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CLIENT ALERT

CMS Releases Draft Guidance on Shared Space Arrangements

By Arthur J. Fried and Sidra S. Zaidi

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The Centers for Medicare & Medicaid Services ("CMS") recently released draft guidance for state survey agencies regarding shared space and co-location arrangements between hospitals and other hospitals or health care entities.[1] The draft guidance provides much-anticipated insight on how state surveyors are expected to assess the manner in which hospitals may share space, clinical services, and staff with other co-located hospitals and health care facilities, which will have significant implications for Medicare and Medicaid billing and reimbursement. In sum, the draft guidance would, if finalized without change, clarify CMS rules surrounding the definition of "shared space" so as to clearly prohibit certain shared space arrangements. While a hospital can be located on the same campus of or in the same building used by another hospital or health care facility, the draft guidance states that the hospital may not share space other than public spaces and public paths of travel that are utilized by both the hospital and the co-located hospital or health care entity, with certain exceptions.

If the draft guidance is adopted in its present form, hospitals may be restricted in their ability to enter into certain leasing arrangements. Hospitals and co-located health care entities, such as federally qualified health centers and ambulatory surgical centers, that have questions about the draft guidance should consider submitting comments to CMS. **Comments on the draft guidance are due by July 2, 2019.**

The Draft Guidance, Generally

At the outset, CMS clarifies in the draft guidance that under the Medicare Conditions of Participation ("CoP"), hospitals are permitted to co-locate with other hospitals or health care entities. CMS further states that federal agency and state agency surveyors will assess CoP compliance with respect to a hospital with shared or co-located space or shared staff. The draft guidance also clarifies that, while co-location is permitted, all co-located hospitals "must demonstrate separate and independent compliance with the

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[1] U.S. Dep't. of Health & Human Services, Centers for Medicare and Medicaid Services, QSO-19-13-Hospital (May 3, 2019), *available at* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-13-Hospital.pdf.

hospital CoPs," and that any noncompliance with the CoPs identified in one entity's space may be identified as noncompliance for the other entity.

Distinct Space and Shared Space

CMS states that "distinct" clinical space is necessary to protect patients' rights to personal privacy and confidentiality of medical records. The draft guidance therefore limits "shared spaces" to public spaces and public paths of travel that are utilized by both the hospital and the co-located health care entity. CMS provided examples of such approved shared spaces to include:

- public lobbies, waiting rooms, and reception areas (but only if there are separate "check-in" areas and clear signage);
- public restrooms;
- staff lounges;
- elevators;
- main corridors through non-clinical areas; and
- main entrances to a building.

CMS further states that non-public paths of travel include (1) a hallway, corridor, or path of travel through an inpatient nursing unit or (2) a hallway, corridor, or path of travel through a clinical hospital department. The draft guidance states that such space must remain separate and distinct and may not be shared.

The draft guidance further instructs state surveyors to review floor plans for compliance with rules regarding "distinct" versus "shared" space. The floor plan must clearly identify which health care entities use the spaces. The surveyors are also required to ask hospital leadership to provide a list of all services that the hospital has contracted to use from the other co-located entity or health care entities to ensure that the spaces are clinically distinct. If both entities utilize the same space, then it is expected that any noncompliance found in that space could be considered noncompliance for both entities.

Sharing of Contracted Staff and Services

The draft guidance states that hospitals may share contracted services, such as laboratory, dietary, pharmacy, maintenance, housekeeping, food preparation, and delivery and security services, with other co-located hospitals and health care entities. In addition, the draft guidance states that two entities may share utilities, such as fire detection and suppression, medical gases, suction, compressed air, and alarm systems, such as oxygen alarms.

Sharing of Staffing Contracts

The draft guidance does not totally prohibit hospitals and other co-located hospitals or health care entities from sharing staff that are under contract, but it does place restrictions on such arrangements. The general rule offered under the draft guidance is that staff employed by, or contracted to work for, co-located entities may only provide services for one entity at a time. For example, the draft guidance states that employed or contracted staff may not be on a shift at one hospital and on call at another at the same time and/or may not "float" between two hospitals during the same shift. The draft guidance emphasizes that shared nursing staff arrangements are especially concerning from a compliance perspective.

However, it appears that the draft guidance would allow medical staff to be on call at two entities at the same time, as long as the governing body of each entity approves of such arrangements and the staff are privileged and credentialed at each entity. Nevertheless, hospitals should request clarification as to this point, because the draft guidance is unclear regarding the extent to which medical staff may be shared between co-located entities.

Emergency Services

The draft guidance states that hospitals without emergency departments must continue to have appropriate policies and procedures in place for addressing emergency care needs 24 hours per day and seven days per week. The draft guidance clarifies that such policies and procedures should do the following: (1) identify when a patient is in distress, (2) explain how to initiate an emergency response (e.g., calling for staff assistance and the on-call physician), (3) clarify how to initiate treatment (e.g., CPR and the use of an automated external defibrillator (or "AED")), and (4) recognize when the patient must be transferred to another facility to receive appropriate treatment. Hospitals are required to identify potential emergency scenarios depending on the patient population they routinely serve and design their emergency services policies and procedures to take them into account.

The draft guidance sets out specific rules for dealing with emergencies where space or staff are shared between entities. For instance, the draft provides that a host hospital may permit its staff to perform other duties within the hospital and be immediately available for emergency assistance at the co-located hospital, but the staff may not perform duties at the co-located entity during that shift. However, a hospital without an emergency department may not generally arrange to have another co-located hospital respond to its emergencies by evaluating the patient and providing initial emergency treatment.

The draft guidance distinguishes shared space emergency services rules from obligations under the Emergency Medical Treatment and Labor Act ("EMTALA"). In particular, CMS acknowledges that a transfer from a hospital (such as a rehabilitation hospital) to a co-located hospital with separate acute care may be warranted if the hospital cannot provide care beyond initial emergency treatment.

Finally, the draft guidance notes that hospitals without emergency departments that contract for emergency services with another hospital's emergency department are considered to provide emergency services and must meet the requirements of EMTALA.

Discussion

While the draft guidance clarifies that CMS defines "shared space" to include public thoroughfares and provides insight on how hospitals may share space and staff, particularly for emergency or on-call services, the proposal points out the significant limits applicable to the sharing of clinical space by hospitals with other hospitals or health care providers/entities. The draft guidance could have a substantial impact on hospitals and co-located health care entities, especially where an entity desires to lease clinical space from the hospital that is not physically distinct. Hospitals may therefore wish to submit comments to CMS on this aspect of the draft guidance.

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This Client Alert was authored by **Arthur J. Fried** *and* **Sidra S. Zaidi.** *For additional information about the issues discussed in this Client Alert or if you have questions about comment submissions or shared space arrangements more broadly, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*