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New survey guidance could affect microhospitals

Recent CMS revisions to the *State Operations Manual for Hospitals* are zeroing in on the agency's definition of a "hospital." According to one expert, this new survey guidance may be an attempt to define the parameters of a microhospital.

"CMS is concerned that if a hospital holds itself out to be a hospital, that it is indeed a hospital. What that means is that it is providing the requisite core of services and treating a population that needs hospital services," says **Lyndean Lenhoff Brick, JD,** president and CEO of The AdvisGroup (formerly Murer Consultants), a healthcare management consulting firm in Mokena, Illinois, that has guided client health systems through microhospital builds. "In short, the proliferation of microhospitals was the advent of this; CMS is seeking to ensure hospital-level care is provided."

Technically, there is no such thing as a microhospital under CMS regulations. "Microhospital" is an industry-coined term, not a formal regulatory or reimbursement designation.

What is a microhospital?

Typically, microhospitals have fewer than 30 beds and offer a slim portfolio of lower-acuity services tailored to a specific community need. Common focuses include emergency services, psychiatry, women and children, and orthopedics.

"Microhospitals are so flexible, they really can be developed for a whole host of situations. Whether it is to provide needed psychiatric and mental health care to an underserved area, whether it is to provide a women's and children's hospital, it could be an orthopedic hospital, it can be in a rural setting," says Brick. "Because you don't have the massive overhead that our hospitals have historically had, this is a very important sea change. We are going to continue to see microhospitals. The hospital of the future is going to be a microhospital.

"We may see a hospital that is nothing more than an intensive care unit and emergency department with a large outpatient surgery center," adds Brick.

Given their scale, microhospitals also have much smaller ecological and economic footprints. Typically, they range in size from 15,000 to 75,000 square feet and, according to *Kansas City Business Journal*, cost $7 million to $30 million. They're also faster to build than larger hospitals, says Brick.

In terms of oversight, microhospitals are typically part of health systems, or offshoots of large independent hospitals, which grants them access to valuable resources they might not otherwise be able to afford—including, in many cases, a dedicated credentialing team.

The disciplines, specialties, and volume of practitioners tapped for microhospital practice depend on a facility's specific operational circumstances and care focuses. In system-based varieties, practitioners typically have existing affiliations with the parent organization. They may, for example, be part of a contracted hospitalist or emergency services group that provides care at other locations.

Beyond microhospitals affiliated with a health system or large hospital, private operators may run freestanding chains of these facilities, says Brick. Stand-alone microhospitals are few and far between.

"Microhospitals are vital to the future of a reformed healthcare environment," says Brick. "They provide access, efficiency, and flexibility. So clarity in this guidance will help foster the development of a whole complement of microhospitals. I believe that is a good thing."

Clarity needed

However, there is confusion about the guidelines. According to Brick, microhospitals and state survey agencies are struggling to understand how to interpret the survey guidance. The AdvisGroup is working closely with its microhospital clients, state survey agencies, and CMS to ensure microhospitals meet the definition of a hospital and are an appropriately recognized venue of care and are paid as such.

The revised survey guidance focuses on whether a hospital is "primarily engaged in providing inpatient services."

According to Interpretive Guidelines §482.1(a)(1):

"Generally, a hospital is primarily engaged in providing inpatient services under section 1861(e)(1) of the Act when it is directly providing such services to inpatients. Having the capacity or potential capacity to provide inpatient care is not the equivalent of actually providing such care. Inpatient hospital services are defined under section 1861(b) of the Act and in the regulations at 42 CFR Part 409, Subpart B. CMS guidance describes an inpatient as 'a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services … Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.' The 'expectation of a two midnight stay' for an inpatient is that the intent of the physician was that the patient be admitted to the hospital for an inpatient stay as opposed to that of observation status which is an outpatient service.

