

MEMORANDUM

Texas Department of Human Services * Long Term Care/Policy

TO: LTC-Regulatory
HCSSA Program Administrators

FROM: Jim Lehrman
Associate Commissioner
Long Term Care-Regulatory & HCSSA
State Office MC: E-340

SUBJECT: Medicare-Certified Home Health Agencies' Compliance with Medicare Conditions of Participation (CoPs), Including Outcome and Assessment Information Set (OASIS) Requirements; and Operating Separate Entities -- **S&CC #01-08**

DATE: January 4, 2002

Compliance with Medicare CoPs

In accordance with §1861(o)(6) of the Social Security Act, all Medicare CoPs are applicable to all individuals served by the home health agency (HHA) and not just Medicare beneficiaries. The purpose of the CoPs is to help ensure proper care for Medicare beneficiaries. The CoPs do this by defining standards for an HHA in which Medicare beneficiaries may be treated, instead of establishing requirements applicable only to Medicare beneficiaries served by the HHA.

- A licensed agency that is not Medicare-certified and categorized to provide only "licensed home health" services is not required to meet Medicare CoPs.
- **Effective February 1, 2002**, a licensed agency that is Medicare-certified and categorized to provide both "licensed and certified home health" (LCHH) services and "licensed home health" (LHH) services **must meet all Medicare CoPs, including OASIS requirements.** When an agency is operating both LCHH and LHH categories of service, the LHH category will be subject to Medicare CoPs, unless it can be demonstrated that the HHA meets the separate-entity criteria described in the following section.

Note: If a provider chooses to pursue a separate license for each category instead of having one license with multiple categories, the provider will still have to differentiate its operation and demonstrate that it is operating each of its licenses as a separate entity to meet licensure criteria. Also, pursuing a separate license may affect current and future opportunities to contract with the Department of Human Services (DHS). For specific contracting questions, please contact Marilyn Eaton, Director, Community Care Contracting at (512) 438-2080.

- With regard to applicability of Medicare CoPs to Medicaid waiver clients, Medicare CoPs will be applicable unless the agency can demonstrate that it is operating as a separate

entity. When Medicaid waiver clients are served through the LHH category of service, the agency providing both LCHH and LHH categories of service must demonstrate separateness, or the Medicare CoPs will apply.

Operating Separate Entities

In order for an agency providing LCHH services to be exempt from meeting the Medicare CoPs for the LHH service category, the agency must be able to provide evidence that it is operating as a separate entity. CMS recognizes that an HHA may be part of a larger organization and allows the agency to demonstrate that it is a separate entity from the larger organization. Neither the Social Security Act nor Medicare regulations define "separate entity"; however, CMS has outlined criteria regarding this issue in its Medicare State Operations Manual (SOM), Section 2183. Agencies may access this criteria and other important guidance issued in SOM Transmittal 25 through the CMS web site:
<http://www.hcfa.gov/pubforms/transmit/R25SOM.pdf>.

When an agency providing LCHH services alleges that it is operating as a separate entity to which the CoPs do not apply, the HHA must be able to differentiate its operation from the larger organization. An HHA may be identified as a department, program, or component of the larger organization. Surveyors will utilize criteria pertaining to: 1) Operation of the Home Health Agency; 2) Consumer Awareness; and 3) Staff Awareness to determine if the agency providing LCHH services is operating as a separate entity.

Operation of the Home Health Agency

The HHA administrator will be asked to describe the organizational, functional, and clinical boundaries of the Medicare-certified program in relation to any other programs the larger organization offers. Other programs should be separate and distinct from the HHA. The surveyor may ask:

- Does the HHA have separate policies and procedures for admission to the HHA, including separate consent forms?
- Does the HHA have separate clinical records for all patients receiving HHA services?
- Does the agency have separate personnel records?
- Does the HHA have time sheets or other records to demonstrate distinct assignment of personnel to the HHA?
- Does the HHA have a separate budget?

Consumer Awareness

The organization should differentiate the services of the HHA from other services offered by the larger organization. The surveyor will review brochures, advertisements, and written information to determine if the HHA has differentiated its services from other programs, departments or entities of the larger organization.

- Does the written material provided to the community clearly identify the HHA as separate and distinct?
- How does the HHA describe itself to the community?

Staff Awareness

HHA staff should be knowledgeable about the HHA's policies and procedures and the regulatory requirements related to their role in the delivery of care in an HHA. They should also be able to identify the difference in services they provide for the HHA and other programs, departments, or entities of the larger organization. The surveyor may ask:

- Is the staff knowledgeable about the HHA's policies and procedures?
- Is the staff able to identify the differences in services they provide for the HHA and the other programs?
- Are the personnel who divide time between the separate entity and the HHA appropriately trained to deliver HHA services?

Based on information provided by the agency, the surveyor will make a recommendation as to whether the licensed and certified home health agency is operating a separate entity. If it is determined that the agency is not operating as a separate entity, or if the agency or parent organization is unable or unwilling to provide the information, the agency will be informed of one or more of the following:

- It is in violation of the provisions of §§1861(o) and 1891 of the Act which require compliance with Medicare CoPs, particularly those conditions that relate to clinical records and disclosure of HHA ownership.
- It is in violation of its agreement with the Secretary under §1866 of the Act and the regulations related to this agreement [42 CFR Part 489.53(a)], because it has failed to provide information about ownership and information concerning clinical records.
- It is in violation of §1128(b)(12)(A) of the Act, because it has denied access to records to determine compliance with the CoPs, including those that relate to OASIS requirements; and
- It may be in violation of various requirements related to its Medicare cost reports, which mandate information about all HHA's clients in order to properly pay Medicare costs. Furthermore, the HHA's intermediary must be notified about the regulation of separate entities.

If you need further information regarding separate entities, please contact Mary Jo Grassmuck, R.N., HCSSA, Long Term Care-Regulatory, at (512) 438-2100. For questions regarding the application of OASIS requirements, you may refer to the CMS Regional Survey and Certification Letter #01-02 posted on the DHS Policy Section web site: <http://www.ltc.dhs.state.tx.us/policy>, or the OASIS web site: <http://www.hcfa.gov/medicaid/oasis/oasishmp.htm>.

- Signature on File -

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