

October 12, 2001

Mr. Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
314G Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Scully:

All of our organizations (listed below) representing home health care thank you for the opportunity to submit recommendations for streamlining the Outcomes and Assessment Information Set (OASIS) data set and related requirements. We understand that the Centers for Medicare and Medicaid Services (CMS) is currently considering reducing paperwork and streamlining patient assessment requirements for home health providers as was done previously for other Medicare providers. Our purpose is to provide input to that process.

Because our focus was on reviewing OASIS from clinical, practical and consumer viewpoints, we did not address OASIS case mix payment issues, which we believe should be reviewed separately by CMS and provider representatives within the context of case-mix reform. However, we did address the costs that providers have incurred -- and continue to incur -- for meeting OASIS regulatory mandates.

The formation of this task force was in response to the hundreds of letters, e-mails and phone calls that the provider organizations have received from their memberships. While there is industry-wide support for an outcome-based assessment process, members have consistently requested that CMS eliminate the non-essential and redundant OASIS components and requirements. They continue to plead for OASIS reform because of the toll that the increased OASIS paperwork is having on their ability to recruit and retain nurses and because of the staggering costs involved in implementing and maintaining OASIS regulatory compliance.

OASIS is often cited as the number one reason why nurses are leaving home health care. As a result, it has exacerbated the already scarce supply of available and qualified nurses nationwide. A home health nurse typically must spend more time complying with federal paperwork requirements than providing hands-on care during one 60-day episode of patient care. In addition, the cost of OASIS far exceeds the reimbursement since home health agencies are not compensated for the cost of professional staff time or for the technology that has been necessary for OASIS and PPS implementation.

Finally, since the OASIS data set is not a comprehensive assessment, home health agencies are required to incorporate OASIS into the individual agency's comprehensive assessment process. However, surveyors have adopted a punitive approach toward agencies whose comprehensive assessments do not fit into their subjective view of how a comprehensive assessment should appear.

GENERAL RECOMMENDATIONS

1. The requirements to collect and transmit OASIS information should only apply to Medicare patients because:

The policy of requiring OASIS for all patients does not comport with CMS' goal to move home care oversight from the current process-driven orientation to an outcome-driven orientation. We believe that collecting OASIS data from only Medicare patients (and measuring their outcomes) is likely to be the best and most efficient process for determining an agency's overall level of quality care because it is a clean set of data from a more homogenous patient population. If an agency is consistently achieving good outcomes for its Medicare case load, it would be highly unlikely that the same agency would provide less quality care to its non-Medicare patients (especially in light of requirements to comply with all other Medicare conditions of participation for all patients.)

CMS's primary rationale for mandating OASIS requirements - as stated in the OASIS final regulation - is to use this information for payment purposes for Medicare beneficiaries:

The immediate publication of rules requiring the collection and reporting of OASIS data and OMB approval of these requirements (OASIS) pursuant to the Paperwork Reduction Act of 1995 are essential because these data are required for the development of the home health prospective payment system, required by statute in October of 2000 (Page 3765 of the January 25, 1999 Federal Register).

In other words, OASIS was mandated for payment purposes before its original intended use for measuring patient outcomes (i.e. quality of care). Collecting only Medicare data now is consistent with the current use of OASIS.

Limiting OASIS to Medicare patients is especially important because nurses and patients alike are experiencing difficulties due to the length and frequency of assessments. This is particularly true in cases where patients have minimum to moderate health care needs. Limiting OASIS to Medicare patients will help alleviate stress on patients and nurses and reduce the cost of OASIS administration for home health agencies.

