

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**LIMITED OVERSIGHT OF  
HOME HEALTH AGENCY  
OASIS DATA**



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Inspector General

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OEI-01-10-00460

## **EXECUTIVE SUMMARY: LIMITED OVERSIGHT OF HOME HEALTH AGENCY OASIS DATA: OEI-01-10-00460**

### **WHY WE DID THIS STUDY**

Outcome and Assessment Information Set (OASIS) data are the basis for home health agency (HHA) payment, quality measures, and consumer information on the Home Health Compare Web site. Timely and accurate submission of these data is vital for HHAs' efforts to improve quality and for consumers researching HHAs. In addition, State survey staff use OASIS data in the survey and certification of HHAs, which ensures that HHAs are meeting all Conditions of Participation required by Medicare.

### **HOW WE DID THIS STUDY**

We surveyed all States regarding their responsibilities for OASIS data. We conducted structured interviews with Centers for Medicare & Medicaid Services (CMS) staff. We also obtained all home health Part A claims and OASIS records for 2009 to determine which submitted claims were missing a required OASIS record. We obtained a list of all HHAs that CMS penalized from 2007 to 2010 by assessing the 2-percent payment reduction.

### **WHAT WE FOUND**

HHAs did not meet all Federal reporting requirements. They did not submit required OASIS data for 392,180 (6 percent) of claims in 2009, which represented over \$1 billion in Medicare payments. Only 199 HHAs were penalized by CMS with the 2-percent payment reduction from 2007 through 2010. Furthermore, HHAs submitted 15 percent of OASIS datasets late. Some States provided training and technical support to HHAs and almost all restricted access to OASIS data. States conducted limited data analysis and review of the accuracy of OASIS data. Finally, CMS did not ensure the accuracy or completeness of OASIS data and did not validate States' processes for monitoring submitted OASIS data.

### **WHAT WE RECOMMEND**

Our report made three recommendations to CMS. First, identify all HHAs that failed to submit OASIS data and apply the 2-percent payment reduction to them. Second, establish and implement enforcement actions for HHAs that submit OASIS data after the 30-day deadline. Third, develop clear guidelines that delineate expectations for States regarding timely and accurate OASIS data. CMS concurred with our first recommendation and did not concur with our second or third recommendation.

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## OBJECTIVES

1. To determine the extent to which home health agencies (HHA) meet Federal reporting requirements for the Outcome and Assessment Information Set (OASIS) data.
2. To determine the extent to which States meet Federal reporting requirements for OASIS data.
3. To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) oversees the accuracy and completeness of OASIS data submitted by HHAs.

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## BACKGROUND

Medicare beneficiaries who are generally confined to their homes may be eligible to receive certain medical services at home.<sup>1</sup> Home health services include part-time or intermittent skilled nursing care, as well as other skilled care services, such as physical, occupational, and speech therapy; medical social work; and home health aide services.<sup>2</sup>

### OASIS

When a beneficiary begins home health care, and at regular intervals thereafter, a registered nurse or rehabilitation therapist conducts a comprehensive assessment of the beneficiary using the OASIS, a standardized dataset.<sup>3</sup> HHAs use the OASIS to assess patients' continuing need for home care and to identify patients' medical, nursing, rehabilitative, social, and discharge-planning needs.

Medicare reimbursement and consumer information presented on CMS's Web site depend on accurate and timely submission of OASIS data. In addition, State survey staff use OASIS data in surveying and certifying HHAs to ensure that HHAs are meeting all Conditions of Participation (CoP) required by Medicare. Finally, OASIS data will play a crucial role as CMS explores pay-for-performance systems that offer incentive payments to Medicare HHAs for maintaining high levels of quality care or for making significant improvements in the quality of their services.

### Home Health Prospective Payment System

Under the prospective payment system (PPS), which CMS implemented in October 2000, HHAs receive a standardized payment for each 60-day episode of home health care that a Medicare beneficiary receives. The

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<sup>1</sup> Social Security Act, §§ 1835(a)(2)(A) and 1861(m).

<sup>2</sup> CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 7, § 40.

<sup>3</sup> 42 CFR §§ 484.55(b) and (d)(1).

payment covers skilled nursing care, home health aide visits, therapy, medical social services, and routine and nonroutine medical supplies provided by HHAs.<sup>4</sup> HHAs use the OASIS to determine the payment code for each 60-day episode of care they submit for reimbursement.

