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CMS Loosens Restrictions on Co-Located Healthcare Providers; Enforcement Interpretation Still to Be Determined

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On November 12, 2021, the Centers for Medicare and Medicaid Services ("CMS") revised and finalized draft guidance first issued on May 3, 2019, for co-location of hospitals with other hospitals or healthcare providers[1] (the "Finalized Guidance"). The Finalized Guidance is intended to guide CMS Surveyors in evaluation of such hospitals' compliance with Medicare Conditions of Participation related to shared space, services, and staff.

SPACE

The Finalized Guidance revises requirements for sharing space by loosening prior restrictions. The draft guidance required a co-located hospital to have "defined and distinct" spaces of operation over which the hospital maintained "control at all times," with no overlap in "clinical spaces." However, the Finalized Guidance removes the "defined and distinct" requirement, instead requiring only that the hospital "consider whether the hospital's spaces that are used by another co-located provider risk their compliance with these requirements." CMS advises that areas of such consideration may relate to "patient rights, infection prevention and control, governing body, and/or physical environment."

When assessing compliance of a co-located hospital's space, the Finalized Guidance makes clear that Surveyors are "not expected to be evaluating spaces for co-location"; Surveyors are to determine if the hospital being surveyed is in compliance with the Conditions of Participation, independent of the co-located provider. As such, the Finalized Guidance reduces the breadth of such surveys, including eliminating the requirements for Surveyors to undertake extensive floor plan reviews.

CONTRACTED SERVICES

The Finalized Guidance confirms that contracted services are acceptable for co-located facilities in numerous instances. The Finalized Guidance states that such 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."

This simplification extends to the survey guidance, providing that, “The procedures for surveying contracted services would be the same for co-located hospitals as it would be for surveying any other hospital that has contracted services.” The Finalized Guidance removes from the draft guidance the extensive requirements and guidelines for surveying contracted services of a co-located hospital, including (but not limited to) the review of documentation of how the contracted services are incorporated into the hospital’s Quality Assurance and Performance Improvement program.

STAFFING

The Finalized Guidance also makes significant changes to the guidelines for staffing. The draft guidance required any staff obtained “under arrangement” from another entity to “be assigned to work solely for one hospital during a specific shift,” disallowing such staff to “‘float’ between the two hospitals during the same shift, work at one hospital while concurrently being ‘on call’ at another,” or providing services simultaneously. The Finalized Guidance loosens these restrictions as well, requiring only that “there be evidence that the hospital’s staff are meeting the needs of patients for whom they are providing care,” as well as “statutory and regulatory requirements for the activity.”

EMERGENCY SERVICES

The Finalized Guidance removes the prohibition on hospitals without emergency departments arranging to have a co-located hospital respond to its emergencies “in order to appraise the patient and provide initial emergency treatment.”

For surveys, the Finalized Guidance streamlines requirements, delineating between co-located hospitals that have emergency departments or hold themselves out as providing emergency services 24/7 and those that don’t. For those that do, Surveyors will defer to emergency services and EMTALA requirements. For those that don’t, Surveyors simply have to assure that the co-located hospital’s medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.

IDENTIFIED DEFICIENCIES

Lastly, the Finalized Guidance also simplifies the guidelines for any deficiencies, requiring Surveyors to cite identified deficiencies “in the same manner as in other hospital surveys.” If the deficiency extends to the co-located provider, then the surveyor should determine if the cited deficiency warrants a complaint investigation of the co-located provider (if possible, while still on-site). These two separate surveys would result in two separate survey reports.

INDUSTRY RESPONSE

Largely, the Finalized Guidance has been lauded by industry stakeholders. As detailed above, the revisions provide significantly greater flexibility than the draft guidance that preceded it. However, some apprehension has been expressed, including concern over whether the Finalized Guidance provides sufficient clarity in how Surveyors will interpret and apply these guidelines and how these revisions will interplay with existing statutory and regulatory requirements, as well as state rules. Considering these concerns and the significant changes to co-location requirements initiated by the Finalized Guidance, co-located hospitals should proactively examine these relationships and their compliance with all applicable requirements.

FOOTNOTES

[1] The Guidance clarifies that the term “healthcare providers” does not include critical access hospitals, as such hospitals have specific distance and location requirements, nor to private physician offices, including those that may be participating in a timesharing or lease arrangement.

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