Measures for Medicaid Managed Long Term Services and Supports Plans
Technical Specifications and Resource Manual

September 2018

Center for Medicaid and CHIP Services

Centers for Medicare & Medicaid Services

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ACKNOWLEDGMENTS

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I. MEASURES FOR MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS PLANS

Background

Medicaid Managed Long-Term Services and Supports (MLTSS) refers to the delivery of long-term services and supports (LTSS) through capitated managed care programs. A growing number of states are implementing MLTSS programs, which contract with managed care plans and pay them a fixed monthly rate per member to provide a broad array of LTSS to people with disabilities who need assistance to perform activities of daily living (ADLs), and instrumental activities of daily living (IADLs). LTSS may be provided in a variety of settings, including nursing facilities or intermediate care facilities, in the home, or in community-based settings such as adult day health centers.

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research[1] and its partner the National Committee for Quality Assurance, to develop measures for people receiving LTSS through managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs).

These measures provide information about assessment and care planning processes among MLTSS plan members that can be used by states, managed care plans, and other stakeholders for quality improvement purposes.

Table 1 lists each measure, the measure owner, and the data collection method -- administrative (such as claims, encounters, vital records, and registries) or case management record review. The technical specifications in Chapter III of this manual provide additional details for each measure.

Table 1 – MLTSS Measures

Measure Owner	Measure Name	Data Collection Method(s)
CMS	Long-Term Services and Supports Comprehensive Assessment and Update This measure is aligned with HEDIS measure LTSS-CAU; specifications for LTSS-CAU are available from the NCQA Store website.	Case Management Record Review
CMS	Long-Term Services and Supports Comprehensive Care Plan and Update This measure is aligned with HEDIS measure LTSS-CPU; specifications for LTSS-CPU are available from the NCQA Store website.	Case Management Record Review

[1] Measures developed as part of CMS contract: Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees, HHSM-500-2013-13011I, Task Order #HHSM-500-T0004.

Measure Owner	Measure Name	Data Collection Method(s)
CMS	Long-Term Services and Supports Shared Care Plan with Primary Care Practitioner This measure is aligned with HEDIS measure LTSS-SCP; specifications for LTSS-SCP are available from the NCQA Store website.	Case Management Record Review
CMS	Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge This measure is aligned with HEDIS measure LTSS-RAU; specifications for LTSS-RAU are available from the NCQA Store website.	Case Management Record Review
NCQA	Screening, Risk Assessment, and Plan of Care to Prevent Future Falls Falls Part 1 - Screening Falls Part 2 - Assessment and Plan of Care	Case Management Record Review
CMS	Long-Term Services and Supports Admission to an Institution from the Community	Administrative
CMS	Long-Term Services and Supports Minimizing Institutional Length of Stay	Administrative
CMS	Long-Term Services and Supports Successful Transition After Long-Term Institutional Stay	Administrative

II. DATA COLLECTION

To support consistency in reporting the Medicaid MLTSS plan measures, this chapter provides general guidelines for data collection, preparation, and reporting. The technical specifications are presented in Chapter III and provide detailed information on how to calculate each measure. For technical assistance with calculating and reporting these measures, contact the TA mailbox at MLTSSMeasures@cms.hhs.gov.

Data Collection and Preparation for Reporting

- **Version of specifications**. This manual includes the most applicable version of the measure specifications available to CMS as of September 2018. For HEDIS measures (i.e., LTSS-CAU, LTSS-CPU, LTSS-SCP, and LTSS-RAU), this manual follows HEDIS 2019 specifications (2018 measurement year).
- **Value sets**. Some measure specifications reference value sets that must be used for calculating the measures. A value set is the complete set of codes used to identify a service or condition included in a measure.
- **Data collection time frames for measures**. States should adhere to the measurement years identified in the technical specifications for each measure. All measures are collected on a calendar year basis (i.e., January 1 through December 31), but may require examining data in the year prior to the measurement year. Data collection time frames should align with the calendar year prior to the reporting year; for example, calendar year 2018 data should be reported for FFY 2019. For some measures, the denominator measurement year for FFY 2019 corresponds to calendar year 2018 (January 1, 2018–December 31, 2018).
- **Continuous enrollment**. This refers to the time frame during which a member must be eligible for benefits to be included in the measure denominator. To be considered continuously enrolled, an individual must also be continuously enrolled with the benefit specified for each measure (e.g., long-term services and support or medical). The technical specifications provide the continuous enrollment requirement for each measure, if applicable.
- **Allowable gap**. Some measures specify an allowable gap that can occur during continuous enrollment. For example, if a measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in enrollment of up to 45 days, a member who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year, because this member has one 38-day gap (January 1–February 7).
- **Retroactive eligibility.** This refers to the time between the actual date when Medicaid became financially responsible for a member and the date when it received notification of the new member's eligibility. For measures with a continuous enrollment requirement, members may be excluded if the retroactive eligibility exceeds the allowable gap.

