THE RISKY BUSINESS OF CO-LOCATION ARRANGEMENTS: WHAT HOSPITALS AND OTHER PROVIDERS SHOULD KNOW

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Introduction

Under pressure to control costs and enhance quality, hospitals and other health care providers are focusing strategy initiatives on achieving greater integration and collaboration between different Medicare-certified providers and suppliers. Co-location arrangements between different Medicare-certified providers and suppliers give the outward appearance of an astute business solution to help many health care providers achieve their strategic goals. Indeed, space sharing and co-location arrangements tend to enhance patient conveniences, improve continuity of care, mitigate unnecessary duplication of overhead costs, and present other cost-sharing opportunities relating to personnel, administrative services, and equipment expenses. However, this good business solution turns into “risky business” if health care leaders move forward with a co-location arrangement unaware of the regulatory parameters in which Medicare-certified providers and suppliers must operate.

The Risky Business of Hospital Co-Location Arrangements

Shared Space Arrangements May Jeopardize Provider-Based Status

Never before has a hospital department’s provider-based status been more vulnerable to government scrutiny than it is today. This increased scrutiny stems from the government’s push to contain costs within the Medicare program, including the facility fees paid to hospitals under the Outpatient Prospective Payment System (OPPS) for outpatient services provided in hospitals and their provider-based departments. In 2012, the Medicare Payment Advisory Commission (MedPAC) raised concerns over increasing costs attributable to provider-based payments and recommended that the Centers for Medicare & Medicaid Services (CMS) align payment rates between provider-based and freestanding entities. Noting MedPAC’s concerns, the Office of Inspector General (OIG) included “provider-based status” as an enforcement initiative in its fiscal years 2013, 2014, and 2015 annual Work Plans, and has sent surveys to hospitals requesting detailed information on their provider-based departments. The Department of Justice recently announced a $3.37 million settlement with a New York hospital following the hospital’s self-disclosure of non-compliance with the provider-based requirements at its hyperbaric oxygen therapy program.

To qualify for payment under the OPPS, a hospital’s provider-based department must comply with CMS’ provider-based regulation, which requires provider-based departments to be under the name, ownership, and financial and administrative control of the main hospital. Among many other requirements, the provider-based regulation requires the provider-based department to be held out to the public as a department of the hospital so that the department’s patients know to expect the higher hospital copayment liability. Hospitals can choose to attest that their provider-based departments meet the provider-based requirements. Historically, CMS and its contractors did little to verify that the attestations were accurate. But in recent years, the government has heightened its review of provider-based departments through audits, closer inspection of provider-based attestations, and surveys.

As a focal point of CMS’ provider-based review activities, CMS has voiced its disapproval of shared space and co-location arrangements between hospitals and other Medicare-participating entities, including other hospitals, physician groups, ambulatory surgery centers, and other providers and suppliers. While CMS has issued no formal guidance on the provider-based implications of shared-space arrangements between hospitals and freestanding entities, its Regional Offices have opined on the issue through letters, emails, and phone conversations with providers and their counsel. In this informal guidance, CMS has taken a strict approach disapproving of any shared space between a hospital provider-based department and a freestanding entity.

In 2011, the Chicago Regional Office (CMS Region V) issued a letter to a hospital concluding that the hospital’s provider-based radiology department failed to meet several of the provider-based requirements due to its co-location with a freestanding entity. Since 2011, this letter has been widely circulated among the nation’s health care lawyers as it outlines detailed guidance on what constitutes an impermissible hospital space-sharing arrangement. In the letter, the Chicago Regional Office (RO) determined that the department did not comply with the definition of “department of a provider” found in 42 C.F.R. § 413.65(a)(2), stating that “CMS does not recognize facilities that share space with freestanding facilities to meet the definition of a ‘department’ of a hospital. A facility that shares space with a freestanding entity cannot have provider-based status as a department of a hospital.” The Chicago RO also found
non-compliance with 42 C.F.R. § 413.64(g)(3), noting that except for certain special provider types that are permitted to be co-located as a distinct part unit (DPU), a hospital may not “carve out areas as non-hospital spaces,” and that a hospital’s provider agreement “must apply to the provider in its entirety.” CMS indicated that “shared entryways, interior hallways, bathroom facilities, treatment rooms, waiting rooms, and registration areas are all indications that a purported hospital space may instead be part of a larger component.” Providing some helpful guidance, CMS stated that, depending on the circumstances, a separate suite in a medical office building could be considered a “singular component” for purposes of complying with the provider-based rule. The Chicago RO also found that due to the co-location issue, the radiology department was not adequately financially integrated with the hospital under 42 C.F.R. § 413.65(d)(3); not held out to the public as hospital space in violation of 42 C.F.R. § 413.65(d)(4); and not operated under the ownership, control, administration, and supervision of the main provider as required by 42 C.F.R. § 413.65(e).

