NEW CO-LOCATION GUIDANCE PROVIDES LEEWAY FOR HOSPITALS – SURVEY IMPLICATIONS REMAIN UNCERTAIN

November 18, 2021

Co-location has continued to be a perplexing and often problematic analysis for hospitals when evaluating potential arrangements which involve sharing space, staff, or other resources with another co-located hospital or healthcare provider. Over recent years, CMS's policies on hospital co-location arrangements were not written in formal guidance but were communicated through survey activity and informal PowerPoint presentations. On May 3, 2019, CMS memorialized its policies in subregulatory guidance by publishing draft guidance for hospital co-location arrangements (the "Draft Guidance"). After more than two years, CMS has now finalized its guidance, but questions remain regarding the impact.

On November 12, 2021, CMS finalized its Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities. The guidance, which will be included in the State Operations Manual, Appendix A, is meant to provide clarity about how CMS and State Agency surveys will evaluate a hospital's sharing of space, staff, and contracted services with another healthcare provider located on the same campus or in the same building as the hospital. The final guidance is much broader than the initial Draft Guidance, seemingly providing greater leeway for hospital co-location arrangements. However, the final guidance places the burden on the hospitals to demonstrate the co-location arrangements comply with the Medicare Condition of Participation ("CoPs") and provides little detail on how such compliance will be surveyed.

A. CO-LOCATION ARRANGEMENTS WITH PHYSICIAN OFFICES

CMS guidance applies to arrangements in which a hospital is co-located with another hospital or healthcare provider. Notably, the newly issued guidance exempts private physician offices and critical access hospitals. This leaves more questions than answers. CMS did not clarify whether this was meant to allow physician offices to enter timesharing block lease agreements with hospitals, or if a physician office is prohibited from entering into any type of co-location arrangement.

B. SPACE SHARING

The final guidance requires hospitals to demonstrate that the co-location arrangements meet the relevant CoPs at 42 CFR Part 482. Specifically, the guidance states the areas of consideration "may relate to patient rights, infection prevention and control, governing body, and/or physical environment, among others." Unlike the Draft Guidance, the final guidance does not detail how these CoPs must be met when entering a hospital co-location arrangement. Consequently, hospitals may still want to look at the Draft Guidance. Under CMS's Draft Guidance, it was clear each co-located provider

must have defined and distinct spaces for operation. Clinical spaces designated for patient care must be located in these distinct spaces and cannot be shared between the co-located providers. Travel between the co-located providers using paths through clinical space was expressly not permitted. That being said, the co-located providers were permitted to share public spaces and public paths of travel such as lobbies, waiting rooms, reception areas (with separate "check-in" areas and designated signage), public restrooms, and elevator corridors.

C. STAFF SHARING

Another important area where CMS was not as descriptive in the final guidance, as compared to the Draft Guidance, is the sharing of staff between co-located healthcare providers. For example, the final guidance no longer explicitly prohibits staff "floating," but still requires hospitals to demonstrate compliance with the staffing requirements of the CoPs and for any of the services the hospital provides. Although this initially indicates more flexibility for staffing arrangements, the practical implications of the final guidance are consistent with the Draft Guidance. Under the Draft Guidance, staff could only serve one of the providers at a single time. Staff could serve both providers at different shifts, but staff could not "float" between the co-located providers during the same shift. The Draft Guidance remains relevant as certain CoPs continue to require staff to be "immediately" available.

Implicit in all these areas is that hospitals must individually and independently comply with the CoPs. For example, when considering space sharing, areas of consideration may relate to patient rights, infection prevention and control, governing body, and/or physical environment. Although the final guidance gives the appearance that CMS is allowing more flexibility and potentially minimizing the enforcement of co-location arrangements, providers should take caution as the guidance is clear that the CoPs must still be met. The prior Draft Guidance may serve as an important guide in how surveyors will apply the CoPs in co-location arrangements. What remains clear, is that providers must still meet all other regulatory requirements including Medicare provider-based rules and state licensure requirements.

If you have any questions regarding hospital co-location arrangements or CMS's final guidance, please contact a member of Hancock Daniel's Licensure, Certification and Enrollment team.