- **Anchor date**. Some measures include an anchor date, which is the date that an individual must be enrolled and have the required benefit to be eligible for the measure. For example, if an enrollment gap includes the anchor date, the individual is not eligible for the measure. For these measures, the anchor date is the last day of the measure's FFY 2019 measurement year (December 31, 2018). States should use the specified anchor dates along with the continuous enrollment requirements and allowable gaps for each measure to determine the measure-eligible population.
- **Date specificity**. A date must be specific enough to determine that an event occurred during the time frame in the measure. There are instances when documentation of the year alone is adequate; for example, most optional exclusions and measures that look for events in the "measurement year or the year prior to the measurement year." Terms such as "recent," "most recent," or "at a prior visit" are not acceptable.
- **Reporting unit**. Individual states should determine the appropriate reporting unit at the state, plan or product line level.
- **Eligible population for measurement**. For all measures, the denominator includes Medicaid beneficiaries who satisfy measure-specific eligibility criteria (e.g., age, continuous enrollment, benefit, event, and the anchor date).
- **Members with partial benefits.** For each measure, states should include only the Medicaid/CHIP beneficiaries who are eligible to receive the services assessed in the numerator. If a member is not eligible to receive the services assessed in the measure, the member should not be included in the denominator for the measure. The technical specifications for some measures have guidance regarding which benefits an individual must be eligible for to be included, but each state should assess the specific benefit packages of the beneficiaries in their state.
- **Aggregating information for state-level reporting**. To obtain a state-level rate for a measure that is developed from the rates of multiple units of measurement (such as multiple managed care organizations [MCOs]), the state should calculate a weighted average of the individual rates. How much any one entity (for example, individual MCOs) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that reporting units with larger eligible populations will contribute more toward the rate than those with smaller eligible populations. Hybrid and administrative data from different sources can be combined to develop a state/program-level rate as long as the specifications allow the use of both data sources to construct the measure.
- **Representativeness of data**. States should use the most complete data available and ensure that the rates reported are representative of the entire population enrolled in their Medicaid program. For a measure based on a sampling methodology, states should ensure that the sample used to calculate the measure is representative of the entire eligible population for the measure.
- **Data collection methods**. The measures included here have two possible data collection methods: administrative and review of case management records. Each measure specifies the data collection method(s) that must be used. If a measure includes a choice of methods, any of the listed methods may be used.

- The administrative method uses transaction data (e.g., claims) or other administrative data sources to calculate the measure. These data can be used in cases in which the data are known to be complete, valid, and reliable. When administrative data are used, the entire eligible population is included in the denominator.
- The case management record review method uses data available to the managed care plan as part of case management records. This data could include information collected by the state and provided to the managed care plan, information collected directly from the managed care plan for the purposes of coordinating and delivering care, or information collected by delegated providers in the managed care plan (e.g., community based organization contracted to coordinate long-term services and supports). The denominator consists of a systematic sample of the measure's eligible population which is identified through enrollment data and in some measures administrative claims.

- **Sampling**. For measures that use the case management record review method, sampling guidance is included in the technical specification if available from the measure steward. Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion.
  - For measures that use the case management record review method, the sample size should be 411, unless special circumstances apply. Regardless of the selected sample size, CMS recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure.
- **Small numbers**. For non-risk adjusted measures, if a measure has a denominator that is less than 30, the managed care plan or state may choose not to report the measure due to small numbers. For risk adjusted measures (i.e., LTSS Minimizing Institutional Length of Stay and LTSS Successful Transition after Long-Term Institutional Stay), if a measure has a denominator that is less than 150, the managed care plan or state may choose not to report the measure due to small numbers.

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III. TECHNICAL SPECIFICATIONS

This chapter presents the technical specifications for each measure. Each specification includes a description of the measure and information about the eligible population, key definitions, data collection method(s), instructions for calculating the measure, and any other relevant measure information.

These specifications represent the most applicable version available as of September 2018.

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LONG-TERM SERVICES AND SUPPORTS (LTSS) COMPREHENSIVE ASSESSMENT AND UPDATE

A. DESCRIPTION

The percentage of MLTSS plan members 18 years of age and older who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core elements. The following rates are reported:

1. *Assessment of Core Elements*. MLTSS plan members who had a comprehensive LTSS assessment with nine core elements documented within 90 days of enrollment (for new members) or annually.
2. *Assessment of Supplemental Elements*. MLTSS plan members who had a comprehensive LTSS assessment with nine core elements and at least twelve supplemental elements documented within 90 days of enrollment (for new members) or annually.

Data Collection Method: Case Management Record Review

Guidance for Reporting:

- This measure applies to Medicaid MLTSS plan members ages 18 and older.
- Two performance rates should be reported for this measure: (1) Assessment of Core Elements and (2) Assessment of Supplemental Elements.
- The rates of required exclusions should also be reported: (1) Member could not be contacted for assessment and (2) Member refused assessment.