2. Allow home health providers to have access to the studies on the validity and reliability of OASIS data and adverse event measurements, which are now being used to evaluate home health agencies with potential negative consequences.
3. Provide rationale for why many of the items (that are indicated below by a "*") were determined by CMS to be good indicators of quality care. For these items, and for changes to OASIS in general, we also strongly recommend that CMS develop a process to evaluate the suitability of any OASIS items whose need is not readily apparent. The process should include providers, researchers and consumer advocates and contain a general public comment phase. Each item on the form should be required to have above average inter-rater reliability and should be judged by its incremental performance in patient classification systems or outcome risk adjustment methodologies, or be necessary as an outcome measure. Any review process must be designed to explicitly balance the natural desire for more information with the need for efficient data collection and patient privacy.
4. Allow agencies to use a single, universal form for all OASIS data collection time points (i.e., start of care, transfer/discharge, resumption/change of care and recertification). Questions specific to a particular assessment would be easily identified on the universal form. A universal form would prevent the confusion over what form to use for a particular visit. If a nurse mistakenly fills out the wrong

form, which may be nearly identical to other OASIS forms, he or she must complete the minimum 45 minutes of OASIS paperwork again.

5. Eliminate the current OASIS assessment requirement for significant change in condition. The ambiguity of what is considered to be "a significant change in condition" has essentially forced each home health agency to establish its own significant change policy, particularly involving cases where there is not a hospitalization. This subjectivity leads to questionable validity and usefulness of the data for outcome measurements.
6. Eliminate the requirement to perform an OASIS assessment in cases where it is known that a patient will require only a single visit or is a predictable LUPA patient.
7. Allow any practitioner of a qualifying service to conduct the initial assessment and comprehensive assessment regardless of whether skilled nursing is included on the plan of care.
8. Amend the required "complete and lock dates" as follows: 10 calendar days to complete OASIS and 14 calendar days from the day of completion to enter and lock the data.
9. Revise the guidelines for the OASIS resumption of care (ROC) assessment so that it is only required for patients who have been hospitalized for more than 72 hours. The need for a ROC could serve as a proxy for what is considered to be "a significant change in condition" until a better definition is developed and agreed on by CMS and national provider representatives.
10. Increase reimbursement to home health agencies to reflect the true costs of OASIS, including the cost of professional time spent training and completing forms, and the cost of technology systems necessary to implement OASIS for OASIS and PPS compliance. A recent report by the General Accounting Office (GAO) clearly identified "an increase in time spent for patient assessments after the implementation of OASIS mandate. These HHAs also reported additional costs associated with verifying and transmitting data to HCFA, as well as with training new hires to collect OASIS data." (*OASIS Data Use, Cost and Privacy Concerns*, GAO, January, 2001). It is important to point out that the GAO study only focused on the extra time associated with start-of-care assessments. Although we disagree with GAO's assessment that HHAs will be able to finance these extra costs from PPS payments, we do generally agree with the additional magnitude of the extra costs as identified in the GAO study. CMS' before-the-fact assertion that agencies will have no additional costs after the going through the learning curve is erroneous and needs to be re-examined in light of the significant actual experience to the contrary.
11. Inform home health agencies and surveyors that basic demographic data is not required on the comprehensive assessment form if available elsewhere on the agency record for formatting and reporting to the State Agency.
12. Eliminate the requirements to perform two or more assessments when those particular assessments fall within a close proximity of time (e.g. cases involving a change in payer) and when the additional assessment is performed to accommodate the CMS systems rather than for clinical purposes.
13. Eliminate requirements to make home health visits that are "non billable" solely for the purpose of fulfilling CMS OASIS time frames. Allow completion of the assessment on the next billable visit. These requirements have increased the cost to the Medicaid waiver programs for long-term and chronic patients.
14. Require CMS compliance with coding rules, including ICD-9 coding, as mandated by HIPAA.
15. Eliminate duplication and inconsistency between OASIS and the 485 (plan of care) forms.

RECOMMENDATIONS FOR INDIVIDUAL OASIS ASSESSMENT ITEMS

The task force identified the following assessment items as items that should be either: 1) deleted for identified reason; 2) deleted unless it is determined after examination that the item is useful for casemix and/or risk adjustment; 3) revised; or 4) redefined to improve the item's comprehension by nurses and therapists (several of these questions and options are so intricate that precision is lost in the collection of the data).

