A. Background

The purpose of this PRA submission is to request OMB approval of a revised version of the Outcome and Assessment Information Set, Version C1 which is titled ***"OASIS-C1/ ICD-9 Version"*** to be processed under the emergency clearance process associated with Paperwork Reduction Act of 1995 (PRA), specifically 5 CFR 1320.13(a)(2)(i). Public harm is reasonably likely to occur if the normal, non-emergency clearance procedures are followed.

The approval of this data collection instrument is essential because OASIS data is used in the calculation of provider payment as well as for measurement of the quality of care provided by Home Health Agencies (HHAs). Without PRA emergency approval, it is highly likely that CMS will need to delay by approximately 4 months the implementation of the ***OASIS-C1/ ICD-9 Version*** data item set beyond the planned implementation date of 01/01/2015.

OASIS-C1 was created mainly because of the need to enable the coding of diagnoses using the ICD-10-CM coding. In addition, OASIS-C1 was also designed to address issues raised by stakeholders, such as updating clinical concepts and modifying item wording and response categories to improve item clarity, and incorporates a significant reduction in burden by removal of items used in OASIS-C that were not useful for payment, quality, or risk adjustment purposes. However, on April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted. This legislation mandated that CMS cannot adopt ICD-10 prior to October 1, 2015. As a result, CMS will not be able to implement OASIS-C1 prior to October 1, 2015 and has been faced with the dilemma of how to handle the collection of OASIS data during the ICD-10 delay.

OASIS-C1/ICD-9 Version is an interim version of the OASIS-C1 data item set that was created in response to the legislatively mandated ICD-10 delay. ***OASIS-C1/ICD-9 Version*** incorporates the updated clinical concepts and modified wording and improved item clarity that was incorporated into OASIS-C1. Data items from OASIS-C1 that use ICD-10 codes have been replaced with the corresponding items from OASIS-C that use ICD-9 codes. Use of ***OASIS-C1/ ICD-9 Version*** will not cause any increase in burden nor change the way in which OASIS data will be collected and reported to CMS by HHAs. In fact, provider burden will be significantly decreased due to the elimination of a number of non-essential data items from the OASIS-C data item set.

Collection and Use of OASIS Data

Since 1999, the Conditions of Participation (CoPs) at § 484.55 have mandated that HHAs use the OASIS data set when evaluating adult non-maternity patients receiving skilled services.[1] OASIS is a core standard assessment data set that agencies integrate into their own patient-specific,

1 In meeting the CoPs, HHAs are expected to collect OASIS data on all of the patients served by the agency with the following exceptions: 1) maternity patients; 2) those under 18; and, 3) those receiving only personal care services (e.g., housekeeping, chore services). In 2003, Section 704 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) temporarily suspended OASIS collection for non-Medicare/non-Medicaid patients until the outcome of an OASIS study is presented to Congress. This study was completed in December 2005 and has been submitted to Congress.

comprehensive assessment to identify each patient's need for home care that meets the patient's medical, nursing, rehabilitative, social, and discharge planning needs. CMS sees the OASIS as one of the most important aspects of the HHA's quality assessment and performance improvement efforts:

> "By integrating a core standard assessment data set into its own more comprehensive assessment system, an HHA can use such a data set as the foundation for valid and reliable information for patient assessment, care planning, and service delivery, as well as to build a strong and effective quality assessment and performance improvement program." [2]

HHAs are required to collect the OASIS data at specific time points (admission, resumption of care after inpatient stay, recertification every 60 days that the patient remains in care, transfer, and at discharge). Since 2000, elements of the OASIS data have served as the basis for the Prospective Payment System (PPS) that determines home health reimbursement for Medicare patients. Using the same data elements for both quality monitoring and payment allows CMS to ensure that HHAs are not maximizing profits at the expense of beneficiary outcomes while realizing the efficiency of using a single data source.[3] OASIS is also instrumental in assisting CMS to address the new challenges presented by Pay for Reporting (as mandated in the Dec. 2005 Deficit Reduction Act), which dictates that "for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points." Additional information about the legal basis for OASIS data collection is presented in Section B.1: Need and Legal Basis; additional information about OASIS data use is presented in Section B.2: Information Users.

