guidance, please contact any of the listed Hogan Lovells lawyers.

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