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OASIS Alert

OASIS Reform: REFORM PROPOSALS COULD DELIVER HHAs FROM THE DESERT

The **Centers for Medicare & Medicaid Services** actually is taking action to reduce home health agencies' workloads, which could make agencies feel like they've found a little slice of paradise.

HAs had to look twice at a June 10 **Department of Health and Human Services** release promising a 25 percent reduction in time spent on OASIS assessments and a 27 percent reduction in the total number of OASIS data items collected. HHS wants to "streamline Medicare's paperwork requirements for home health nurses and therapists so that they can focus more on providing quality care to their patients," HHS Administrator **Tommy Thompson** says.

In fact, HHS proposes to reduce items on the OASIS "renewal assessment" a whopping 72 percent from 92 to 25 items. CMS hasn't yet issued a list of the particular items it will cut on the various assessments, but has plans to do so, a CMS spokesperson tells **Eli**.

"We have tried to eliminate the items that are duplicative and those that aren't used for payment, quality management or survey purposes," the CMS rep says. For example, "there's no reason to collect demographic information every time once you've got it, you've got it."

In addition to culling items from the OASIS assessment tools, CMS also proposes to cut two OASIS assessments altogether. The first is the start of care assessment when no further visits are planned. "For example, when an agency visits a patient to perform one dressing change after [he or she comes] out of the hospital and plans no further visits," the agency won't have to perform a SOC OASIS assessment, the spokesperson explains.

The second assessment slated for elimination is a discharge OASIS when no visits have been completed in that episode.

CMS hasn't said which OASIS items it is proposing for elimination, or whether items will be eliminated from all OASIS assessment tools or just followup assessments. However, the committee recommended cutting M0190, M0340, M0640-680 and M0780.

CMS must run these changes through Paperwork Reduction Act procedures and wants to gather comments from interested parties, the CMS spokesperson says. It's likely at least some of the changes will come out as a proposed rule in the Federal Register requiring a 60-day comment, a period to "work out the major issues," then a final rule all of which will put implementation of these proposals months away. "We want to make sure we are compliant" with all notice and procedural requirements, the source says.

CMS officials say they want to get the changes in place by December, reports **Bob Ward-well**, a former CMS senior official now with the **Visiting Nurse Associations of America**.

Other changes could materialize more quickly, however. HHS will "carefully consider the committee's other recommendations and take steps to promote quality care for all Americans," CMS says.

Recommendations for changes such as completion and lock date extensions might be possible before December, Wardwell speculates, while some of the committee's other suggestions could be considered on a much longer timeframe.

New Bill Is Industry's Second Line of Defense

Many HHAs might not trust CMS' claims to help them out, and would rather see OASIS changes made by Congress.

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Luckily, a bill introduced by Rep**. John Sununu** (R-NH), the Home Health Nurse and Patient Act of 2002 (H.R. 4659), would enact more sweeping OASIS changes than those HHS is considering.

The legislation calls for establishment of an 11-member OASIS Task Force composed of CMS officials, national home health industry representatives and patient advocates. The task force would study the effectiveness of the number of OASIS assessments and OASIS items required, and OASIS collectionfornon-Medicare/non-Medicaidpatients. The task force would submit a report on the issues to HHS and Congress.

Other proposals in the bill:

1. making optional OASIS data collection for non-Medicare/non-Medicaid patients and eliminating OASIS requirements for personal care service-only patients;
2. HHS review and revision of demand billing regulations to improve claims review for beneficiaries who are dually eligible for Medicare and Medicaid home care services; and
3. establishment of an 11-member Claims Review and Audit Task Force to study and report on medical review bugaboos such as statistical sampling, technical denials, review deadlines and alternative dispute resolution.

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