Prior OASIS Refinement Efforts

In 2002, CMS introduced the "reduced-burden" OASIS that was a product of the Secretary's Regulatory Reform Advisory Committee to help guide HHS's broader efforts to streamline unnecessarily burdensome or inefficient regulations that interfere with the quality of health care. The Advisory Committee studied OASIS and recommended deleting those items and assessments not used for payment, quality measurement, or survey purposes in an effort to ease paperwork burden on HHAs and their clinicians. This resulted in a burden reduction of 28 percent, and the revised OASIS was implemented in December 2002. After the 2002 revision, CMS continued soliciting input on potential refinements and enhancements of the OASIS instrument from HHAs, industry associations, consumer representatives, researchers, and other

2 Medicare and Medicaid Programs: Use of the OASIS as Part of the Conditions of Participation for Home Health Agencies, 42 CFR Part 484 [Final Rules], *Federal Register*, Volume 64, Number 15, January 25, 1999, Pages 3747-3784.

3 Sections 4602 and 4603 of the Balanced Budget Act require the implementation of a home health prospective payment system (PPS) to replace an interim payment system. In defining PPS for home health agencies (HHAs), the statute requires the Secretary to consider an appropriate unit of service, the number, type and duration of visits provided within that unit of service, and their cost. Payment for a unit of service was modified by a case-mix adjustor, set by the Secretary, to explain a significant amount of the variation in the cost of different units of services. The home health PPS was implemented October 1, 2000.

stakeholders. A revised version of the OASIS (OASIS-C) was developed and field tested in 2008. Testing included time analysis and inter-rater reliability of paired assessments, medical record review, and clinician focus groups to evaluate validity, reliability, burden, feasibility, and usability. The resulting modifications were incorporated in the version of OASIS-C that is currently approved by OMB.

OASIS-C1 Refinement Efforts

Significant revisions were made to the OASIS-C data item set to create the OASIS-C1. These revisions included the addition of ICD-10 coding, updated clinical concepts, modified item wording and response categories and improved item clarity, and reduction of burden associated with OASIS data collection by removing items not currently used by CMS for payment, quality, or risk adjustment.

A detailed comparison between the OASIS-C data item set and the OASIS-C1 data item set is provided in ***Attachment A*** titled, ***"OASIS-C to Revised Draft OASIS-C1–Items, Timepoints & Uses Crosswalk."***

OASIS-C1/ ICD-9 Version

A detailed list of the changes that have been made to OASIS-C1 to create the OASIS-C1/ICD-9 Version data item set is provided in ***Attachment B*** which is titled "***Changes to Be Made to OASIS-C1 to Create OASIS-C1/ICD-9 Version."***

B. Justification

1. Need and Legal Basis

Section 1861(o) of the Social Security Act ("the Act") (42 U.S.C.1395x) specifies certain requirements that a home health agency must meet in order to participate in the Medicare program. (Regulations at 42 CFR 440.70(d) specify that HHAs participating in the Medicaid program must also meet the Medicare CoP.) In particular, section 1861(o)(6) of the Act requires that an HHA must meet the CoP specified in section 1891(a) of the Act and such other CoP as the Secretary finds necessary in the interest of the health and safety of its patients.