### **Home Health Quality Measures**

CMS uses OASIS data as the basis for its Outcome-Based Quality Improvement effort. CMS developed 41 quality measures to evaluate patients' improvement or stabilization in activities of daily living and health status. Quality measures include improvement or stabilization in bathing, toileting, speech, and language; in cognitive functioning; in management of oral medications; and in bowel and urinary continence. CMS reports 12 of these quality measures on its Home Health Compare Web site, which informs patients and their families about HHAs.

### **Overseeing Medicare HHAs**

Through agreements between CMS and the States, State survey agencies (State agencies) survey HHAs to certify their compliance with Medicare CoPs.<sup>5</sup> State agencies conduct initial onsite certification surveys before HHAs enroll as Medicare providers, and the States conduct recertification surveys at least every 36 months.<sup>6</sup> State agencies have the authority to cite HHAs for failure to meet the standards specified in the CoPs. State agencies review OASIS data to prepare for surveys of individual HHAs and to audit the accuracy of OASIS data.<sup>7</sup> The CMS *OASIS Guidance Manual* instructs HHAs on how to verify OASIS accuracy through clinical record and data entry audits. As part of the survey, CMS expects State agencies to examine how HHAs monitor the accuracy of OASIS data; to review clinical records; and to observe a home visit, if possible.<sup>8</sup>

### **Transmitting OASIS Data**

CMS requires HHAs to submit OASIS data to their States for all Medicare beneficiaries they serve.<sup>9</sup> State agencies are responsible for collecting and managing OASIS data. The CMS OASIS submission system, housed in State agencies, automatically validates transmitted OASIS data. The system rejects submissions with significant data problems, but it does not prevent transmission of records with minor errors. HHAs receive confirmations when data transmissions are complete. A CMS contractor

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<sup>4</sup> 65 Fed. Reg. 41128 (July 3, 2000).

<sup>5</sup> Social Security Act, § 1864.

<sup>6</sup> Social Security Act, § 1891(c)(2)(A).

<sup>7</sup> 42 CFR § 488.68(c).

<sup>8</sup> CMS, *State Operations Manual*, Pub. No. 100-07, Appendix B, Section G322, § 484.20(b). Standard: Accuracy of Encoded OASIS Data.

<sup>9</sup> HHAs must submit an OASIS for all Medicare and Medicaid patients; however, this study is limited to Medicare patients.

collects the data from all State agencies and computes the quality measures that CMS uses for monthly Outcome-Based Quality Improvement Reports and quarterly updates to its Home Health Compare Web site.

*CMS requirements for HHA OASIS submission.* CMS requires that all HHAs encode and electronically submit OASIS data to State agencies within 30 calendar days after completing each patient assessment.<sup>10, 11</sup> It also requires HHAs to ensure that submitted data accurately reflect the condition of each patient at the time of assessment.<sup>12</sup>

The Deficit Reduction Act (DRA) of 2005 included a provision that HHAs submit required OASIS data. The DRA stipulates that an HHA's failure to submit data will result in a 2-percent payment reduction to its home health market basket index increase for a year.<sup>13, 14</sup> CMS works with Medicare contractors to identify HHAs that have submitted claims but have not transmitted any OASIS data. The contractors notify any such HHAs in writing, and those HHAs have 30 days to dispute the reduced payment. During this time, an HHA disputing the reduction must submit documentation to confirm that it did transmit the data. If CMS upholds the decision, the contractor programs the payment system to apply a 2-percent payment reduction to that HHA's market basket index increase for the upcoming calendar year.<sup>15</sup>

As of January 1, 2010, CMS required HHAs to submit OASIS data as a Medicare condition for payment in addition to a CoP. Since that date, all HHAs must submit OASIS data before submitting a final claim for payment, and the payment codes on the final claim and OASIS submission must match.<sup>16</sup>

*CMS OASIS requirements for States.* CMS delegates overall responsibility for OASIS data collection and database management to State agencies.<sup>17</sup> Although CMS regulations specify that State agencies are to establish and maintain OASIS databases, States in fact house CMS OASIS servers and

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<sup>10</sup> 42 CFR § 484.20.

<sup>11</sup> 42 CFR § 484.55.

<sup>12</sup> 42 CFR § 484.20(b).

<sup>13</sup> DRA of 2005, P. L. 109-171, § 5201(c)(2) (February 8, 2006) (adding Social Security Act § 1895(b)(3)(B)(v)).

