UnityPoint Health

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July 2, 2019

Director Karen Tritz
Quality, Safety & Oversight Group
Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, MD 21244–1850

RE: QSO-19-13-Hospital – Draft Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities dated May 3, 2019

Submitted electronically via HospitalSCG@cms.hhs.gov

Dear Director Tritz,

UnityPoint Health ("UPH") appreciates the opportunity to provide comment on this draft guidance related to hospital co-location with other hospitals or healthcare facilities. UPH is one of the nation's most integrated healthcare systems. Through more than 32,000 employees and our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits.

In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint Accountable Care (UAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UAC is a current Next Generation ACO, and it contains providers that have participated in the Medicare Shared Savings Program (MSSP) as well as providers from the Pioneer ACO Model. UnityPoint Health also participates in a Medicare Advantage provider-sponsored health plan through HealthPartners UnityPoint Health.

UPH appreciates the time and effort of CMS in developing this draft guidance and respectfully offers the following comments.

SURVEYING HOSPITAL CO-LOCATED WITH OTHER HOSPITALS AND HEALTHCARE FACILITIES

This guidance clarifies how a hospital can be co-located with another healthcare provider to demonstrate independent compliance with the Medicare Conditions of Participation for hospitals (CoPs) for shared spaces, services, personnel and emergency services.

Comment: While we applaud CMS' initial step to provide further clarity on this issue, ***we are extremely disappointed that the scope of this guidance does not include Critical Access Hospitals (CAH).*** There are 1,345 CAHs nationwide, representing 29.4% of all hospitals.[1] As a vital part of our integrated health care system, UPH is affiliated with 20 CAHs in Illinois, Iowa and Wisconsin. CAHs also comprise 34% of all rural hospitals that have closed since 2010.[2] Of the 17 at-risk financial rural hospitals in Iowa identified by Navigant, 13 are CAHs.[3] We attribute the worsening CAH financial situation, in part, to an overly burdensome regulatory environment. A prime example is the current restrictions on CAH co-location that hamstring the ability of CAHs to efficiently use facility space and resources, detract from care coordination and increase patient inconvenience. Of particular concern for CAHs are distinct versus shared space requirements. It is not a good use of limited resources to require CAHs to raise and divert capital dollars to reconfigure and construct their physical footprint for separate entrances and waiting rooms for specialty providers. ***We urge CMS to expedite rulemaking that encourage the use of CAHs as health care hubs through flexible regulations that facilitate centralized access to a variety of other health care services and partnerships.***

DISTINCT SPACE AND SHARED SPACE

Distinct spaces would include clinical spaces designated for patient care and is necessary for the protection of patients, including but not limited to their right to personal privacy and to receive care in a safe environment under §§482.13(c)(1) and (2), and right to confidentiality of patient records under §482.13(d). Shared spaces are considered those public spaces and public paths of travel that are utilized by both the hospital and the co-located healthcare entity. Survey procedures are proposed to include the designated space(s) of the co-located hospital and its distinct separation from the other hospital or healthcare entity, and the use of contracted services from the co-located entity and outside healthcare entities.

Comment: We disagree with the proposition that registration personnel and resources must be separate and distinct. ***We believe that CMS should recognize that hospitals and co-located health entities can have electronic firewalls to assure patient record confidentiality during a "check-in" process and that sharing these resources would further promote interoperability constructs.*** Requiring duplicative resources, instead of incentivizing streamlined processes, seems contrary to the Patients over Paperwork initiative and CMS' overall emphasis on value-based care. Also, in terms of visiting specialists, CMS has not included explicit language to permit timeshare arrangements in provider-based space that meet the Stark law exception at 42 C.F.R. § 411.357(y). ***We would urge CMS to revise this guidance to permit these timeshare arrangements.***

[1] MedPAC 2018 Databook, Chapter 6 – Acute inpatient services.
[2] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
[3] Navigant, Rural Hospital Sustainability, February 2019.

We are pleased to provide input on this draft guidance and its impact on our integrated health system and the individuals and communities we serve. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government & External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener, JD
VP, Government & External Affairs