Section 1891(a) of the Act establishes specific requirements for HHAs in several areas, including patient rights, home health aide training and competency, and compliance with applicable federal, state, and local laws. Section 1891(b) of the Act states that the Secretary is responsible for assuring that the CoPs, and their enforcement, are adequate to protect the health and safety of individuals under the care of an HHA, and to promote the effective and efficient use of Medicare funds. To implement this requirement, state survey agencies generally conduct surveys of HHAs to determine whether they are complying with the CoPs. Section 1891(b) of the Act (42 U.S.C. 1395bbb) requires the Secretary to assure that the CoPs and their requirements adequately protect the health and safety of individuals under the care of a home health agency, and 1891(c)(2)(C)(i)(II) of the Act requires that a standard HHA survey shall

include a survey of the quality of care and services furnished by the agency as measured by indicators of medical, nursing, and rehabilitative care. In accordance with section 1891(d)(1), we are required to monitor the quality of home health care with a "standardized, reproducible assessment instrument." Based on industry input, we selected the OASIS as the instrument to improve the quality of care and to comply with the law. The use of OASIS is a requirement that HHAs must meet to participate in the Medicare program (See 42 CFR § 484.55).

The Home Health CoPs (42 CFR §484.20 and §484.55) mandate that all HHAs collect and report OASIS data to CMS. However, these regulations exclude certain categories of patients from the OASIS reporting requirements. Under the Home Health CoPs, HHAs are not required to report OASIS data for the following categories of patients:

- Patients receiving only non-skilled medical services;
- Patients for which neither Medicare nor Medicaid is paying for the home health care (***HOWEVER;*** *patients receiving care under a Medicare or Medicaid Managed Care Plan are not excluded from the OASIS reporting requirement);*
- Patients receiving pre- or post -partum services, or
- Patients under the age of 18 years.

Section 4603 of the Balanced Budget Act of 1997 (BBA) created section 1895(a) of the Act, which required the development of a prospective payment system (PPS) for HHAs beginning October 1, 2000. Specifically, section 1895(b)(4)(C) of the Act requires the Secretary to establish appropriate case-mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services. Section 4601(d) of the BBA provided the statutory authority for the development of a case-mix system by requiring the Secretary to expand research on a PPS for HHAs under the Medicare program that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case-mix adjuster that explains a significant amount of the variances in costs. Further, section 4601(e) of the BBA provides the authority for the submission of data for the case-mix system, effective for cost reporting periods beginning on or after October 1, 1997, by permitting the Secretary to require all HHAs to submit additional information necessary for the development of a reliable case-mix system. Regulations implementing these requirements are codified at 42 CFR 484 Subpart E. We have plans to eventually link beneficiary information across provider settings with other administrative data (for example, payment and utilization data). Beneficiaries may have very complex service delivery histories, moving among various services and benefits. It would be difficult to track outcomes and facilitate administrative tasks involved with integrating the care of individuals in our data systems if OASIS data were not collected.

OASIS is also instrumental in assisting CMS to address the challenges presented by Pay for Reporting (as mandated in the Dec. 2005 Deficit Reduction Act [DRA]). Specifically, section 5201(c)(2) of the DRA added section 1895 (b)(3)(B)(v)(II) to the Social Security Act, requiring that "every home health agency [HHA] shall submit to the Secretary [of Health and Human Services] such data that the Secretary determines are appropriate for the measurement of health care quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause." In addition, section 1895 (b)(3)(B)(v)(I), as also added

by 5201 (c)(2) of the DRA, dictates that "for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points."

2. Information Users

- HHAs: Individual HHAs use the patient-specific information in the OASIS data set to conduct patient assessment, care planning, quality assessment, and program improvement activities. Using Outcomes-based Quality Improvement (OBQI) reports based on the OASIS data set, HHAs are able to examine their specific care domains and types of patients and can compare present performance to past performance with national performance norms. HHAs use the outcome reports to evaluate the effectiveness of care provided to specific types of patients and, in the context of investigating processes of care, to individual patients. They also use the data from outcome reports to continuously monitor quality improvement outcomes over time, and to objectively assess their own strengths and weaknesses in the clinical services they provide. These outcome reports inform the HHA of the care-related areas, activities, and/or behaviors that result in effective patient care, and alert them to needed improvements. Such information is essential to HHAs in initiating quality improvement strategies. They can also be used to improve HHAs' financial planning and marketing strategies.