<sup>14</sup> The primary source of CMS's market basket index is the Medicare cost reports supplied by providers to construct weights of major cost categories. The market basket reflects price inflation of these cost categories, and CMS uses the weights to update payments and cost limits of various CMS payment systems.

<sup>15</sup> CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 10, § 120.

<sup>16</sup> 74 Fed. Reg. 58078, 58111 (Nov. 10, 2009) (revising 42 CFR §§ 484.210(e) and 484.250).

<sup>17</sup> 42 CFR § 488.68.

do not create their own databases.<sup>18</sup> Additional State agencies' responsibilities for operating the OASIS submission system include:

- analyzing and editing OASIS data,<sup>19</sup>
- ensuring accuracy of OASIS data,<sup>20</sup>
- restricting access to OASIS data,<sup>21</sup> and
- providing training and technical support for HHAs.<sup>22</sup>

CMS offers States agencies no guidance or details on their responsibilities for operating the OASIS submission system. Federal regulations do not include specific oversight responsibilities for CMS with respect to OASIS data. CMS oversees State agencies' survey competence through annual reviews of States' performance as measured by standards that CMS establishes.<sup>23</sup>

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## METHODOLOGY

### Scope

This evaluation determined whether HHAs and States met Federal reporting requirements for OASIS data in 2009. It also determined the extent to which CMS oversaw the accuracy and completeness of OASIS data that HHAs submitted. We reviewed the extent to which CMS instituted the 2-percent payment reduction for HHAs that failed to submit data since the DRA provision went into effect in 2007. We analyzed HHAs that CMS penalized with a 2-percent payment reduction from 2007 to 2010 and documented any HHAs that CMS similarly penalized in multiple years. Finally, we calculated how many claims from 2009 had a corresponding OASIS data submission to a State agency. We limited our analysis to Medicare patients for this evaluation. This evaluation also did not determine the extent to which OASIS data submitted by HHAs accurately reflected patients' conditions at the time of assessments.

### Data Sources

We used the following five data sources to analyze the OASIS data that HHAs submitted: (1) an online survey of State officials, (2) the National Claims History File (NCH), (3) OASIS data, (4) structured interviews with

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<sup>18</sup> 42 CFR § 488.68(a).

<sup>19</sup> 42 CFR § 488.68(b).

<sup>20</sup> 42 CFR § 488.68(c).

<sup>21</sup> 42 CFR § 488.68(d).

<sup>22</sup> 42 CFR § 488.68(e).

<sup>23</sup> CMS, *Quality Assurance for the Medicare and Medicaid Programs: Fiscal Year 2011 Mission and Priority Document*, pp. 21–22, revised October 15, 2010.

CMS staff, and (5) CMS data identifying HHAs that were penalized with the 2-percent payment reduction between 2007 and 2010.

*Survey of States.* We surveyed all 50 States and the District of Columbia (States) in May 2011 about their efforts to fulfill their oversight responsibilities for OASIS data. The survey focused on States' policies and procedures for ensuring the accuracy and completeness of OASIS data that HHAs submitted. We sent the survey to the States' OASIS Automation Coordinators as identified on the CMS Web site. We had a 98-percent response rate; only the District of Columbia failed to respond.

*NCH and OASIS data.* We obtained all 6,633,582 home health Part A claims from 2009 to determine the number of OASIS records that HHAs should have submitted. We linked those claims to the submitted OASIS records from the same period to determine which claims were missing required OASIS records in 2009.

In addition, we reviewed the OASIS records to determine whether HHAs submitted the data within 30 days from the patient assessment date, as required.

*Interviews with CMS staff.* We conducted structured interviews with CMS officials knowledgeable about the OASIS database and data validation procedures in the Center for Medicaid, CHIP, and Survey and Certification as well as from the Office of Clinical Standards and Quality. We also interviewed staff working in claims processing and asked how CMS implements the 2-percent payment reduction for failure to submit OASIS data.

*CMS data on HHAs penalized with the 2-percent payment reduction.* We obtained a list from CMS of all HHAs that it penalized with the 2-percent payment reduction in 2007, 2008, 2009, and 2010 for failure to submit the required OASIS data. We analyzed the data to determine the trend of 2-percent payment reductions and calculated how many HHAs CMS repeatedly penalized between 2007 and 2010.

