WISCONSIN HOSPITAL ASSOCIATION

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July 2, 2019

David R. Wright, Acting Deputy Center Director
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

***Re: Ref: QSO-19-13-Hospital – Draft Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities***

Dear Director Wright:

On behalf of our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) draft guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals (CAHs), mid, and large-sized academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

**Background**

WHA has been very active in addressing Medicare and Medicaid compliance issues that create undue burdens for our Wisconsin Hospitals, making it more difficult for them to focus on providing high quality health care to the patients they serve. Back in 2016, WHA convened meetings with our local members and regional CMS representatives to address concerns about a disconnect between certain CMS regional offices and leadership in Baltimore. The issue surrounded the approval of shared space/mixed-use sites, namely, those where the provider-based and non-provider-based locations utilized the same space. A number of our members, particularly rural critical access hospitals, had heard that CMS was revoking provider-based status of hospital clinic operations because of a hospital's leasing agreement with visiting providers.

This was very worrisome, as these space sharing arrangements are a cost-effective means to expand access to specialist care in underserved areas, particularly in rural communities. In an era where the federal government has been reducing reimbursements for hospitals and asking them to do more with less, prohibiting CAHs from utilizing space sharing arrangements with visiting providers removes a straight-forward option for hospitals to maximize the utility of their buildings, increase efficiencies, reduce costs, and increase to care access in their communities.

During these talks, the CMS regional representatives we engaged told our members they understood our concerns, and that there was clearly a need for CMS leadership to clarify what is and is not acceptable for rural hospitals. WHA also engaged our Wisconsin Congressional delegation; please find the attached letter from July of 2016 which highlighted their concerns over how this policy was being applied. In the letter, Congressional Members requested CMS to take a comprehensive look at the issue and engage CMS's Rural Health Council to review the issue.

**Draft Guidance Applicability to Rural, Critical Access Hospitals**

Given the promising discussions with regional CMS representatives, WHA and its member hospitals were pleased to see that CMS has attempted to provide additional clarity regarding co-location and mixed-use agreements. Unfortunately, it appears that the guidance does not provide critical guidance sought by CAHs.

**Specifically, we were recently told that CMS representatives are definitively stating that the draft guidance does <u>not</u> apply to them, because rural CAHs cannot co-locate with other *hospitals*, due to requirements they be a 35-mile drive from another hospital**.

However, this misunderstands the question posed by critical access hospitals: Is a CAH's provider-based status at risk because it enters into an agreement with a visiting physician or other health care professional – ***not another hospital or facility*** - to temporarily utilize the hospital's provider-based clinic space when such physician or other health care professional will independently bill Medicare for services provided as non-hospital-based services? Such an arrangement would actually result in a *lower* cost to Medicare, yet our members have heard that CMS has revoked provider-based status of CAH hospital-based clinic operations solely because the hospital had a space leasing agreement with visiting providers.

As outlined above, hospitals have been seeking clarity regarding this flexibility for years. CMS's various regulations can often be confusing and even contradictory, and hospitals spend a great deal of resources on attorneys and compliance officers that would be better spent on direct patient care. We have examples of members who have put on hold plans to use shared space agreements with visiting physicians that would offer more services to their communities. Unfortunately, due to concerns that CMS would revoke provider-based status and the reimbursements from that status which sustain them, they have chosen not to expand these services. This means that community needs are going unmet purely due to CMS's inflexibility and lack of clear guidance.

In today's every changing health care environment, hospitals need certainty so they can plan for the future. As you know, Wisconsin Hospitals have sustained a reputation as delivering some of the highest quality health care in the country. At the same time, our hospitals are being asked to do more with less. Federal reimbursements in Medicare and Medicaid seem to be constantly diminishing. While the passage of the Affordable Care Act has increased the number of people covered by health insurance in Wisconsin, the projected 10-year impact of cuts made in the ACA as well as other federal cuts made since are estimated to add up to more than $4 billion. This has led hospitals to seek more efficiencies that bring costs down for consumers. Maximizing facility space by forging agreements with non-hospital providers is one way that hospitals can improve efficiency and increase the value of services offered in their communities. However, without these tools, it will only become harder for rural hospitals.

According to a 2018 report from the GAO, rural hospital closures more than doubled over the last 5 years; 31 rural hospitals closed from 2008 to 2012 and 64 closed from 2013-2017[1]. While Wisconsin has fortunately staved off these closures, we still had 13 CAHs that had negative total margins (lost money) last year, despite the perception by some that hospitals are flush with cash. We invite both your regional staff and Baltimore staff to visit our rural Wisconsin hospitals to better understand the challenges they face and how cumbersome regulations increase those challenges. We are concerned about the apparent disconnect between this administration's stated goal of "addressing any government burdens that may be getting in the way of

[1] Government Accountability Office. (2018) *Rural Hospital Closures.* (Publication GAO-18-634). Retrieved*: https://www.gao.gov/assets/700/694125.pdf* See M. Clawar et al., Range Matters: Rural Averages Can Conceal Important Information (Chapel Hill, N.C.: North Carolina Rural Health Research Program, 2018),

integrated, collaborative, and holistic care for the patient,"[2] and how CMS regional staff appear to be interpreting regulations in a way that conflicts with that goal.

**Flexibility Provided in this Draft Guidance**

While we are disappointed that CMS has indicated that the recent draft guidance does not apply to rural, critical access hospitals, we would nonetheless like to offer our support of and comments on some of the guidance which we believe is a step in the right direction. For example, we were pleased to see this memo clarify that certain non-clinical space may be shared between hospitals and facilities under the Distinct Space and Shared Space portion of the memo.

Yet, the memo restricts clinical spaces from being shared, including registration areas and hallways between certain clinical settings. While CMS states the reason for this is infection control and patient privacy, hospitals are already able to coordinate infection control with separate entities that share the same space, and can also ensure patient privacy remains protected, particularly in an age where medical records are electronic. Additionally, providers are trying to reduce the stigma associated with receiving behavioral health or addiction services, and requiring patients to use separate entrances for these services contradicts that effort.

We were also pleased to see clarification that physicians can float between two entities. While we welcome this, additional elaboration on whether such clarification also applies to advanced practice providers would be appreciated; such are becoming more and more important to the health care delivery system, particularly in rural areas. Additionally, while we understand the rationale that certain staff need to be dedicated to only one entity at a time, there are other staff in more managerial positions such as nurse managers, and pharmacy and lab directors who would also benefit from this flexibility. Disallowing it in all circumstances unnecessarily adds costs for both entities, which are ultimately passed onto patients.

WHA appreciates the opportunity to provide comment on this proposed draft guidance. While we would again like to reiterate our appreciation for this guidance which represents a step in the right direction, we also urge CMS to act quickly to ensure more flexibility is provided, particularly for our rural, critical access members.

Sincerely,

Eric Borgerding
President & CEO

[2] Azar, Alex, Remarks on Value-Based Transformation to the Fed'n of Am. Hosps. (March 5, 2018), https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html.