- State Agencies/CMS: Agency profiles are used in the survey process to compare an HHA's results with its past performance. The availability of performance data enables state survey agencies and CMS to identify opportunities for improvement in the HHA, and to evaluate more effectively the HHA's own quality assessment and performance improvement program. CMS and state agency surveyors use the reports off-site in a pre-survey protocol to target areas of concern for the on-site survey. Quality assessment and performance improvement programs are not currently required under the regulations, but surveyors look at how the HHA uses OASIS data internally, and they use the information to more effectively target survey activities.

- Accrediting Bodies: Upon specific request, national accrediting organizations such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) the Community Health Accreditation Program (CHAP), and the Accreditation Commission for Health Care, Inc. (ACHC) are able to obtain the information only for the facilities they accredit and that participate in the Medicare program by virtue of their accreditation (deemed) status. The accrediting bodies do not have direct access to the system, but CMS provides the OASIS information to enable them to target potential or identified problems during the organization's accreditation review of that facility.

- Beneficiaries/Consumers: Since November 2003, a subset of Outcome Based Quality Improvement (OBQI) measures has been publicly reported on the Home Health Compare (HHC) website.

- The HHC website is available to consumers on www.Medicare.gov and provides information about the quality of care provided by individual HHAs, allowing them to see how well patients of one agency fare compared to other agencies and to the state and national average. The home health measures reported on the website include process of care measures, outcome measures and measures of care utilization, all calculated based on OASIS data and presented in consumer-friendly language. As with the nursing home quality initiative, the home health agency initiative uses quality measures to assist consumers in making informed decisions when choosing a home health agency; to identify agencies that practice processes of care recognized as optimal practice; to monitor the care their home health agency is providing and; and to stimulate home health agencies to further improve quality.

3. Use of Information Technology

The OASIS represents uniform formulations for collecting data items that are customarily collected in the course of the clinician's assessment of adult patients receiving skilled home health care in order to create or update the plan of care, or to document the patient's status during an episode of care. The data are generally collected in the patient's home, though some items require consulting of patient records or data received from the patient's previous health care providers (such as the hospital discharge summary.) As such, the OASIS items are integrated into home health agencies' clinical records, and the modality of data collection is dictated by agencies' choices of documentation systems. Many home health agencies utilize electronic point of care technology (laptop computers, handheld devices, or other technology) that allows for assessment data to be entered electronically as it is collected. Other agencies' clinicians utilize a paper form in the home, and the data are later entered into an electronic system.

For purposes of reporting, the Medicare Conditions of Participation for home health agencies (42 CFR § 484.20) require that the OASIS items collected for Medicare or Medicaid patients be submitted electronically to the appropriate state agency. CMS provides the HAVEN software free of charge for agencies to use in electronically encoding and submitting these data, though some agencies have clinical and billing systems or vendors that perform this function for them. One hundred percent (100%) of responses are submitted electronically. OASIS data do not require a signature from the respondent.

4. Duplication of Efforts

The OASIS dataset collection does not duplicate any other data set collection, and the information cannot be obtained from any other source. It uses elements that are currently collected as part of the condition of participation at 42 CFR § 484.55, which has required a standardized assessment to be integrated into the HHA's current patient data collection and care planning processes since July 1999.

5. Small Businesses

Since OASIS data collection was mandated in 1999, CMS has taken steps to reduce OASIS-related burden to all providers, including those that are small businesses. For example, we provide a hotline for troubleshooting purposes and free software to HHAs. This software, which contains the data items to be completed at each of the OASIS data time points, is available for download from the CMS website free of charge. Small business home health providers that cannot afford the expense of an electronic health records/computer programming vendor can use this software free of charge as the means by which to submit their OASIS-C1data to CMS.

