California Hospital Association

Federal Regulatory Summary

from the California Hospital Association

CHA EXECUTIVE SUMMARY – DECEMBER 2021

CMS Final Co-Location Guidance

Overview

On November 12, the Centers for Medicare & Medicaid Services (CMS) issued final revisions to its guidance to hospitals and health systems on co-location with other hospitals or health care entities. Specifically, QSO-19-13-Hospital, titled *Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities,* provides guidance to CMS and state agency surveyors on how to evaluate a hospital's space sharing or contracted staff and service arrangements with another hospital or health care entity when assessing the hospital's compliance with the Conditions of Participation (CoPs).

The final guidance makes key revisions to draft guidance issued in 2019, allowing for additional flexibility in these important arrangements. In the guidance, CMS expressly states that hospitals can be co-located with other hospitals or health care providers, whether on the same campus or within the same building. Each co-located entity is responsible for demonstrating its independent compliance with all applicable CoPs.

The guidance is specific to requirements of the hospital CoPs and does not address specific location and separateness requirements for any other Medicare-participating entity, such as psychiatric hospitals. CMS also notes that, due to specific distance and location requirements, the guidance does not apply to critical access hospitals (CAHs). However, CMS acknowledges that CAHs are permitted to enter into agreements with other providers, like physicians' offices, for shared space or contracted services, so long as they remain in compliance with applicable CoPs.

The guidance was effective upon issuance on November 12. CHA urges members to carefully review the guidance with legal and compliance departments. Questions about this summary should be directed to Megan Howard, vice president of federal policy, at (202) 488-3742 or mhoward@calhospital.org.

A high-level summary of the guidance's key provisions is provided below.

Key Provisions of Final Guidance

- **Space:** CMS clarifies that hospitals can share space with co-located entities; however, each hospital will be evaluated by itself for compliance with applicable CoPs. Hospitals should consider whether any space-sharing agreement will put CoPs compliance at risk, specifically focusing on potential issues around patient rights, infection prevention and control, governing bodies and/or physical environment requirements. Notably, CMS has removed specific references to sharing clinical vs. non-clinical space that were included in the 2019 draft guidance.

- **Contracted Services:** A hospital may enter into an agreement with its co-located facility for contracted services. CMS provides examples of such as laboratory, dietary, pharmacy, maintenance, housekeeping, and security services. The hospital must ensure that contracted services are being provided in compliance with the CoPs.
- **Staffing:** Hospitals may contract for staff from a co-located facility but must demonstrate that all statutory and regulatory staffing requirements are met, and that the hospital's staff are meeting the needs of their patients. All individuals providing services to a hospital patient, whether directly or under contract, should receive appropriate education and training in all relevant hospital policies and procedures as if each individual is a direct employee. When utilizing contract staff, the governing body is responsible for ensuring compliance under the CMS contracted services standard.
- **Emergency Services:** A hospital must have policies and procedures in place for addressing the emergency care needs of an individual even if the hospital does not have an emergency department. These policies and procedures should include (1) identifying when a patient is in distress, (2) how to initiate an emergency response (e.g., calling for staff assistance and the on-call physician), (3) how to initiate treatment (e.g., CPR and the use of an automated external defibrillator), and (4) recognizing when the patient must be transferred to another facility to receive appropriate treatment. It is permissible for a hospital to transfer patients with emergency conditions to a co-located acute care hospital for any care beyond initial emergency treatment.
- **Survey Procedures:** The guidance provides clarification for survey procedures related to space, contracted services, and emergency services. When surveying a shared space, surveyors are not expected to be evaluating spaces for co-location, but rather determining if the hospital being surveyed is in compliance with the hospital CoPs, independent of its co-located provider. However, if a deficiency is identified in the shared space of the hospital being surveyed, it could trigger a complaint for the co-located hospital. For contracted services, survey procedures would be the same for co-located hospitals as for surveying any other hospital that has contracted services. For emergency services, surveyors will determine if the hospital has an emergency department or is holding itself out as providing emergency services 24 hours a day, seven days a week. Where the hospital is not providing these services, the surveyor will look for compliance with applicable governing body requirements for having in place appropriate medical staff policies and procedures. For hospitals with an emergency department, surveyors will assess compliance with requirements for emergency services and ensure compliance with EMTALA requirements.
- **Identification of Deficiencies:** In instances where deficiencies are identified during a survey of a co-located hospital, the deficiency should be cited in the same manner as in other hospital surveys. The surveyor is responsible for determining the scope and pervasiveness of the deficiency and could determine that a cited deficiency warrants a complaint investigation of the co-located provider. If a complaint survey is authorized, it would result in two separate surveys with two separate survey reports.