DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

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DATE: **May 10, 2002**

FROM: Director
Survey and Certification Group
Center for Medicaid and State Operations

SUBJECT: Requests for Home Health Agency Branch Office Approval and the Use of a Reciprocal Agreement

TO: Associate Regional Administrators, DMSO
State Survey Agency Directors

The purpose of this memorandum is to clarify the Centers for Medicare & Medicaid Services' (CMS) policies regarding the review of a home health agency's (HHA) application for a branch office and the requirements for HHAs interested in providing services across state lines.

HHA Branch Offices

Section 42 CFR 484.2 defines a branch office as a location or site from which an HHA provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the HHA and must be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the Conditions of Participation (CoP) as an HHA. However, delineating the term "sufficiently close" in a definitive manner has proven difficult. As a result, Section 506(a)(1) of the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) mandated that neither the time nor distance between a parent office of the HHA and a branch office shall be the sole determinant of an HHA's branch office status.

While we believe our current policies governing approval of HHA branch offices are consistent with this provision of the BIPA, there have been numerous inquiries regarding the criteria for approval of an HHA branch office. Therefore, to assist the state survey agencies and the CMS regional offices (RO) in the review of an HHA's branch application, we outlined many factors for consideration in the decision to approve a branch on a case by case basis. The factors to consider are the following:

- A review of the HHA's ability to supervise the branch to assure the provision of quality care for the patients served by the branch;
- A review of the HHA's past compliance history;
- A review of relevant state issues and recommendations including a required written reciprocal agreement between the states to assure that at least one of the state agencies assumes responsibility for any necessary surveys of the branch in situations in which an HHA provides services across state lines; and
- A review of the ability of the branch office to meet the regulatory definition of a branch as defined in 42 CFR 484.2. The regulations require the branch to be within the HHA's geographical service area and close enough to the HHA to share supervision, administration and services on a daily basis. While mileage and travel times are significant factors to consider because they are implicitly referenced in the regulations, each alone should not be the single issue in determining approval or denial of the branch.

While all of the above factors should be considered when reviewing branch office applications, the focus should be on the ability of the HHA to demonstrate how it can monitor all services provided in its entire service area, including any branch offices, to ensure compliance with the conditions of participation found at 42 CFR 484. The decision to approve a branch should be based on the HHA's ability to adequately supervise the branch to assure that the quality and scope of items and services provided to all patients is of the highest practicable functional capacity for each patient so as to meet their medical, nursing, and rehabilitative needs. If a review of an HHA's branch office application is determined to be insufficient, the disapproval letter should include some discussion of these criteria. A model disapproval letter is included in attachment A.

Consider the following information in your review of an HHA's request for a branch office:

- The HHA's supervising nurse or physician, as required by 42 CFR 484.14(d) must be available by phone or other means of communication during operating hours. The presence of an effective branch supervisor or manager, who is formally appointed by and under the direct supervision of the HHA parent, is permissible;
- The HHA's governing body is responsible for the overall operations of the parent and branch;
- The HHA parent may use technological means for supervision in conjunction with periodic onsite visits. The HHA parent should be aware of the staffing, patient census and any issues/matters affecting the operation of the branch. The lines of authority and professional and administrative control should be clearly delineated in the HHA's organizational structure and in practice and should be traced to the HHA parent agency;
- The administrator of the HHA must be able to maintain an ongoing liaison with the branch to ensure that staff is competent and able to provide appropriate, adequate, effective and efficient patient care so as to ensure that any clinical and/or other emergencies are immediately addressed and resolved;