CMS also offers an OASIS training page on the cms.gov website. The OASIS webpage offers many great informational and educational tools that can be used by small business home health providers such as the OASIS Q&A mailbox which publishes answers to provider questions on a quarterly basis and the OASIS User's Manual. CMS also provides training through its OASIS contractors either directly or via satellite.

6. Less Frequent Collection

Frequency of collection will not change from the currently mandated OASIS time collection requirements. Since one of the purposes of this data collection is to assess patient outcomes, and since outcome quality measures quantify change in patient health status over time, data must be gathered at a minimum of two time points. Therefore, patient health status data obtained through the OASIS are collected at least twice (i.e., at admission and discharge for patients seen by the HHA for less than 60 days), and at 60-day intervals for patients receiving care for longer periods. Sixty-day intervals correspond to other data collection points required by the Medicare program (i.e., for prospective payment). Since the average length of stay in Medicare home health care is less than 60 days, the majority of data collection is completed at two time points (the beginning and end of care).

7. Special Circumstances

Under the Medicare Conditions of Participation (42 CFR § 484.20), Medicare-certified Home Health Agencies must report OASIS data electronically to the appropriate state agency or CMS OASIS contractor within 30 days of the assessment completion date. This allows OASIS data to be available from the state and national repositories on a timely basis for a number of key CMS functions, thus avoiding separate (and duplicative) data collection efforts:

- OASIS data can be accessed from the repositories by staff from the Home Health and Hospice Medicare Administrative Contractors (HH&H MACs) for use in assuring the accuracy of case-mix classification for payment;
- OASIS data can be accessed from the repositories by state survey and certification staff for use in surveys to assure home health agency compliance with the CoPs;
- OASIS data can be accessed from the repositories by CMS to assess home health agency compliance with the Pay for Reporting requirements of section 5201(c)(2) of the December, 2005 Deficit Reduction Act.

Less frequent reporting of OASIS data would require that separate systems of data collection be established to collect the required data, which would increase the burden on home health agencies.

We continue to believe that if data collection occurs less frequently than the specified time points, as stated in 42 CFR § 484.55, the ability to make proper Medicare payments and to evaluate the quality of care provided by HHAs to Medicare and Medicaid beneficiaries will be compromised.

8. Federal Register/Outside Consultation

The Federal Register notice (79 FR 51572) published August 29, 2014. There is a 14 public comment period.

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents.

10. Confidentiality

We pledge confidentiality of patient-specific data as provided by the Privacy Act of 1974 as amended at 5 U.S.C. 552a. The System of Records Notice associated with this data collection effort (09-70-0522) was published 2007-11-13.[4]

11. Sensitive Questions

There are no sensitive questions.

12. Burden Estimates (Hours & Wages)

Part 1. Estimated Time Burden
Average Number of HHA in U.S. = **12,014**
Average Number of OASIS Assessments Submitted Per All HHAs per Year = **17,268,890**
Average Number of OASIS Assessments Submitted Per Each HHA per Year = **1,437**
Average Number of OASIS Assessments Submitted Per Each HHA per Month = **119.75**

(The above figures were calculated as follows:
17,268,890 OASIS submissions per all HHAs per year/**12,014** HHAs in U.S. = **1,437** OASIS submissions per ALL HHAs per year
1,437 OASIS submissions per HHA per year / 12 months per year = **119.75** OASIS submissions per each HHA per month)

Part II. Estimated Cost/Wage Calculation

A. Time Estimates

4 http://www.cms.gov/Regulations-and-Guidance/Guidance/PrivacyActSystemofRecords/downloads/0522.pdf

Average time spent per each OASIS Assessment/Patient = 52.8 minutes
47.8 minutes of clinical time spent to perform the OASIS assessment
5.0 minutes of administrative time to submit data from each OASIS assessment to CMS

Estimated Annual Hourly Burden per each HHA for OASIS = 1264.5 hours per HHA
119.75 OASIS assmts. per HHA per month x 52.8 min/assessment = 6,322.8 min per HHA per month.
6,322.8 min per HHA per month / 60 minutes per hour = 105.38 hours per HHA per month.
105.38 hours per HHA/mo. x 12 months per year – 1264.5 hours per each HHA per year