### **Limitations**

We did not analyze the completeness or accuracy of OASIS data submitted for individual patients.

### **Standards**

This study was conducted in accordance with the Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

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## FINDINGS

### Home health agencies did not meet all Federal reporting requirements for OASIS data

Our analysis found that HHAs were deficient in meeting two Federal reporting requirements for OASIS data: that HHAs submit OASIS data for all Medicare beneficiaries they serve and that they submit them within 30 days from the date of the patient assessment.

#### HHAs did not submit required OASIS data for 6 percent of claims in 2009, which represented over \$1 billion in Medicare payments

In 2009, 392,180 (6 percent) Medicare home health claims submitted by HHAs did not have OASIS data for the same period. Although the missing OASIS data account for over \$1 billion in Medicare payments, submitting OASIS data did not become a Medicare condition of payment until January 1, 2010. This means that for 2009 these claims were not paid in error. Furthermore, in 2009, 85 percent of HHAs did not submit OASIS data for at least one claim. Over half of those HHAs did not submit OASIS data for at least 10 claims in 2009. (See Table 1.)

**Table 1: Distribution of HHAs With Claims Missing OASIS Data, 2009**

Number of Claims per HHA	Number of HHAs Missing Claims	Percentage of HHAs
1–5	2,106	23%
6–10	1,369	15%
11–20	1,787	19%
21–40	1,718	19%
41–100	1,521	16%
101 or more	773	8%
<b>Total</b>	<b>9,274</b>	<b>100%</b>

Source: NCH and OASIS data, 2009.

From 2007 through 2010, CMS penalized only 199 HHAs by assessing the 2-percent payment reduction for not submitting OASIS data (see Table 2). Among these HHAs, CMS penalized 13 for 2 of the 4 years reviewed, and CMS penalized 1 for 3 consecutive years.

**Table 2: HHAs CMS Penalized With a 2-Percent Payment Reduction, 2007–2010**

	2007	2008	2009	2010
HHAs with 2-percent payment reduction	41	62	36	60
Total HHAs	9,404	10,036	10,961	11,488
Percentage of total HHAs	0.4%	0.6%	0.3%	0.5%

Source: CMS 2-percent payment reduction data, 2007–2010.

The small number of HHAs penalized may be explained, in part, by CMS’s failure to verify the completeness of OASIS data submitted. CMS officials told us that it penalizes only those HHAs that failed to submit any OASIS data for that year. An HHA needs to submit only one OASIS out of potentially hundreds or thousands during the yearlong reporting period to avoid the 2-percent payment penalty.

#### **HHAs submitted 15 percent of OASIS datasets late**

CMS does not penalize HHAs for late submissions. In 2009, HHAs submitted 15 percent of OASIS datasets after the required 30-day timeframe (see Table 3).<sup>24</sup> HHAs submitted almost a million OASIS (962,646) datasets late; about a third of those (342,936) were more than 21 days late.

**Table 3: Timeliness of HHA OASIS Submissions, 2009**

	Number of Submissions	Percentage of Total Submissions
Within 30 days	5,278,756	85%
1 to 10 days late	423,068	7%
11 to 20 days late	196,642	3%
21 to 30 days late	101,548	2%
31 to 60 days late	140,096	2%
61 days or more late	101,292	2%
<b>Total OASIS submissions</b>	<b>6,241,402</b>	<b>100%*</b>

Source: NCH and OASIS data, 2009.

\*Does not equal 100 percent because of rounding.

<sup>24</sup> Our analysis calculated the number of days between assessment date and OASIS submission. Our analysis does not account for HHAs that may have resubmitted a previously rejected OASIS. The date of submission reflects the most current rather than the first submission by the HHA.

## States met some, but not all, OASIS requirements

Our survey of States showed that they provided training and support for OASIS and that most restricted access to the data. However, they conducted limited data analysis or review of the data's accuracy.

### Some States provided training and technical support to HHAs, and almost all restricted access to OASIS data

According to our survey results, 30 States provided OASIS training to HHAs, and 45 States provided OASIS technical support to HHAs in the 12 months before our survey was sent in May 2011 (see Table 4).

**Table 4: OASIS Training Topics Covered**

	Number of States Covering This Topic
Administering the OASIS dataset	22
Transmitting OASIS data	21
Integrating the OASIS dataset into the HHAs' recordkeeping	17
Ensuring privacy and confidentiality of the OASIS dataset	14
Using software to encode OASIS data	14
Transitioning to the latest OASIS reporting requirements	5
Using regulatory resources and guidance	5
Coding accurately	3

Source: OIG survey of States, 2011.

