Washington State Hospital Association

July 1, 2019

Administrator Seema Verma
Centers for Medicare and Medicaid Services

Via email HospitalSCG@cms.hhs.gov

Re: CMS' DRAFT ONLY – Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities

Dear Administrator Verma,

On behalf of our 114 hospital and health system members, the Washington State Hospital Association appreciates the opportunity to comment on the DRAFT ONLY – Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities. Our letter commends the agency for its efforts to encourage flexibility in partnerships between hospitals and other health care entities and offers feedback aimed at the Centers for Medicare and Medicaid Services (CMS) providing increased clarity and more nuanced direction around this important issue.

Co-location arrangements between hospitals or between a hospital and another type of provider such as freestanding physician office, including space sharing in the same building or on the same campus, operational commingling and service sharing, are crucial tools to providing coordinated, efficient and cost-effective health care. Our members are dedicated to providing the safest and highest quality health care. We believe that the guidance should help foster greater utilization of these arrangements, which in turn will improve the delivery of services at the highest level.

We see several areas of opportunity for improving upon the draft guidance and hope you will consider our feedback and especially the feedback of our members. Many Washington hospitals and health systems have worked closely with CMS and Washington State Department of Health surveyors to achieve compliance on co-location. Their expertise is crucial to developing final guidance that reflects how these arrangements can and do operate to achieve safe, quality care and encourages the creative use of space that results in increased access to all range of services.

We also write to echo the comments submitted by the American Hospital Association (AHA), with which we fully agree.

In particular:

Implementation

- As a matter of implementation, **we recommend that this guidance be forward-looking.** It will be important for state surveyors and hospitals alike to be able to rely on previously established compliance for long-standing arrangements. A grandfather clause or the like will recognize the significant investments already made to comply with the Conditions of Participation and it will also ensure that hospitals do not need to revisit building or staffing plans so long as they were previously found compliant.[1]

[1] There is precedent for this approach. See the Bipartisan Budget Act of 2015, which applied a "site neutral" payment policy for only certain off-campus provider-based hospital outpatient locations established on or after November 2, 2015; those in existence on that date were excluded from the policy change.

- We also strongly endorse AHA's recommendation regarding the need for appropriate and thorough training of state surveyors to ensure that compliance is uniformly evaluated, and that hospitals who comply with the guidance are viewed as compliant by state surveyors.

Shared Space

- There are two areas where the guidance is silent and which we hope CMS will consider commenting on. First, we encourage CMS to comment on the use of "timeshare" agreements or physician leasing agreements, whereby hospital licensed space may be used for hospital services part of the time and physician services part of the time. Certain smaller and more rural hospitals may not have enough utilization to operate a clinic full-time, but their patients still require access to specialist services. We feel this is an important component of co-location arrangements and one that has potentially significant impact on many of our smaller members and their communities' access to services. Explicit guidance allowing for such arrangements will be important so that risk-averse hospitals and providers are encouraged, rather than deterred, to come up with creative solutions that meet the needs of their communities.
- Second, we encourage CMS to comment on co-location arrangements with provider-based clinics. We especially invite clarification and guidance on co-located sites involving a provider-based clinic and non-provider-based hospital outpatient department from separate hospitals that share the same floor or suite in a building and whether the same direction contained in the draft guidance governing co-location between hospitals and other health care facilities would apply (we believe it should).
- Regarding the distinction between distinct space and shared space, while we appreciate the underlying rationale for drawing bright lines – patient safety and privacy are top priorities for our members, too – we see several areas that warrant reconsideration or further clarity.
- First, the guidance is silent on support space such as utility rooms, medication rooms and staff work rooms. We recommend non-clinical, non-public spaces be explicitly identified as possible shared space, since there is no patient care impact and would encourage great utilization of space in a given location.
- Second, while we agree with and appreciate the utmost importance on maintaining patient privacy, we question the utility of maintaining separate check-in areas, especially for hospitals that may operated within a single health system or are part of the same Organized Health Care Arrangement (OHCA).[2] For instance, a small, rural health system may have two hospitals co-located and operating with one reception area. Under the draft guidance, it would seem that two receptionists would be required—one for each hospital. This could result in patients being underserved, while a receptionist sits idle. This would undermine patient care (insofar as the wait would prolong their visit and delay access to a provider) and increase costs without a corresponding patient benefit. Afterall, the patients' records would be on a shared electronic medical records (EMR) system. Relatedly, we also encourage the guidance to acknowledge the permissibility of shared EMR systems, which is elsewhere promoted within CMS as a matter of improving care coordination and overall quality of care. It is important to emphasize that these systems do not mean records are co-mingled. To the contrary, patient records of one hospital are distinct and separate from the records of another. Beyond that, one of the benefits of EMR systems are the safeguards to prevent unauthorized access. We have heard from several members that surveyors have questioned the use of a shared EMR system and

[2] AHIMA; United under HIPAA: a Comparison of Arrangements and Agreements (HIPAA on the Job); https://bok.ahima.org/doc?oid=60011#.XREVQVWpGUl

we encourage CMS to offer surveyors guidance to help them better understand the operability of these important tools.