Estimated Annual Hourly Burden for all HHA for OASIS = 15,191,703 hours
119.75 OASIS assmts. per HHA per month x 52.8 min/assessment = **6,322.6** min per HHA per month.
6,322.6 min per HHA per month / 60 minutes per hour = 105.38 hours per HHA per month.
105.38 hours per HHA/mo. x 12 months per year – 1264.5 hours per each HHA per year
1,264.5 hours per HHA per year x 12,014 HHAs = 15,191,703 hours for all HHAs per year.

Estimated Annual Hour Burden per ALL HHAs per year for ongoing OASIS Training
8 hours of training per each HHA per year x 12,014 HHAs = 96,112 training hours

B. Wage Costs for Completion of OASIS Assessments

Average Time/Cost per OASIS Assessment per HHA = 52.8 minutes

47.8 minutes clinician's time to collect clinical data – paid @ $32.41 per hour =	$25.82
5.0 minutes administrative time paid @ $14.01 per hour =	$ 1.17

$26.99

Medical Clinician's Time:

Calculation Method #1
47.8 minutes x 1,437 OASIS forms per HHA per year = 68,689 minutes per HHA per year
68,689 minutes per HHA per year / 60 minutes = 1,145 hours per HHA per year
1,145 hours per HHA per year x $32.41 per hour = **$37,109.45** clinical wages/ per each HHA/year
$37,109.45 x 12,014 HHAs = **$445,832,932** per ***all*** HHAs per year

Calculation Method #2
47.8 min. of clinical/nursing time x 119.75 OASIS forms per HHA per year = 5,724 min per HHA mo.
5,724 min. per each HHA monthly x 12 months per year = 68,688 minutes per HHA yearly
68,688 minutes per HHA yearly / 60 minutes per hour = 1144.8 hours per HHA yearly
1145 hours per HHA yearly x $**32.41** per hour = **$37,109.45** nursing wages per HHA yearly
$37,109.45 x 12,014 HHAs = **$445,832,932** per ***all*** HHAs per year

Administrative Assistant Time:

Calculation Method #1
5 min per OASIS form x 1,437 OASIS forms per HHA per year = 7,185 minutes per HHA per year
7,185 minutes per HHA per year / 60 minutes = 119.75 hours per HHA per year
119.75 hrs per HHA per year x $14.01 per hrs. **= $1,677.70** admin assistant wages per HHA per year

$1,677.70 x 12,014 HHA HHAs = **$20,155,888** per all HHA HHAs/year

Calculation Method #2

5 min of Admin. Staff time x 119.75 OASIS forms per HHA per year = 598.75 min per HHA monthly

598.75 minutes per each HHA monthly x 12 months per year = 7,185 minutes per HHA yearly
7,185 minutes per HHA yearly / 60 minutes per hour = 119.75 hours per HHA yearly
119.75 hours per HHA yearly x $**14.01** per hour = **$1,677.70** nursing wages per HHA yearly
$1,677.70 x 12,014 HHAs = **$20,155,888** per ***all*** HHAs per year

Total Annualized Staff Wages for Time Required Completing OASIS Assessments per Each HHA:

$37,109.45	Clinical/Nursing wages per each HHA per year
$ 1,677.70	Administrative assistant wages per each HHA per year
$38,787.15	**Total Annualized Cost to Each HHA Provider**

Total Annualized Staff Wages for Time Required to Complete OASIS Assessment Across All HHAs

$445,832,932	Clinical/Nursing wages per all HHA providers per year
$ 20,155,888	Administrative assistant wages per all HHAs per year
$465,988,820	**Total Annualized Cost to All HHAs Providers**

Training Costs:

2 hours of OASIS update training per each HHA x 18 staff members = 36 total training hrs. per HHA
36 hours of training per HHA x 12,014 HHAs = 432,504 hrs. OASIS updates training/year for all HHAs