The Philadelphia RO (CMS Region III), in answering informal inquiries on the subject, has stated that “[a] hospital has to be a hospital at all times 24 hours a day 7 days a week.” Region III stated that it does not permit time-sharing, time-block leasing, or shared waiting space. In follow-up conversations, the Philadelphia RO stated that this prohibition on shared space arrangement applies not only to arrangements between hospitals and other health care providers, but also to subleases of space (such as a therapy gym) to community-based non-health care provider entities.

The potential penalties for violation of the provider-based rules can be significant—from the recoupment of increased payments for all cost report periods subject to reopening to potential False Claims Act liability. In addition to repayments, a hospital that has been out of compliance with the provider-based rule will have to correct the problem. If the provider-based space is co-located with another provider or supplier, one of the two will have to vacate, leading to the early termination of leases or costly construction to achieve appropriate separation. With CMS’ attention focused on shared space arrangements, and the potential for significant repayment liability, hospitals should take a close look at their current compliance with the provider-based criteria, taking into account CMS’ view on shared space. Hospitals also should engage in discussions with CMS early in the planning process for new provider-based departments and seek approval of floor plans from their respective ROs. Hospitals are more likely to obtain a favorable opinion from CMS if the provider-based department has its own U.S. Post Office address (such as a separate suite number), is exclusively used by the hospital (no time-block leases), and has clear signage indicating that the department is part of the main hospital.

Space and Layout Requirements for Hospital Distinct Part Units

As explained above, CMS guidance is clear that hospitals are certified by Medicare in their entirety. The CMS State Operations Manual (Chapter 2, Section 2026) requires Medicare surveyors to evaluate each general hospital as a whole for compliance with the Conditions of Participation (CoPs) and to certify the hospital as a single provider institution. The Manual is clear that co-located components that are appropriately certified as other kinds of providers or suppliers, i.e., “distinct part units,” are not to be considered as parts of the hospital and should be excluded in the surveyor’s evaluation of the hospital’s compliance with the CoPs.9
DPUs typically are CMS-approved inpatient psychiatric, rehabilitation, or skilled nursing units that are excluded from the Inpatient Prospective Payment System (IPPS) for hospitals and are paid by Medicare under a different payment methodology. Although DPUs can be located within the hospital, they must comply with certain physical layout requirements. For example, the DPU must be physically distinguishable from the larger hospital institution. The DPU beds must be located within a defined space and must be physically separated from and not commingled with hospital beds. Building plans must clearly demarcate hospital space from DPU space.

Additionally, DPUs may share services and personnel with the hospital. The State Operations Manual explains that “it is rare that a distinct part of a hospital is completely self-contained.” CMS also acknowledges that DPUs routinely share with the hospital “such central support services as dietary, housekeeping, maintenance, administration and supervision, and some medical and therapeutic services.” If the sharing of services can be done without jeopardizing the quality of care, health, and safety of the patients, CMS explains that such sharing is appropriate.

Hospital-within-Hospital Arrangements
Another permissible co-location arrangement is the hospital-within-hospital (HwH) concept. In this type of arrangement, a hospital that is excluded from the IPPS—such as a long term care hospital (LTCH), inpatient psychiatric facility (IPF), or inpatient rehabilitation facility (IRF)—may be co-located with an IPPS hospital if it meets certain criteria set forth in 42 C.F.R. § 412.22(e). Among other requirements, the HwH must have a separate governing body, separate chief medical officer, separate medical staff, separate chief executive officer, and perform basic hospital functions on its own (or through contracts with entities other than the hospital with which the HwH shares space). By meeting these requirements, the IPPS-excluded hospital can continue to receive the advantageous reimbursement of its own payment system. These arrangements have seen increased CMS scrutiny based on the potential for fraud and abuse. Under CMS’ interrupted stay policy, if the number of discharges and readmissions between an LTCH and a co-located hospital exceeds 5% of the total discharges during a cost reporting period, Medicare makes only one MS-LTC-DRG payment to the LTCH for all such discharges and readmissions, regardless of the time spent at the intervening facility. The risks of not complying with the HwH regulations include loss of the provider’s exclusion from the IPPS and the favorable payments associated with that exclusion, so specialty providers like LTCHs, IRFs, and IPFs that are co-located with acute care hospitals should ensure compliance with these requirements.

Other Provider/Supplier Types Beware
Hospitals are not the only Medicare provider-type that should exercise caution when entering into “sharing” arrangements with other providers. For each provider or supplier type, CMS has established specific practice location requirements, and some of them preclude co-locating with other Medicare providers and suppliers. The following discussion highlights a few of these requirements.

Ambulatory Surgery Centers
To qualify for participation in the Medicare program, an Ambulatory Surgery Center (ASC) must meet CMS’ definition of ASC. The definition provides, in part, that an ASC must be a “distinct entity.” To satisfy the “distinct entity” criterion, the ASC must be “wholly separate and clearly distinguishable from any other healthcare facility or office-based physician practice.” The CMS State Operations Manual provides the following guidance relating to this requirement: An ASC may share certain physical space with another entity so long as they are separated in their usage by time.

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An ASC may share non-clinical spaces (e.g., reception area, waiting room, or restrooms) with another entity, but may not share clinical space with another entity unless the other entity is also an ASC.