Also, according to our survey results, almost all States (49) had policies and procedures to restrict access to OASIS data. Almost all kept the CMS OASIS server in a secure room (47 States), protected the data with a password (43), and followed encryption standards (43).

### States conducted limited data analysis and review of the accuracy of OASIS data

States' analyses of OASIS data were generally limited to CMS's automated OASIS submission system. Forty-seven States reported that they did nothing beyond CMS automated checks. Only three States reported that they further validated data by checking for missing data and reconciling duplicate patients. No States reported conducting analyses to ensure that the OASIS data accurately reflected patients' conditions at the time of assessments.

Furthermore, States took little action when they identified problems with OASIS reporting. States most commonly responded that they contacted HHAs when they identified problems with submissions or quality; however, three States indicated that they did not take any action. Few States responded that they took formal action to address OASIS data problems. For example, four States initiated a quality improvement plan for HHAs, and three States scheduled training for HHAs with OASIS reporting problems.

Twenty-three States reported that they informed the State surveyors about HHAs with OASIS reporting problems. State surveyors have the authority to inspect HHAs for compliance with the Medicare CoPs and to cite deficiencies when HHAs do not meet those standards. However, Federal law requires State surveyors to inspect HHAs only once every 36 months.

### **CMS did not ensure the accuracy or completeness of OASIS data**

Federal regulations do not specify oversight responsibilities for CMS with respect to OASIS data accuracy or completeness, and we found little evidence that CMS reviewed or validated OASIS data nationally. In addition, CMS did not review States' protocols or procedures for collecting OASIS data from HHAs.

### **CMS did not review OASIS data collected by States for accuracy or completeness**

CMS has direct access to OASIS data in the national database; however, our interviews with CMS staff revealed that CMS did not access, review, edit, or validate OASIS data nationally. In responses to our survey, only four States reported that CMS had requested information or reviewed OASIS data in the last 12 months; only two States reported that CMS requested a specific analysis of OASIS data in the 12 months before our survey was sent in May 2011. Those requests addressed reviewing data transmissions and administering the 2-percent payment reduction.

### **CMS did not validate States' processes for monitoring submitted OASIS data**

Twenty States reported that CMS had never reviewed their States' protocols or procedures for collecting OASIS data from HHAs. Twenty-four States could not say whether CMS had ever reviewed their OASIS data collection procedures. In our interviews, CMS staff told us that CMS provided no guidance to States on establishing procedures for submitting and validating OASIS data. CMS also stated that it did not specifically advise States to monitor the timeliness or validity of OASIS data submissions.

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## RECOMMENDATIONS

OASIS data are the basis of Medicare reimbursement, and inaccurate or missing data could indicate potential Medicare fraud. If HHAs submit inaccurate information, they could be reimbursed for services they did not deliver to beneficiaries. OASIS errors also undermine the integrity of the home health quality measures, potentially affecting the Home Health Compare Web site on which beneficiaries and their families rely. In 2009, States and HHAs did not meet all Federal reporting requirements for OASIS data. HHAs did not submit OASIS data for 6 percent of claims representing over \$1 billion in Medicare payments, and they submitted 15 percent of OASIS data late.

Congress and CMS established a financial disincentive for HHAs' failure to submit OASIS data; however, at the time of our review, CMS had not imposed the 2-percent payment reduction on the market basket index increase on all HHAs that did not submit all required OASIS datasets, which may have minimized its effect.

Our review also found that most States did not perform additional data validation beyond the steps in the automated CMS OASIS submission system. No States had systems to ensure that submitted OASIS data accurately reflected the patients' conditions at the time of assessments.

In light of our findings, we recommend that CMS:

### **Identify all HHAs that failed to submit OASIS data and apply the 2-percent payment reduction to them**

Our analysis showed that many HHAs did not submit OASIS data according to Federal reporting requirements, yet CMS penalized only a small number with the 2-percent payment reduction. CMS considers HHAs to be in compliance if they submit at least one OASIS regardless of how many they completed.

In 2010, CMS began requiring HHAs to submit OASIS data before the final claim as a condition for payment. When CMS fully implements this condition, the 2-percent penalty may become unnecessary. Until that time, CMS should raise the threshold for compliance to deter other HHAs from failing to comply with this important requirement.