- Services offered by the HHA parent are also offered by the branch;
- The branch and its service area must be located within the HHA parent's geographic service area. If the branch is extending the current geographic service area, the new geographic area must be contiguous;
- The HHA must be able to maintain a system of communication and integration of services throughout the agency, whether provided directly or under arrangement, that ensures the identification of patient needs, an ongoing liaison between all disciplines providing care, and physician availability when necessary for relevant medical issues;
- The HHA parent should have a system in place to review patient records and care at the branch to ensure that the branch is implementing all policies and procedures and complying with the conditions of participation for all patients;
- The HHA parent must be able to monitor branch activities (clinical and administrative) and the management of services, as well as personnel and administrative issues;
- Depending on the organization, the HHA's administrator, quality improvement personnel, supervisory personnel etc., should conduct periodic on-site visits to the branch to ensure the delivery of quality care;
- The HHA parent provides ongoing in-service training to ensure that all staff is competent to provide care and services;
- The HHA parent is responsible for any contracted arrangements with any individuals or organizations, even when the contracted services are used exclusively by the branch; and
- Whether the required group of professional personnel, which reviews the agency's policies, is directed to service delivery throughout the entire agency, including the HHA parent and any branches.

Ask the HHA parent to:

- Provide a roster of all branch staff and their job descriptions;
- Provide proof of staff qualifications (resume, licensure, aide training, etc.);
- Provide contracts for any services provided under arrangement;
- List any services shared with the HHA parent;
- Define service area and any intention to cross state lines (need a reciprocal agreement between states and RO approval at that time);
- Provide policy for addressing clinical and other emergency situations;
- Provide plans for addressing staff absenteeism;
- Identify any high-tech services provided;
- Identify how staff will coordinate care and services;
- Identify person who will resolve patient care issues at the branch, and explain how supervision by the HHA parent will occur;
- Attach organizational chart delineating lines of authority, professional and administrative control for the HHA and the branch; and
- Provide certificate of need, if applicable.

Onsite monitoring of the operations of an approved branch should reveal that:

- A copy of the HHA's policies and procedures is maintained in each branch. Branch office personnel should be knowledgeable of the policies and consistently apply them;
- Methods of communication between HHA parent and branch assure that all patients receive the necessary care and services identified through the comprehensive assessment and plan of care;
- The branch retains the active clinical records for its patients. Duplicate clinical records need not be maintained at the HHA parent, but must be available to the surveyor upon request; and
- Patients are receiving appropriate care and services at the branch.

Reciprocal Agreement

Section 2184 of the State Operations Manual (SOM) grants states and providers flexibility in the provision of the home health benefit. The intent of this policy is to recognize and permit the business efficiencies that may be gained by permitting providers to define their geographic service area across contiguous state boundaries. However, in issuing this guidance, CMS also established an administrative safeguard to ensure prudent administration of this added flexibility. Specifically, section 2184 of the SOM only permits HHAs to provide services across state lines when a written reciprocal agreement has been established between the relevant states. The written reciprocal agreements are intended to detail the responsibilities of each state in conducting the required oversight and monitoring activity. The provision of interstate service without a written reciprocal agreement could severely undermine a state's ability to fulfill its statutory responsibilities under section 1864 of the Social Security Act to enforce Medicare's health and safety requirements. And, it is at the discretion of the states to decide whether entering into reciprocal agreements is in the best interest of their residents, provider markets, and quality assurance and oversight systems.

Attachment B contains a model reciprocal agreement document that states may use to assist them in fulfilling their statutory responsibilities under section 1864 of the Social Security Act to enforce Medicare's health and safety requirements when an HHA provides services across state lines. When administering this agreement, please be advised that in those states that have a reciprocal agreement, providers are not required to be separately approved in each state; consequently they would not have to obtain a separate Medicare provider agreement/number in each state. Providers who reside in a state that does not have a written reciprocal survey agreement with a contiguous state will be precluded from providing services across state lines. If a state does not have a written reciprocal agreement with other states, the HHA must establish a separate parent agency or subunit in the state in which it wishes to provide services.

We appreciate your cooperation in promoting national consistency in our program administration of HHAs.

Effective Date: The information contained in this memorandum is effective immediately.

Training: This policy should be shared with all survey and certification staff, surveyors, their managers, and the state/regional office training coordinator.

I hope this information is helpful to you. If you would like to discuss this further, please contact your regional office representative for HHAs.

/s/
Steven A. Pelovitz

Attachments:
A- Model letter for disapproval of a branch office
B- Model Reciprocal Agreement

Attachment A

Model Denial Letter

Dear HHA Administrator:

This is to inform you of the Centers for Medicare & Medicaid Services' (CMS) decision to deny your request to establish a branch office in (City, County, State.)