❯ Any sharing of space must be separated by time. This means that the common space may not be used during concurrent or overlapping hours of operation of the ASC and the other entity. The ASC and other entity must have their own medical records and policies and procedures. Neither entity shall have access to the other's medical records and/or policies and procedures.

❯ ASCs may not share space, even when temporally separate, with an Independent Diagnostic Testing Facility, hospital, or Critical Access Hospital.19

Independent Diagnostic Testing Facilities (IDTF)

In 2007, CMS revised the IDTF performance standards to preclude a fixed-based IDTF from sharing a practice location or equipment with any other Medicare enrolled individual or entity.20 Under this rule, a fixed-based IDTF that is located somewhere other than in a hospital building may not enter into any type of arrangement with an ASC, a physician practice, or other entity that involves leasing or subleasing the IDTF’s office space and/or imaging equipment. It is important to note that this standard does not prohibit an IDTF and another provider from being located in the same building or from sharing certain common areas, such as hallways, reception areas, waiting rooms or parking spaces. Although the regulations are not explicit on this point, CMS guidance appears to apply the “separate post office address” rule when addressing impermissible IDTF space sharing arrangements. If the IDTF and the provider entity are in space that has one post office address, then the two entities would be impermissibly “sharing space.” However, if the two entities have different post office addresses, with at least different suite numbers, the two entities are not “sharing space,” even if they do share common areas.21

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers

CMS standards prohibit DMEPOS suppliers from sharing a practice location with any other Medicare provider or supplier, except under the following scenarios:

❯ The DMEPOS supplier shares a practice location with a physician, non-physician practitioner, PT, or OT (qualified practitioner) and furnishes items to the qualified practitioner’s patients as a part of the qualified practitioner’s professional services.

❯ The DMEPOS supplier is co-located with and owned by a Medicare provider (e.g., hospital, skilled nursing facility, etc.), and the DMEPOS supplier operates as a separate unit, complies with all DMEPOS supplier standards, and is open to the public at least 30 hours per week (hour requirement has certain exceptions).22

The DMEPOS supplier co-location prohibition applies to a “practice location” (e.g., a specific address or suite) and not to an entire building with multiple suites. CMS has provided clarification that a DMEPOS supplier may be located in an office building that also houses other providers in separate suites. Furthermore, CMS has been clear that it frowns upon DMEPOS suppliers that share (at their operating location) other resources (e.g., equipment or personnel) with another provider or supplier entity.

Comprehensive Outpatient Rehabilitative Facilities (CORFs)

Although CMS allows a CORF to coordinate with another type of Medicare provider in relation to shared space, equipment, and personnel, the CORF must demonstrate functional and operational independence as follows:

❯ A CORF may be located on the premises of another Medicare provider or supplier, but the other entity may not use CORF space during CORF hours of operation. Furthermore, a CORF may not share common space with the other entity unless the CORF is able to fully function without...
Avoiding “Risky Business”

So how do you prevent a good business solution from turning into “risky business”? Good planning! The many operational and financial benefits derived from a co-location arrangement can still be achieved with little risk, but require extensive planning. Engage in discussions with CMS early in the process. Seek CMS review and approval of the layout and design of co-located providers. And stay on top of CMS’ current related enforce-ment initiatives. Consider attending the May 5, 2015 AHLA webinar presented by a CMS Central Office representative on

rules relating to co-located hospitals (for more information see https://www.healthlawyers.org/Pages/webinars.aspx).

Endnotes

3 Department of Justice, Our Lady of Lourdes Memorial Hospital has paid more than $3.37 million to resolve self-disclosed billing improprieties, Oct. 16, 2014.
4 42 C.F.R. § 413.65.
5 In the case of an off-campus hospital department that is used as a site where physician services of the kind ordinarily furnished in a physician office are furnished, CMS presumes the location is a free-standing facility unless a provider-based attestation has been submitted and CMS has determined the location is provider-based. 42 C.F.R. § 413.65(b)(4).
7 42 C.F.R. § 413(k).
8 CMS State Operations Manual, Chapter 2, Section 2026A.
9 CMS State Operations Manual, Chapter 2, Section 2048B.
10 CMS State Operations Manual, Chapter 2, Section 2048C.
11 Id.
12 A HwH is co-located with another hospital if it “occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital.” 42 C.F.R. § 412.22(a).
13 42 C.F.R. § 412.22(e)(1)(i)-(v).
15 42 C.F.R. § 416.25.
16 42 C.F.R. § 416.2.
18 42 C.F.R. § 416.44(b).
20 42 C.F.R. § 410.33(g)(15)(i).
22 42 C.F.R. § 424.57(c)(29).

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> A CORF may share equipment with another Medicare provider or supplier, but the shared equipment must be available on the CORF’s premises during all hours of the CORF’s operations. Furthermore, the common equipment may not be used at the same time by the other entity for any purpose.

> CORF personnel may also be associated with another Medicare provider or supplier, but must be available to the CORF during all hours of the CORF’s operations.23