<u>MOOOO</u>	<u>Description</u>	<u>Action/Reason</u>
M0140*	Race/Ethnicity	Examine and determine the usefulness of this item for casemix and/or risk adjustment; delete item if it is determined to be not useful.
M0160*	Financial Factors	Examine and determine the usefulness of this item for casemix and/or risk adjustment; delete item if it is determined to be not useful.
M0190	Inpatient diagnosis	Delete (unnecessary and unreliable responses).
M0200*	Treatment change	Examine and determine the usefulness of this item for casemix and/or risk adjustment; delete item if it is determined to be not useful.
M0210	Changed diagnosis	Delete (unreliable responses).
M0220*	Prior conditions or inpatient stay	Examine and determine the usefulness of this item for casemix and/or risk adjustment; delete item if it is determined to be not useful.
M0260*	Overall prognosis	Examine and determine the usefulness of this item for casemix and/or risk adjustment; delete item if it is determined to be not useful. In addition, the item is already documented on the 485 form.
M0270*	Rehab prognosis	Examine and determine the usefulness of this item for casemix and/or risk adjustment; delete item if it is determined to be not useful. In addition, the item is already documented on the 485 form.
M0280	Life expectancy	Delete (inherently subjective).
M0290*	High risk factors	Examine and determine the usefulness of this item for casemix and/or risk adjustment; delete item if it is determined to be not useful.

M0310-M0330	Living arrangements	Limit item to only start-of-care (SOC) assessment. Complete thereafter only if a change in living arrangement occurs.
M0340-M0360	Living arrangements	Retain and simplify to "yes" "no" responses.
M0400	Hearing	Simplify to general terms that clinicians can easily understand.
M0420-M0430	Pain	Examine other more reliable pain scales.
M0440	Skin lesions	Redefine to identify active pathology and specify the types of lesions that would be considered "skin lesions" in a manner that is understandable to the nurse and eliminates his/her subjectivity.
M0460	Most problematic wound	Redefine using medical terminology that is understandable to the nurse and eliminates subjectivity. This is especially important because a "most problematic wound" may be a different wound for each assessment.
M0468	Stasis ulcers	Redefine to include arterial, venous diabetic and neuropathic ulcers.
M0560-M0620	Neuro/Emotional/Behavioral	Redefine to improve reliability of assessment by simplifying options in a manner that is understandable to the nurse, eliminates subjectivity, and facilitates a level of trust between provider and patient who may have issues related to depression. In addition, the items should be optional if the patient reserves his/her right to privacy.
M0630	Psychiatric Nursing Services	Delete (very limited provision of psychiatric nursing in home care).
M0640-M0800	ADLs/IADLs/Medications	Delete "prior" column (unreliable and non-verifiable responses).
M0720-M0770	Instrumental Activities of Daily Living (IADLs)	Delete "current" column (unreliable responses).

M0830-M0840*	Emergent Care	Examine and determine the usefulness of this item for casemix and/or risk adjustment; delete item if it is determined to be not useful.
M0890-M0900*	Inpatient Reason/Reason for Nursing Home	Examine and determine the usefulness of this item for casemix and/or risk adjustment; delete item if it is determined to be not useful.

The OASIS Provider Task Force would appreciate the opportunity to discuss our recommendations with you and your staff in person. Such a meeting would facilitate collaboration between CMS and constituent organizations thus maintaining the spirit of CMS' "open door" initiatives, which have been deeply appreciated by the home health care and hospice communities.

Contact persons for the task force are Kathy Thompson, Visiting Nurse Association of America (VNAA) (202/737-3707), and Mary St. Pierre, National Association for Home Care. (NAHC) (202/547-7424).

Thank you again for your consideration of our recommendations.

Sincerely,

American Hospital Association
 American Home Care Association
 American Association for Homecare
 Connecticut Association for Home Care
 Gentiva Health Services
 Medstar Health VNA, Washington, D.C.
 National Association for Home Care
 Visiting Nurse Associations of America

cc: Dallas R. Sweezy, Director of Public Affairs, CMS
 Rob Foreman, Director of the Office of Legislation, CMS
 Tom Hoyer, Director of the Chronic Care Purchasing Policy Group, CMS
 Bob Wardwell, Director of the Division of Community Post-Acute Care, CMS
 Pat Bousliman, Professional Staff Member, Senate Finance Committee
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 Deborah Williams, Professional Staff Member, House Ways and Means' Health Subcommittee