### **Establish and implement enforcement actions for HHAs that submit OASIS data after the 30-day deadline**

CMS does not penalize HHAs for submitting OASIS data late. In addition, HHAs lack an incentive to submit the OASIS before final claims, which they can submit as long as 3 to 4 weeks after the OASIS data are due. CMS should identify HHAs that are consistently or egregiously late in submitting

data. CMS should also consider enforcement actions for HHAs that consistently miss the 30-day deadline.

### **Develop clear guidelines that delineate expectations for States regarding timely and accurate OASIS data**

CMS holds States accountable for ensuring that HHAs submit timely and accurate OASIS data; however, it does not provide guidance on how States oversee this process. In addition to reviewing HHAs as part of the 3-year survey cycle, CMS should evaluate all States' protocols and procedures for analyzing and editing OASIS data to find vulnerabilities and highlight best practices.

CMS should also develop guidelines to ensure data accuracy. OASIS data have multiple uses, from reimbursement to quality measures, yet the current system uses self-reported data from HHAs with little to no validation. CMS should work with States to develop procedures that can detect both data input errors and willful misrepresentation of patients' conditions at the time of assessments.

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## **AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In its comments on the draft report, CMS concurred with our first recommendation, but it did not concur with our second and third recommendations. CMS noted that it had implemented measures to improve oversight of States and HHAs and to address accuracy and completeness of the OASIS data process.

CMS concurred with our first recommendation stating that it is pursuing a plan of action consistent with our recommendation. It is exploring methods to increase the compliance threshold for the 2-percent payment reduction. In addition, CMS is working to link the Medicare claims processing system and the State OASIS repositories to deny payment to HHAs that fail to submit OASIS data.

CMS did not concur with our second recommendation. CMS stated that our findings failed to note that the error code for late submissions also included corrected OASIS data submissions. CMS also noted that the survey process looks at OASIS data submissions and targets late submissions. CMS added that it will revise the worksheet surveyors complete before starting the survey to emphasize the error for late OASIS submissions. We understand that CMS uses the survey process to review OASIS data submissions for timeliness and accuracy. However, CMS requires State agencies to survey HHAs only once every 3 years.

Although this survey cycle may be sufficient for other purposes, it could be inadequate to review timeliness of OASIS data. Rather than relying solely on the survey process, CMS could, for example, analyze data in the OASIS repository to identify HHAs that consistently submit OASIS data late.

CMS also did not concur with our third recommendation. CMS stated that our report failed to identify the magnitude of costs associated with additional workload on State agencies to monitor error messages. It also noted that identifying willful misrepresentation of data is outside the scope of the States' technical ability. We remain concerned that the current system relies on self-reported data from the HHAs without further validation. Finally, CMS stated that the findings do not support the significant investment that would be required to modify the survey process. We understand the constraints of the survey process and are aware of resources required to modify it. In our recommendation, we did not intend for CMS to modify the survey process. CMS should work with States outside the survey process and develop guidelines that States could follow to improve the quality and accuracy of OASIS data. Based on CMS's comments, we clarified the wording of this recommendation.

See the Appendix for the full text of CMS's comments.

## APPENDIX A

### Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** DEC 14 2011

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Marilyn Tavenner  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Limited Oversight of Home Health Agency OASIS Data (OEI-01-10-00460)

Thank you for the opportunity to review and comment on the subject OIG draft report. The Centers for Medicare & Medicaid Services (CMS) appreciates the contributions and valuable input by the OIG in reviewing the oversight of CMS activities to assess the collection of OASIS data. The purpose of this report was to determine the--(1) Extent to which Medicare home health agencies (HHAs) meet Federal reporting requirements for the Outcome and Assessment Information Set (OASIS) data; (2) Extent to which States meet Federal reporting requirements for OASIS data; and (3) Extent to which CMS oversees the accuracy and completeness of OASIS data submitted by HHAs.