- Third, even if CMS maintains the direction that some or all co-location arrangements require separate check-ins, **we encourage CMS to make explicit that it does not intend to be prescriptive about how the separate check-ins requirement should be implemented.** We understand from the June 27 listening session hosted by CMS subject matter expert on co-location, Danielle Miller, that it will be the responsibility of each co-located hospital to ensure patient privacy and they may do so in a variety of ways. This is invariably standard practice now and we are pleased to see that practice recognized.
- Fourth, we question the practicality of broadly restricting travel through a host hospital's clinical space. Ms. Miller reiterated this aspect of the draft guidance in the listening session. **We strongly endorse AHA's more practical approach to distinguishing between shared spaces and clinical spaces.** Some hallways may not be considered public paths of travel and may lead to clinical space insofar as they lead to care rooms but there is no risk to patient privacy in travelling these areas. In fact, overly broad conceptions of clinical space could actually compromise patient safety and undermine the provision of care by requiring a more circuitous, less efficient route to access contracted services.

Shared Staffing

- On shared staffing, **we recommend that the guidance explicitly permit co-located entities discretion to share non-clinical staff, as appropriate**. This would include care coordination staff (e.g. administrative and reception) as well as environmental services such as housekeeping, engineering, and infection control. Again, considering our smaller members, efficiencies of scale are crucially important in maintaining healthy operating systems, which in turn leads to great investments in patient care and quality innovation.
- Similarly, while we certainly appreciate and agree with the need for maintaining distinct nursing services, **we also strongly recommend the draft guidance draw more nuanced boundaries around which clinical and administrative staff may be shared between entities**. Specifically, we recommend that administrators, management and executives be explicitly permitted as shared resources and have the ability to "float" between entities. **We believe that a shared Director of Nursing or Chief Nursing Officer, for instance, would afford smaller health systems and shared entities important efficiencies with no discernable impact on patient safety and quality of care.** To the contrary, having one director serve both entities is in the best interests of patients. It will remove barriers and differences in processes that could otherwise invite, rather than reduce, the risk of error. Each individual hospital will still be staffed with appropriate registered nurses (RN) supervisors and of course, bedside RNs, all of whom are dedicated to that single licensed entity. However, applying this restriction to the leadership and executive levels will challenge workforce availability and cost containment—both of which impact on our members' ability to provide comprehensive services across all settings. Above all, a more coordinated approach is in the best interests of patients.
- **We also recommend a more nuanced approach to allowing non-bedside service lines to "float" between co-located entities**. For instance, there may be a small, specialty hospital located within a general acute hospital offering specific services to very few patients. These patients may require occupational therapy, respiratory therapy, physical therapy, pharmacy and other rehabilitation services. To require a tiny hospital to staff these occasional positions would be practically difficult from a workforce availability perspective and prohibitively expensive. We are especially concerned by Ms. Miller's comments that if a service is offered at all, it must be available at all times. Not all types of services are called for 24/7—physical therapy is not done

late at night, as one example. It would set an unworkable precedent to require these occasional services to be held to the same standard as, say, a bedside RN. We are concerned that this requirement, if maintained, would chill hospitals' efforts to provide these services due to workforce availability, cost, and patient safety concerns.

Contracted services

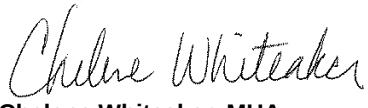
- We encourage CMS to provide greater direction about the training required of contracted staff. Presently, the guidance appears to require contracted individuals to receive the "same training" as employed staff. Taken literally, that would appear to create an unworkable standard in which less experienced and more general staff would be held to the same standard as staff with decades of experience on a specialty unit. We believe that CMS intended to establish a more reasonable standard in which all staff receive "appropriate education and training in relevant hospital policies and procedures" and that this includes training to familiarize contract staff with the applicable safety practices and patient care procedures relevant to a specific ward, but we have heard confusion that warrants clarity. Ultimately, patients require quality of care and services which are compliant with applicable regulations and standards of practice at all times, and that may be achieved through a variety of means, rather than identical ones.

Emergency services

- While we appreciate and agree with the importance of ensuring that both entities maintain individual access to emergency services, we strongly recommend that CMS adopt the AHA's suggestions on this section of the guidance. We wish to highlight two points. First, it is crucially important to distinguish between emergency departments and maintaining access to emergency services, including clear definitions and removing reference to EMTALA requirements. Second, we strongly encourage CMS to allow emergency services of the host hospital to be used by the co-located entity so long as that host hospital maintains additional emergency services so there is no possible gap in coverage. That is, emergency services may be a shared service for the co-located hospital. In this case, the co-located hospital and host hospital's access to emergency services would be no different from a single hospital with a single emergency response team and the possibility that the hospital faces multiple code blues at same time. Co-located hospitals should not be held to a different standard than a single hospital.

Again, thank for you the opportunity to comment on this proposed guidance. Please feel free to contact me with any questions or have a member of your team contact Jaclyn Greenberg, Policy Director, Legal Affairs.

Sincerely,



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