



Submitted electronically via [HospitalSCG@cms.hhs.gov](mailto:HospitalSCG@cms.hhs.gov)

Association of  
American Medical Colleges  
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399  
T 202 828 0400  
www.aamc.org

July 2, 2019

Ms. Seema Verma  
Administrator  
U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, MD 21244-1850

***RE: DRAFT ONLY – Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities (Ref: QSO-19-13-Hospital)***

Dear Ms. Verma:

The Association of American Medical Colleges (AAMC or the Association) welcomes the opportunity to comment on the “Draft Guidance for Hospital Co-Location with Other Hospitals or Healthcare Facilities” (Ref: QSO-19-13-Hospital) issued May 3, 2019 by the Centers for Medicare & Medicaid Services (CMS or the Agency). We thank CMS for soliciting stakeholder feedback on this draft guidance that seeks to clarify how surveyors will evaluate co-located hospitals’ compliance with Medicare’s Conditions of Participation (CoPs). We hope that CMS will follow this practice in the future for draft CoP guidance as well as other subregulatory guidance such as manual instructions. The AAMC supports CMS’s intent to clarify CoPs for co-located hospitals. As is outlined below, we suggest that CMS provide further clarifications and revisions in the draft guidance.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America’s medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

#### **TERMINOLOGY NEEDS TO BE DEFINED**

Throughout this document CMS uses terms that are undefined or otherwise confusing. For instance, it would be helpful if CMS would distinguish the hospital to which it is referring by using terms such as “host hospital” and “co-located hospital” rather than referring to each entity simply as a “hospital.” Additionally, we request that CMS define the term “other health care entity” used within the draft guidance. For example, would an inpatient hospice unit on a leased floor of a hospital be considered a health care entity or a co-located hospital. Further clarification of CMS’s definition of “emergency services” would be welcomed.

## **DISTINCT SPACE AND SHARED SPACE**

The draft guidance seeks to draw a distinction between distinct and shared spaces as they relate to co-located hospitals. It outlines that distinct spaces are clinical areas used for patient care and shared spaces are public spaces and public paths utilized by both the hospital and co-located health care entity. While we agree that patient privacy and safety are priorities, we question CMS's rationale for limiting patient transport through a distinct space of another hospital.

The draft guidance suggests that patient transport through a clinical unit (distinct space) of a co-located hospital would not be permissible under the new guidance. That this is a common practice and permissible within the space of a single hospital is evidence that patient safety is not compromised. Patient transport between co-located hospitals should not be treated any differently as it does not raise any new health or safety concerns. If the fastest way to another point in the hospital is through a clinical area, then sick patients should not be subject to additional transport time solely to bypass a distinct space. Transporting a patient through public hallways could threaten patient privacy or expose patients to risks that are minimized in patient care areas. Moreover, some clinical areas, such as inpatient units, actually may provide enhanced patient privacy as compared with a hallway traveled by the public. The decision on the best route to transport a patient should be at the discretion of the host hospital based on considerations such as safety, patient privacy, noise, and volume of traffic.

Additionally, due to design and space limitations some hospitals, particularly older ones, have no choice but to transport patients through co-located clinical areas but when this is necessary, care is taken to ensure patient privacy and dignity during transport. Therefore, co-located hospitals should not be penalized due to the structure of the hospital and therefore should be grandfathered and deemed in compliance with the CoPs.

## **CONTRACTED SERVICES – STAFFING**

That draft guidance states that if a co-located entity chooses to use contracted staff, the staff must be assigned to one entity for the entire shift and cannot "float" between the co-located entities during any given shift. This is contrary to the way in which some hospital staff are utilized in a clinical setting. It is not uncommon for hospital staff to work in different parts of the hospital for all or part of an assigned shift in order to accommodate patient care. For example, nursing staff are usually assigned to a unit – whether their home unit or "floated" to another unit – and provide patient care in that unit only during a designated portion of a shift. They are not responsible for care on another unit. For some hospital staff, such as nurses assigned to units, it is not unreasonable for CMS to require that when contracted staff work in one hospital during a shift there is a clear delineation of the time that is spent at the host hospital and the co-located hospital.

However, there are other hospital staff that may provide services between the co-located hospitals. For example, directors should be able to serve both entities at the same time when appropriate. A single pharmacy director, for instance, would be able to ensure a uniform prescribing process and proper oversight of both the host and co-located hospitals. This supports higher-quality patient care and more efficient and effective prescribing. Examples of other positions that should be allowed to float include laboratory technicians that collect blood and physical and respiratory therapists that deliver treatments on the units where the patients are located. Additionally, there may be times when discharge planners, social workers or infection control personnel are required to work between the two entities. These staff

are not responsible for the continuous care of the patients they serve. The staff cover multiple units and provide specific services for which they are trained allowing patients to receive treatment without having to travel throughout the hospital. Therefore, we request that CMS permit contracts between co-located facilities to allow patients to be served by any employee who does not have designated responsibility for the continuous care for a group of patients.