Since the implementation of OASIS in 1999, CMS has implemented a number of measures to improve the oversight of States and HHAs, and some of those measures also address accuracy and completeness of the OASIS data process. For instance--

- Beginning January 1, 2010, HHAs were required to submit an OASIS as a condition for payment. To ensure compliance with OASIS data submission as a condition of payment, HHAs must submit OASIS start of care and recertification assessment data to the State prior to submitting final Medicare claims. Furthermore, HHAs must ensure that the Health Insurance Prospective Payment System (HIPPS) code on the final claim matches that received on the OASIS validation report;
- We instructed surveyors to address late OASIS submissions as part of the pre-survey process. The HHA surveyor worksheet targets HHAs with a 20-percent late submission rate for investigation;
- Currently, the transmission of assessment data to the OASIS Submission System and transmission of HIPPS codes on claims to Medicare contractors are entirely separate processes. The Fiscal Intermediary Shared System (FISS) does not have access to the OASIS Submission System. The payment group determined from

an assessment is transmitted to the submission system, but Medicare contractors can only access this information on an individual query basis if a claim is selected for medical review. CMS has begun work on a multi-component effort to ensure that the HIPPS code on claims received by Medicare contractors match the payment group on the assessment received by the OASIS Submission System; and

- Beginning in February 2010, CMS changed the way HHA users log in to the OASIS Submission and Reporting Systems. CMS required that all HHA users register for a personal user identification and password.

The OIG recommendations and CMS's response to the recommendations are discussed below.

#### **Recommendation 1**

The OIG recommends that CMS identify all HHAs that fail to submit OASIS data and apply the 2-percent payment reduction to them.

#### **CMS Response**

The CMS concurs with this recommendation. As the OIG states in its report, in January 2007 CMS implemented the 2 percent payment reduction for HHAs that failed to submit OASIS data. However, the OIG is now recommending that we pursue two additional steps that include--(1) Fully implementing the requirement that HHAs submit OASIS data prior to the final claim as a condition for payment and until that time; and (2) Raising the threshold for compliance for OASIS submissions used in the current 2 percent reduction process.

The CMS is currently pursuing a plan of action consistent with OIG's recommendations. We are working to enforce OASIS submission so that all claims submitted without OASIS assessments are denied. We are also exploring methods to increase the compliance threshold for the 2 percent payment reduction beyond the current threshold to submit one assessment during the reporting year. As the report notes, CMS began to require OASIS submission as a condition of payment effective January 1, 2010. As a result of that action, at this time only claims that are subject to medical review which do not have corresponding OASIS assessments are now denied. This enforcement is not reflected in the calendar year (CY) 2009 data used for this study.

A historical barrier to enforcement of this condition of payment on all claims has been that the Medicare claims processing system and the State OASIS repositories have not had a systematic interface. In January 2010, CMS instructed our contractors to perform an analysis of how to create such an interface. Work toward building this interface is on-going, with completion targeted in October 2012. Initially, the interface will validate whether the payment group codes submitted on claims match the codes calculated from

OASIS assessments. Once the initial stage is complete, the process can be expanded to include denying all claims if an OASIS assessment has not been submitted.

Effective January 1, 2012, the requirements for the 2 percent payment reduction have been expanded to include submission of the Home Health Consumer Assessment of Health Providers and Systems data. While the OASIS threshold was unchanged for CY 2012 payments, the addition of this reporting requirement has significantly expanded the number of HHAs subject to payment reductions. Raising the OASIS compliance threshold per OIG's recommendation is consistent with our effort to strengthen these requirements. CMS will explore strategies to increase the OASIS threshold for CY 2013 payments.

#### **Recommendation 2**

The OIG recommends that CMS establish and implement enforcement actions for HHAs that submit OASIS data beyond the 30-day deadline. CMS should identify HHAs that are consistently or egregiously late in submitting data. CMS should consider enforcement actions for HHAs that consistently miss the 30-day deadline.

#### **CMS Response**

The CMS does not concur. Most HHAs submit OASIS data within 30 days of the OASIS assessment completion date. The report indicates that 85 percent reported data within 30 days of the assessment and an additional 10 percent submitted the data within the next 10 days. The findings in the report failed to note that the error code for late submissions also included corrected OASIS data submissions. Recent revisions to the OASIS submission error messages will enable surveyors to differentiate true "late submissions" from submissions with corrections. The surveyor worksheet completed prior to survey entrance will be revised to emphasize the error for late OASIS submissions.

HHAs are surveyed every three years. The current survey process looks at OASIS data submission and targets late data submissions as part of the pre-survey task. Standard level deficiencies are issued to providers that fail to submit OASIS data in a timely manner. In 2010, 116 such deficiencies were issued. HHAs submit a plan of correction to rectify this deficiency.

