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By Nina Youngstrom

In May 3 draft guidance on co-location, CMS said hospitals may share nonclinical space with another hospital or entity without risking their Medicare certification, but the same isn't true of clinical space. CMS also said sharing workers is possible if they don't overlap shifts, according to its *Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities*, which looks at co-location through a health and safety prism.

The guidance will be used by surveyors to determine compliance with the Medicare conditions of participation (CoP) for hospitals on sharing spaces, services, personnel and emergency services. In the draft, "you can share common areas, but you can't share clinical areas," says attorney Larry Vernaglia, with Foley & Lardner LLP in Boston. Sharing waiting rooms and reception areas with other providers is the primary concern of many hospitals, he explains. "But the guidance hasn't solved time shares—the ability to have the hospital rent out some clinical space for physicians to use either exclusively or nonexclusively for a period of time," Vernaglia says.

CMS is asking for feedback on the draft by July 2, so there may be revisions before it's finalized. "Nobody should make expensive changes to their facility until the final version," he notes.

This Is First Formal Co-Location Policy

This is the first formal policy on co-location, which often takes the form of independent physicians leasing space in provider-based facilities but encompasses other arrangements, including unrelated hospitals locating on a hospital campus or inside its building. CMS has frowned on co-location, but there's no regulation prohibiting it, and surveyors and regional offices have been inconsistent in their enforcement. Hospitals are anxious about the possibility of recoupment for noncompliance with provider-based rules or citations for Medicare CoP deficiencies, and some steer clear of co-location. But they got a glimmer of hope for co-location in March, when CMS said it would publish guidance on co-location ("Guidance on Co-Location in Provider-Based Space Is Coming; Yes to Elevators, No to Staff," *RMC* 28, no 11). Here it is, and although CMS didn't specifically mention physicians, it references suppliers, which is how Medicare categorizes physicians, Vernaglia says.

"It's interesting CMS acknowledges this is a clear change in policy and that its prior guidance on co-location may have been too prescriptive," says attorney Sara Iams, with Polsinelli in Washington, D.C. Often when CMS changes course, it uses the term "clarification."

The draft emphasizes that co-located hospitals must separately comply with the CoPs, and it must be clear to patients (e.g., at check-in) which entity is providing services. But within certain parameters, hospitals would be able to share some space and staff. The main distinction is clinical.

"Travel between separate entities utilizing a path through clinical spaces of a hospital by another entity co-located in the same building would not be considered acceptable as it could create patient privacy, security, and infection control concerns. Clinical space is any non-public space in which patient care occurs," the draft guidance states. "It is the responsibility of both the hospital and the co-located healthcare entity to protect and

provide a safe environment for their patients and potential risks could result in non-compliance."

Nonpublic paths of travel are closed to co-location. They are hallways, corridors or paths of travel through an inpatient nursing unit or an outpatient clinic, emergency room, pharmacy, lab, operating room, post-anesthesia care unit or imaging services.

But co-location is now open for "public paths of travel," which includes main hospital corridors with "distinct entrances to departments (such as outpatient medical clinics, laboratory, pharmacy, radiology)."

Iams says this is "bright-line guidance" between spaces they expect to be exclusively hospital vs. shared. "The guidance is fairly general, and my guess is they are looking for [feedback] to pinpoint where the gaps may be, where it may be difficult to apply in individual fact patterns, and how they could clarify the way they describe the various limitations," she says.