13 Clinical staff persons per HHA to attend 2 hour training = 26 hours
5 Administrative Staff members attending 2 hour training session = 10 hours

Clinical Staff Training Wage Estimate

26 hours x $32.41 per hour = **$842.66** for training clinical staff at ***each*** HHA per year
$842.66 x 12,014 HHAs = **$10,123,717** for training clinical staff in ***all*** HHAs/per year

Administrative Staff Training Wage Estimate

10 hours x $14.01 per hour = **$140.10** for training clinical staff at ***each*** HHA per year
$140.10 x 12,014 HHAs = **$1,683,161** for training clinical staff in ***all*** HHAs/per year

Wages for One-Time Training Wages for Each Individual HHA

$842.66	Clinical Staff Training Wages per each HHA
$140.10	Administrative Staff Training Wages per each HHA
$982.76	**Total Combined Wages for one-time Staff Training**

Wages for One-Time Training Wages for ALL HHAs

$10,123,717	Clinical Staff Training Wages per each HHA
$ 1,683,161	Administrative Staff Training Wages per each HHA
$11,806,878	Total Combined Wages for one-time Staff Training

Summary of Estimated Costs:

***$*37,109.45**	Nursing wages per each HHA per year
***$* 1,677.70**	Administrative assistant wages per each HHA per year
$ 982.76	Wages for One-time OASIS-C Update Staff Training for each HHA

$39,769.91	**Estimated Total Annualized Cost to Each HHA Provider**
$445,832,932	Nursing wages per all HHA providers per year
***$* 20,155,888**	Administrative assistant wages per all HHAs per year
$ 11,806,879	Wages for One-time OASIS-C Update Staff Training for ALL HHAs
$477,795,699	**Estimated Total Annualized Cost to All HHAs Providers**

C. Other Calculations

1. Average Yearly Cost to Each HHA

$477,795,699 – Cost for all HHAs per year /12,014 HHAs in U.S. **= $39,770**

2. Estimated Average Monthly Cost Across All HHAs

$477,795,699 - Total annual cost to all HHAs per year /12 months per year = **$39,816,308**

3. Estimated Average Monthly Cost to Each Individual HHA

$477,795,699 - Total annual cost to all HHAs/year/12 months per year / 12,014 HHAS = **$3,314**

4. Estimated Cost per Each OASIS Assessment

$477,795,699 - Total annual cost to all HHAs/year/17,268,890 OASIS assessments per year = **$27.67** per each OASIS assessment

13. Capital Costs

At the time of the OASIS implementation, there was a one-time start-up cost for HHAs in the first year. After the first year of OASIS implementation, existing HHAs experience an ongoing cost of reporting the gathered information to the state or OASIS contractor. We continue to acknowledge that the time frames required by § 484.55 serve as a strong performance expectation for HHAs. In identifying standardized data elements that fit within the HHA's overall comprehensive assessment responsibilities, the OASIS includes only information necessary to measure outcomes of care for quality indicators and for HHAs to continue to receive payment through the prospective payment system. Therefore, we require that HHAs use the current version of the OASIS as specified in §484.55(e). We believe this requirement is necessary to continue to build a valid, reliable, comparable data set of outcomes.

We do not believe that the use of the interim version of OASIS-C1 titled "**OASIS-C1/ ICD-9 Version**" will require new capital expenditures on the part of home health agencies. The equipment and systems in use for OASIS-C can handle ***OASIS-C1/ICD-9 Version*** as well. Software will require updating, as it does in most years to deal with incidental changes, and CMS will provide the updated HAVEN software free of charge for agencies that do not wish to update their proprietary systems.