"In making a determination of whether or not a facility is primarily engaged in providing inpatient services and care to inpatients, CMS considers multiple factors and will make a final determination based on an evaluation of the facility in totality. Such factors include, but are not limited to, average daily census (ADC), average length of stay (ALOS), the number of off-campus outpatient locations, the number of provider based emergency departments, the number of inpatient beds related to the size of the facility and scope of services offered, volume of outpatient surgical procedures compared to inpatient surgical procedures, staffing patterns, patterns of ADC by day of the week, etc. Hospitals are not required to have a specific inpatient to outpatient ratio in order to meet the definition of primarily engaged."

CMS also states that a hospital must have at least two inpatients at the time of the survey for CMS to conduct the survey: "If a hospital does not have at least two inpatients at the time of a survey, a survey will not be conducted at that time and an initial review of the facility's admission data will be performed by surveyors while onsite to determine if the hospital has had an ADC of at least two and an ALOS of at least two midnights over the last 12 months."

At the end of October, about a month after it sent out the original memo, CMS sent out a new one with clarification regarding ADC.

CMS calculates ADC by adding the midnight daily census for each day of the 12-month period and then dividing the total number by the number of days in the year. "For facilities that have not been operating for 12 months at the time of the survey, an ADC calculated using 12 months as the denominator may falsely result in an ADC of less than two," it noted.

CMS says that facilities that have been operating less than 12 months at the time of the survey should calculate their ADC based on the number of months a facility has been in operation, but no less than three months. For facilities that have been operating less than three months, they still must use three as the denominator.

In response to CMS' memo, The Joint Commission sent out its own on November 15: "Effective immediately, at least two active inpatients will be required at the time of all initial or resurvey events. If a hospital does not have two active patients at the time of survey, the survey or resurvey will not continue. This new requirement excludes critical access hospitals and psychiatric hospitals."

What microhospitals should do

Brick says the most important thing for microhospitals to do right now is to demonstrate that they are primarily engaged in hospital care. This includes:

- Being open 24 hours a day
- Providing care on weekends
- Having staffing levels that are consistent with inpatient care needs
- Scheduling surgeries on weekends as well as weekdays
- Scheduling inpatient and outpatient surgeries
- Having a management and governance structure that is consistent with inpatient and hospital care

"In short, my message is: They have to have heads in beds 24/7. They have to run it like a hospital; they have to be a hospital," says Brick.

She adds that if a microhospital focuses on running its hospital, the regulations take care of themselves. Microhospitals also need to keep in mind that there is more to running a hospital than being "primarily engaged in inpatient care," such as meeting other *CoP*s, state laws, managed care organizations' standards, and accreditation

bodies’ standards.

However, accreditation and regulatory bodies could make changes to align with CMS’ new survey guidance (as previously mentioned regarding The Joint Commission). Microhospitals need to be aware of any and all changes that could affect them.

The AdvisGroup’s clients are aware of the new survey guidance from CMS and are working to ensure they meet the new guidelines.

“It is going to be important over the coming years to see how CMS really interprets this,” says Brick. “CMS is not setting specific standards in this survey guidance. It is going to be in how the survey guidance is applied. What will be important is consistency in that application of the guidance and clarity in the application of this guidance.

“Nobody is going to argue that being a hospital is not an appropriate thing for CMS to ask for,” she continues. “The whole industry agrees. It is how that gets applied by a surveyor on-site and how that gets interpreted by a regional office or by the CMS office in Baltimore.”

Brick also thinks the survey guidance is anachronistic because it focuses too heavily on inpatient care at the expense of newer models of care that promote efficient and effective outpatient care delivery.

“We need regulations that speak to the current environment that is dependent on reform and efficiency in an outpatient delivery mechanism. This guidance is old-fashioned in that it does recognize the importance of outpatient delivery of care. To handicap [microhospitals] with outdated regulations that do not recognize their role and doesn’t allow them to receive appropriate reimbursement can hurt the delivery of healthcare in a sweeping way,” says Brick.

One thing Brick seems confident about is that this new survey guidance will not slow down the development of microhospitals.

“Microhospitals are vital to reform, and we are going to continue to see more and more microhospitals. They speak to the concept of consumerism, they speak to access, they speak to specialization. The ability to be flexible with a smaller size hospital is not only how we are going to bend the cost curve, but we are going to be able to provide value because of this increased flexibility and access,” she says.