In order to be approved as a branch office of an HHA, an entity must meet the regulatory requirements for a branch. These requirements are found at 42 CFR 484.2. The branch must also meet the applicable licensing or certification requirements for a branch in the state in which it is located and the state in which the HHA parent is located, if different. The branch office is a location or site from which an HHA provides services within a portion of the total geographic area served by the HHA parent agency. The regulations require that a branch be sufficiently close to the HHA parent to share administration, supervision, and services in a manner that makes it unnecessary for the branch to meet the conditions of participation on its own. To accomplish this, the HHA parent agency must assure that the sharing of administration, supervision, and services with the branch can occur on a daily basis.

After a careful review, CMS has determined that the location that you proposed as a branch does not meet the regulatory requirements. This is because:

- The HHA parent has not documented how it will be responsible for supervising and monitoring the services at the branch, and assure that the services are provided according to the HHA parent's policies and procedures.
- The HHA parent has been unable to demonstrate how it will monitor the quality of care provided to all its patients, including the proposed branch, to assure that the patients are receiving the needed care and services to attain and maintain the highest practicable functional capacity for each patient in terms of medical, nursing, and rehabilitative needs.
- The HHA parent has not documented how it intends to provide the daily supervision necessary to assure adequate direction of staff in the delivery of patient care.
- The HHA parent has not documented how the HHA's governing body will be responsible for the overall operations of the HHA parent and branch.
- The proposed location does not meet state licensure or certification requirements for a branch.
- The involved state agencies were unable to come to reciprocal agreement concerning surveys of the branch office.

If you have any questions or concerns, or wish to submit additional information, please contact _____

If you wish to request that this location be considered as a subunit, please contact _____

Sincerely yours,

Associate Regional Administrator
(or equivalent)

Attachment B

Model Reciprocal Agreement

The State of _____and the State of _____, in order to more effectively administer their survey and certification responsibilities relating to providers/suppliers that provide services across state lines, agree as follows:

GENERAL

The State of _____ and _____ will coordinate the administration of the responsibilities under section 1864 of the Social Security Act with respect to providers/suppliers that are approved to provide services across state lines under a single Medicare agreement and/or number. In general, the States of _____and _____ agree to cooperate and conduct their respective responsibilities related to these providers/suppliers in a coordinated manner in order to promote streamlined operations and minimize unnecessary burdens on beneficiaries, providers/suppliers, survey personnel of the states and the Centers for Medicare & Medicaid Services (CMS).

PROCEDURES

The State of _____, where the approved provider/supplier issued the agreement/number is located, shall be referred to as the ***Primary State***. The *Primary State* maintains the overall responsibility for coordinating all surveys, including initial surveys, re-surveys, revisits, and complaint surveys of providers/suppliers providing services across state lines with the State of _____. The *Primary State* will also report the survey results and the certification recommendations to the CMS regional office responsible for the *Primary State*.

The Primary State and the State of_____have agreed that the State of_____will be responsible for conducting any necessary surveys of a practice location in State of _____. The Medicare survey findings of the practice location will be incorporated into the findings of the Medicare survey of the approved provider/supplier. The *Primary State* will notify the approved provider/supplier of the survey findings. It will also process any necessary termination or denials or other recommendations resulting from surveys by either state.

Both the State of _____and the State of _____will use CMS forms, guidelines, policies and instructions in processing surveys of providers/suppliers that practice in more than one state.

STATE LICENSURE

1. The States of _____and _____will be responsible for ensuring that their respective state licensure laws including those related to licensure of personnel, certificate of need and any other applicable requirements relating to (TYPE OF PROVIDER/SUPPLIER) are met.
2. The State of _____ and the State of _____will use survey funds allocated by CMS as compensation for their costs related to a particular survey, re-survey, revisit or complaint survey of a particular provider/supplier.

TERMS OF AGREEMENT

This agreement will remain in effect until terminated by mutual consent of the parties.