14. Cost to Federal Government

CMS will incur costs associated with the collection and handling of OASIS-C1 data using the interim version of OASIS-C1 titled "**OASIS-C1/ ICD-9 Version**" for several reasons. First,

providers can submit their OASIS data using a CMS sponsored web-based program known as HAVEN. The federal government will incur costs associated with the maintenance and upkeep of this web-based computer program. In addition, the federal government will also incur costs for the help-desk support that must be provided to assist providers, not only with the OASIS data collection process, but also the data submission process.

Secondly, once **OASIS-C1/ ICD-9 Version** data has been submitted by HHA providers, it is then transmitted to a CMS contractor for processing and analysis. Thereafter, the data is stored by another CMS contractor for future use. There are costs associated with the transmission, analysis, processing and storage of the **OASIS-C1/ ICD-9 Version** data by the CMS contractors.

Thirdly, pursuant to §1895 (b)(3)(B)(v)(I) of the Act, HHAs that do not submit **OASIS-C1/ ICD-9 Version** data will receive a 2 percentage point reduction of their home health market basket percentage increase. There are costs associated with the tabulation of the data necessary to determine provider compliance with the reporting requirements mandated by §1895 (b)(3)(B)(v)(I) of the SSA.

It is important to note that these costs are not new, but have been associated with the use of the **OASIS-C1/ ICD-9 Version** data collection instrument since it was first introduced in 1999.

The total estimated annual cost to the federal government for the implementation and ongoing management of OASIS (including data collected using the interim version of OASIS-C1 titled "**OASIS-C1/ ICD-9 Version**") data is $1,500,000. These costs are itemized below:

ESTIMATED ANNUAL COSTS TO FEDERAL GOVERNMENT:

Conduct State OEC Training	$100,000
Update OASIS-C1/ICD-9 Version Webinar Training	$150,000
Update OASIS-C1/ICD-9 Version Q&As	$100,000
Update OASIS-C1/ICD-9 Version Manuals and Materials	$100,000
Contractor Costs for Receipt and Storage of OASIS-C1/ICD-9 Data	$550,000
Costs for Upkeep & Maintenance of HAVEN Software by CMS/DNS	$500,000
TOTAL COST TO FEDERAL GOVERNMENT:	**$1,500,000**

15. Changes to Burden

The ***OASIS-C1/ ICD-9 Version*** is an interim version of the OASIS-C1 data item set which was created in response to the legislatively mandated ICD-10 delay. ***OASIS-C1/ICD-9 Version,*** incorporates the updates and burden reduction advantages of OASIS-C1, but replaces the items using ICD-10 codes with corresponding items from OASIS-C that use ICD-9 codes.

There will be no increase in provider burden associated with the implementation of ***OASIS-C1/ICD-9 Version*** for two reasons. First, ***OASIS-C1/ ICD-9 Version*** incorporates the same reduction in provider burden that was achieved in the OASIS-C1 by removing items not currently used by CMS for payment, quality, or risk adjustment. Second, there will be no

change in the way in which OASIS data is collected and reported to CMS using ***OASIS-C1/ICD-9 Version***.

16. Publication/Tabulation Dates

These information collection requirements do not employ sampling techniques or statistical methods. While the patient-level OASIS data is not published, CMS does publish a set of quality measures derived from OASIS assessments on the Medicare Home Health Compare web site. The OASIS data used to calculate the quality measures are updated quarterly and represent a rolling 12 months of data. Data for all episodes of care that end within that 12-month period are included regardless of when the episode of care began. The most recent update occurred on January 17, 2013 and includes episodes ending between October 2011 and September 2012. Additional details about the measures are available on the CMS Home Health Quality Initiative web site: https://www.cms.gov/HomeHealthQualityInits/10_HHQIQualityMeasures.asp

17. Expiration Date

This collection does not lend itself to the displaying of an expiration date.

18. Certification Statement

There are no exceptions to the certification statement.

List of Attachments:

Attachment A
OASIS-C to Revised Draft OASIS-C1 – Items, Timepoints & Uses Crosswalk

Attachment B
Changes to Be Made to OASIS-C1 to Create "OASIS-C1/ICD-9 Version