The deficiencies that would result from increased surveyor scrutiny would be cited at the standard level, and HHAs that have only standard level deficiencies are still found to be in substantial compliance with the Conditions of Participation (CoP) and would not be terminated from the Medicare program. CMS is in the process of developing an alternative sanction regulation suggested by the Omnibus Reconciliation Act of 1987 for HHAs that have condition level deficiencies and may impose these sanctions on HHAs that are not in compliance with the CoP, including submission of OASIS data.

**CMS Action**

The surveyor worksheet completed prior to survey entrance will be revised to emphasize the error for late OASIS submissions. CMS will proceed with the development and eventual implementation of alternative sanctions for HHAs.

**Recommendation 3**

The OIG recommends that CMS develop clear guidelines that delineate expectations for States regarding timely and accurate OASIS data. CMS should review all States protocols and procedures for analyzing and editing OASIS data to find vulnerabilities and highlight best practices. CMS should also develop standards for States to ensure data accuracy. CMS should work with States to develop procedures that can detect both data input errors and willful misrepresentation of patient's conditions at the time of assessment.

**CMS Response**

The CMS does not concur. The OIG survey pertaining to OASIS assistance was sent to the State OASIS Automation Coordinator (OAC) with the suggestion to enlist the State OASIS Education Coordinator (OEC). It is unknown whether the OAC did in fact enlist the OEC.

The OASIS Submission System is intended to connect HHAs to their respective State Agencies for the purpose of electronic interchange of data, reports, and other information. The system supports the transfer of OASIS data from HHAs to their respective State Agency, provides authentication and validation of OASIS records received from HHAs, provides feedback to HHAs indicating acknowledgment of the transmission of the data and specifying the status of record validation, and provides storage of OASIS records in the database repository within the State Agency.

The OASIS submission system looks for technical submission errors. Fatal record error messages are generated when submitted individual records violate the current CMS data specifications and are rejected by the OASIS Submission system. The individual record or assessments that have fatal errors are completely removed from the database for data integrity purposes. "Minor errors" or "warning error" messages are generated when the individual record submitted violates some of the CMS data specifications and can still be accepted by the OASIS Submission System. Warning error messages do not pose a significant threat to the integrity of the data.

The OIG report failed to identify the magnitude of costs associated with additional workload on State agencies to monitor error messages. While error messages do show inconsistencies with data submitted, most would require additional survey visits to determine severity of the issue.

The OIG report failed to identify other sources of assistance for HHAs needing help with OASIS data accuracy and transmission. Providers are offered assistance from multiple sources. Technical assistance is also provided by the Quality Information Enterprise System (QIES) Help Desk in addition to the State OAC. Providers often select the QIES Help Desk since the contact information is posted on the data submission page. Education related to interpretation of OASIS items for data collectors is also provided through multiple sources. The State OECs are supplemented by the OASIS Q&A mailbox which receives approximately 100 questions monthly.

The survey indicated that 23 States reported late transmissions to surveyors. The report also recognized that surveys occur every three years. In 2010, there were condition level deficiencies cited during 75 surveys for HHAs' failure to submit OASIS data. There were standard level citations made during 116 surveys of HHAs for late transmission of OASIS data, and 31 standard level deficiencies cited for accuracy of encoded data. Willful misrepresentation of data is outside the scope of the State's technical ability. Surveyors tri-annual surveys usually represent from 10 to 30 records, half of which are home visits. The ability to identify willful misrepresentation of data requires review of the complete medical record, usually in conjunction with a home visit and patient interview, which is outside the scope of State systems and current survey processes.

The findings of this report do not support the significant investment that would be required to modify the survey process and effort needed to support clinical record reviews and home visits needed. This should be undertaken by medical review.

**CMS Action**

The CMS will monitor the OASIS training efforts of the OECs and OACs by monitoring the HHA training worksheets submitted annually by the OECs. CMS will revise the HHA surveyor worksheet and emphasize compliance with timely submission of data and overall data submission requirements

The CMS appreciates the effort that went into this report. Again, we thank the OIG for the opportunity to review and comment on this draft report and look forward to working with the OIG on this and other issues in the future.

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## ACKNOWLEDGMENTS

This report was prepared under the direction of Joyce Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston regional office, and Russell Hereford, Deputy Regional Inspector General.

Danielle Fletcher served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Boston regional office who contributed to the report include Tim Chettiath and Kim Yates; central office staff who contributed includes Sandy Khoury.

# Office of Inspector General

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