North Carolina
Healthcare Association

Uniting hospitals, health systems and
care providers for healthier communities

July 2, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W. Room 445-G
Washington, D.C. 20201

Ref: Guidance for Hospital Co-Location with other Hospitals

Dear Ms. Verma:

On behalf of the 130-member hospitals and health systems in our state, the North Carolina Healthcare Association (NCHA) appreciates the opportunity to comment on changes proposed to the Interpretive Guidance for Co-location for Hospitals and/or other healthcare entities.

In the guidance, *Distinct Space* is described as clinical areas designated for patient care and established for protection of patients' privacy, safety and confidentiality. Differences in infection control, security and requirements are stated as rationale for maintaining distinct space, and the conclusion that a pathway through a co-located hospital clinical space would not be acceptable. *Shared spaces* include public spaces that are used by the pubic and/or both parties, and the guidance indicates they can be shared.

Page 1 of the May 3 draft guidance letter discusses that hospitals may co-locate with hospitals or other healthcare entity(s) in part or in full, provided each provider can demonstrate independent compliance with the hospital Conditions of Participation. However, it is not clear whether, or how this requirement would pertain to non-hospital co-located entities.

- In its final guidance CMS should clarify the what kinds of facilities are included in the term "healthcare entity," and should establish whether the Hospital Conditions of Participation (Appendix A) or another "healthcare entity" CoP's would be applied to that facility if surveyed under this provision.

Page 2 of the May 3 draft guidance letter establishes that travel through clinical spaces of a hospital by a co-located entity would not be acceptable, even though patients and members of the public do often travel through clinical areas within a hospital.

- We recommend that CMS refrain from a prohibition from transiting through a clinical space in a co-located hospital simply because of its location on a floor plan. Hospitals have processes in place for infection control and protection of personal and medical record privacy. Rather than a prohibition, CMS should establish a means to safely permit these transitions as the alternative may involves costly construction and limits on access to care.
- CMS should also clarify and specifically permit planned use of, distinct or clinical spaces in a co-located hospital for emergencies, such as during an evacuation, if it can provide a safer means of egress for staff and patients.

The requirement in the draft guidance letter discusses that staff cannot "float" between the two hospitals during the same shift, work at one hospital while concurrently being "on-call" at another, and may not be providing services simultaneously. However, it also states that this does not necessarily preclude these individuals from serving those roles in both hospitals, but it cannot be *simultaneously*. The ability of one director to serve multiple entities simultaneously, however, differs from direct care staff and should be retained. Often a common director

can improve service coordination and provide better oversight of both providers, adding improvements to patient care.

- We recommend that guidance be provided that clarifies that (non-caregiving) staff working in registration and other shared spaces can be shared between co-located providers and request that CMS describe any specific documentation requirements it would have for staff in that situation.
- We recommend CMS revise the first paragraph on page three to remove the proposed language prohibiting director "floating" and replace it with the express allowance for co-located entities to have one director of a department, should they choose to do so.
- We recommend that CMS provide further clarification on whether it has specific concerns regarding "shift" length, (such as whether it should be for a minimum number of hours) and should recognize that a direct care employee or a contracted direct care employee could work distinct shifts for both co-located entities as long as they are not working for both providers simultaneously.
- In communications we've received from *Hall Render*, CMS indicated that co-location guidance would allow timeshare arrangements in provider-based space that met the Stark law exception at 42 C.F.R. § 411.357(y). Therefore, if a hospital or CAH entered into an arrangement with a provider that meets the Stark Law exception, the provider may use the hospital/CAH waiting room, registration desk or other space without implicating the co-location restrictions. Under that interpretation, hospitals and CAHs would be afforded greater flexibility, especially in visiting specialist scenarios. We ask that CMS clarify how it would view these arrangements in its final guidance.

Emergency Services are discussed on page 4 of the May 3 draft guidance letter.

- While hospitals are not required to have an Emergency Department, patients undergoing diagnostic procedures and treatment at hospitals may experience emergency situations. We understand that such hospitals must have specific policies in place to provide emergency care, but seek clarification of the references to EMTALA, (which typically pertain to Emergency Department services to the community) and the requirement that the hospital meet EMTALA requirements if it has emergency services provided under a contract with an emergency department of a co-located hospital.

NCHA thanks CMS for providing this long awaited guidance, and for the opportunity to provide comment.

Sincerely,

Stephen J. Lawler
President
North Carolina Healthcare Association