# Long-Term Care Survey Alert

## Industry Notes: Could Functional-Status Quality Measures Be In Your Future?

The **Centers for Medicare & Medicaid Services** (CMS) is pushing hard to develop new functional-status quality measures. Here's what a technical expert panel (TEP) has to say.

CMS contracted with **RTI International** to develop cross-setting functional-status quality measures for skilled nursing facilities (SNFs), as well as for long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs), according to a March 28 CMS announcement. RTI assembled the TEP in September 2013, and now the results of that meeting are posted.

Rehab clinicians, researchers, and administrators with expertise in functional assessment, quality improvement and quality measure development across settings comprised the TEP. The panel meeting aimed to gather input on functional-status quality measures that CMS wants to use on the Continuity Assessment Record and Evaluation (CARE) item set.

Here are some of the recommendations that the TEP members provided:

- Although some of the more challenging mobility activities, such as car transfers, are not assessed as CARE self-care and mobility items in all SNFs and IRFs, they are important to assess for patients returning to home or a community-based setting.
- Patients with incomplete stays should be excluded from the quality measure calculation. This should include patients who died during the stay and those who were unexpectedly discharged to acute care.
- Patients who receive the maximum scores on all function items at the time of admission should be excluded from the quality measure calculation, because no improvement in function is measureable with the existing items.
- Age is an important determinant of functional outcomes, so age categories should be used for risk adjustment of the functional outcomes quality measures.
- Prior functional status and history of falls should be tested in the risk adjustment models, because these variables may potentially affect functional outcomes.
- The post-acute care diagnosis, not the prior acute diagnosis, should be used for risk adjustment of the functional outcome quality measures, because the post-acute care diagnosis reflects the reason for the patient's admission to the facility.

You can read the entire TEP meeting summary in the Downloads section at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html.

**SNFs: FY2015 Could Be A Banner Year For Reimbursement**

The 2015 SNF PPS proposed rule contains a wide array of policy, payment changes. On May 6, CMS published a SNF PPS and Consolidated Billing proposed rule for fiscal year (FY) 2015. And the good news for you is that CMS estimates an overall economic impact to increase aggregate payments to SNFs by $750 million.

Among other things, the proposed rule would revise policies related to the Change of Therapy (COT) Other Medicare Required Assessment (OMRA). The proposed rule discusses SNF therapy payment research that CMS is conducting and a provision involving Civil Money Penalties (CMPs) related to the Affordable Care Act (ACA).

Additionally, the rule includes a proposal to adopt the most recent Office of Management and Budget (OMB) statistical area delineations to identify a facility's urban or rural status, reported Evvie Munley, senior health policy analyst for Washington, DC-based Leading Age, in a May 7 analysis. The purpose of doing so is to determine which set of rate tables

would apply to the facility and to determine the SNF PPS wage index.

The rule would include a proposed one-year transition with a blended wage index for all providers for FY 2015, Munley added. The proposed rule contains a wide variety of other important changes. To read the proposed rule, go to www.gpo.gov/fdsys/pkg/FR-2014-05-06/pdf/2014-10319.pdf.

**2 Payers Face Settlements, CAPs for Laptop Breaches**

Stolen unencrypted laptops were to blame for two HIPAA settlements, which totaled nearly $2 million in settlements, as well as extensive corrective action plans (CAPs). **Concentra Health Services**, a subsidiary of **Humana, Inc**., agreed to a $1.7 million settlement with HHS for alleged HIPAA violations related to a breach notification stemming from a stolen unencrypted laptop.

According to Concentra's HHS-ordered CAP, the company must:

- Implement a security management process, including a risk analysis and risk management plan;
- Provide written updates to HHS describing encryption requirements for all devices;
- Provide security awareness training for all workforce members;
- Submit an Implementation Report to HHS; and
- Submit Annual Reports to HHS.

**QCA Health Plan**, a health insurance provider in Arkansas, paid out a smaller settlement of $250,000, also due to a breach involving a stolen unencrypted laptop. The laptop contained the protected health information (PHI) of 148 individuals. Under QCA's CAP, the insurer must:

- Implement a security management process, including a risk analysis and corresponding risk management plan;
- Provide security awareness training for all workforce members who have access to electronic PHI (ePHI); and
- Submit Annual Reports to HHS.

These two breach cases share many similarities. Among them are three key steps these companies did not take that could have prevented the breaches in the first place  or at least minimized the breach-associated costs and sanctions.