We appreciate the agency's commitment to ensuring that staffing levels are adequate and staff are appropriately trained. In order to better account for the importance of meeting these requirements, we urge CMS to add language permitting the delegation of assurances concerning staffing contracts to each entity's respective clinical leadership groups that handle these issues if applicable. These clinical leadership groups are more experienced in these issues and better positioned to respond to any inquiries that may arise.

During CMS's hospital co-location listening session held on June 27, 2019, CMS staff acknowledged that the guidance was silent on the definition of a "shift." Therefore, we ask that CMS allow each hospital to define the term "shift" to meet its own staffing need. It would be reasonable for the Agency to require that this definition be written and available to surveyors. Additionally, the draft guidance notes contracted staff should receive education and training in all relevant hospital policies and procedures similar to training for direct employees of the hospital and hospitals must provide documentation that such training has been satisfied. The Association believes that documentation of contract staff training should be consistent with hospitals' documentation for permanent staff.

## **EMERGENCY SERVICES**

The draft guidance would permit a hospital to contract with a co-located hospital or entity for the appraisal and initial treatment of patients needing emergency care, only if the contracted staff are *not* working or on duty simultaneously at the other entity. While we understand that CMS's primary concern is with patient health and safety, we do not agree that under all circumstances of being on duty simultaneously at the host and co-located hospitals should be prohibited.

Routinely, employees of the acute care hospital – doctors, nurses and other allied health professionals – are assigned to a code team or rapid response team. These individuals usually work in the intensive care units or emergency departments of the acute care hospitals where advanced training is provided. The draft guidance suggests that if a code team responds to an emergency at a co-located facility, then it would not be immediately available to respond to an emergency within the hospital to which it is assigned. However, at academic medical centers there are multiple designated code teams immediately available to attend to emergencies at any given time during the day as it is not uncommon for a single hospital to need multiple code teams simultaneously. Code teams routinely respond to various locations – *e.g.*, inpatient units, rehab and outpatient facilities – throughout the health system campus. Code teams also use a triaging technique to handle multiple codes within their own hospital and these techniques can be used to guide code response between the co-located hospitals. As long as the host hospital meets the CoPs regarding the availability of addressing emergencies, then it should be allowed to provide a code team to the co-located hospital and other co-located units.

Additionally, the draft guidance does not provide a safety rationale for this proposal. For example, it is advantageous for a rehab hospital to utilize response teams from a co-located acute care hospital. Acute care hospital code teams successfully manage and respond to a variety of emergency events throughout

the hospital campus. Since early intervention by high-skilled health care professionals during medical emergencies often results in positive long-term health care outcomes, we believe that limiting a co-located hospital's ability to contract with the acute care hospital for these services would impact patient care. CMS can ensure that patient safety is not compromised by looking at response time metrics.

#### **MEETING EMTALA REQUIREMENTS**

Page 4 of the draft guidance states that:

Hospitals without emergency departments that contract for emergency services with another hospital's emergency department are then considered to provide emergency services and must meet the requirements of EMTALA.

The draft guidance states on page 7 that:

[h]ospitals without emergency departments that contract for emergency services with another hospital's emergency department are then considered to provide emergency services and must meet the requirements of EMTALA.

The meaning of both statements is unclear. Is the meaning that when a co-located hospital contracts with a host hospital for emergency services, the host hospital must meet EMTALA requirements? Or is the meaning that if a co-located hospital contracts with a host hospital for emergency services the co-located hospital must meet EMTALA requirements? If the former, CMS should clarify. If the latter then, as described below, the AAMC believes that CMS does not have the authority to apply EMTALA to the co-located hospital.

The Emergency Medical Treatment and Active Labor Act (EMTALA) applies to "a hospital that has a hospital emergency department" (42 USC §13955dd) and the EMTALA requirements are triggered when a patient comes to that emergency department. The EMTALA regulations apply when a hospital has a "dedicated emergency department" which is one that meets at least one of the following requirements:

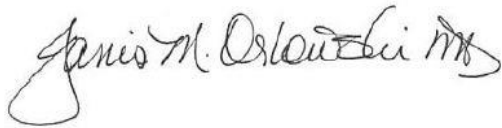
1. It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. (42 CFR §489.24(b).

Quite simply, a co-located hospital meets none of the requirements that indicate that a hospital has a "dedicated emergency department." Since EMTALA requirements are not triggered until an individual comes to a hospital's dedicated emergency departments and requests treatment for a medical condition, CMS cannot use subregulatory guidance to impose those requirements on" hospitals without emergency departments." (page 4 of Draft Guidance)

**CONCLUSION**

Thank you for the opportunity to comment on the Draft Guidance for Hospital Co-location. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic medical community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at 202.909.2084 or [mmullaney@aamc.org](mailto:mmullaney@aamc.org).

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orlowski MD". The signature is written in a cursive style with a large initial 'J' and 'M'.

Janis M. Orlowski, M.D., M.A.C.P.  
Chief Health Care Officer, AAMC

cc: Ivy Baer, AAMC