B. DEFINITIONS

LTSS Assessment	A face-to-face discussion with the member in the home using a structured or semi-structured tool that addresses the member's health status and needs and includes a minimum of nine core elements and may include supplemental elements. There must be documentation that an assessment was conducted face-to-face discussion with the member in the member's home. Assessment by phone or video conference, or in another location that is not the member's home, is not permitted except in the following circumstances: • The member was offered an in-home assessment and refused the in-home assessment (either refused to allow the care manager into the home or requested a telephone assessment instead of an in-home assessment), • The member is residing in an acute facility (hospital, skilled nursing facility, other post-acute care facility) during the assessment time period, OR • The state policy, regulation, or other state guidance excludes the member from a requirement for in-home assessment.
New Member	Members who were newly enrolled in the MLTSS plan between August 1 of the year prior to the measurement year and July 31 of the measurement year.
Established Member	Members who were enrolled prior to August 1 of the year prior to the measurement year.
Home	The location where the member lives; may be the member's residence, a caregiver's residence, an assisted living facility, an adult-foster care, a temporary residence or a long-term care institutional facility.
Standardized tool	A set of structured questions that elicit member information; may include person-reported outcome measures, screening or assessment tools or standardized questionnaires developed by the LTSS organization or state to assess risks and needs.

C. ELIGIBLE POPULATION

Age	18 years and older as of the first day of the measurement year.
Continuous enrollment	Member must be enrolled in a Medicaid MLTSS plan for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For individuals with multiple distinct continuous enrollment periods during the measurement year, look at the assessment completed in the last continuous enrollment period of 150 days or more during the measurement year. **Note*:*** 150 days continuous enrollment allows a single sample to be used across the suite of LTSS measures: LTSS Comprehensive Assessment and Update, which looks for assessment to be conducted within 90 days of enrollment; LTSS Comprehensive Care Plan and Update, which looks for a care plan to be developed within 30 days of assessment or 120 days of enrollment; LTSS Shared Care Plan with Primary Care Practitioner, which looks for a care plan to be shared within 30 days of development; and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measure, which looks for screening for fall risk.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care).
Event/ diagnosis	None.

Exclusions	Required exclusions are reported with the measure rate. (1) Could Not Be Contacted for Assessment: New plan members who could not be contacted for LTSS comprehensive assessment within 90 days of enrollment. Established plan members who could not be contacted for LTSS comprehensive assessment during the measurement year. MLTSS plans use their own process for identifying members who cannot be contacted for assessment, and document that at least three attempts were made to contact the member. To calculate the rate of individuals who could not be reached for assessment: divide the number of individuals meeting this exclusion criterion by the number of people meeting the continuous enrollment criteria. (2) Refusal of Assessment: Plan members who refused a comprehensive assessment. Document that the member was contacted and refused to participate in an assessment. To calculate the rate of individuals who refused assessment: divide the number of individuals meeting this exclusion criterion by the number of people meeting the continuous enrollment criteria.

D. CASE MANAGEMENT RECORD REVIEW SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Note: the same systematic sample may be used to calculate the LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, LTSS Shared Care Plan with Primary Care Practitioner, and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measures.

Numerator

The measure reports two numerators.

Rate 1: Assessment of Core Elements

The number of MLTSS plan members who had either of the following:

- *For new members:* A comprehensive LTSS assessment completed within 90 days of enrollment, with all nine (9) core elements documented, ***or***
- *For established members:* A comprehensive LTSS assessment completed at least once during the measurement year, with all nine (9) core elements documented.

Assessment must be a face-to-face discussion with the member in the member's home. Assessment by phone or video conference, or in another location that is not the member's home, is not permitted except in the following circumstances:

- The member was offered an in-home assessment and refused the in-home assessment (either refused to allow the care manager into the home or requested a telephone assessment instead of an in-home assessment),
- The member is residing in an acute facility (hospital, skilled nursing facility, other post-acute care facility) during the assessment time period, OR
- The state policy, regulation, or other state guidance excludes the member from a requirement for in-home assessment.

The member's assessment must include documentation of the following nine (9) core elements and the date of the assessment:

1. Documentation that Activities of Daily Living (ADL) were assessed, or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
2. Documentation of acute and chronic health conditions (may document condition names only).
3. Documentation of current medications (may document medication names only).
4. Assessment of cognitive function using a standardized tool; for example:
    - General Practitioner Assessment of Cognition (GPCOG).
    - Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE).
    - interRAI Cognitive Performance Scale.
    - Memory Impairment Screen (MIS)
    - Mini-Cog© Screening for Cognitive Impairment in Older Adults.
    - Mini Mental State Examination© (MMSE).
    - Montreal Cognitive Assessment (MoCA).
    - Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE).
    - St. Louis University Mental Status Exam (SLUMS).
    - The Eight-Item Informant Interview to Differentiate Aging and Dementia (AD8™).

    Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.
5. Assessment of mental health status using a standardized tool; for example:
    - Patient Health Questionnaire 2-item or 9-item (PHQ2, PHQ9).
    - Beck Depression Inventory (BDI or BDI-II).
    - Center for Epidemiologic Studies Depression Scale (CES-D).
    - Depression Scale (DEPS).
    - Duke Anxiety-Depression Scale (DADS).
    - Geriatric Depression Scale (GDS).

- Cornell Scale Screening.
- PRIME MD-PHQ2, Generalized Anxiety Disorder 7-Item Scale (GAD7).
- interRAI Depression Scale

Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.

6. Assessment of home safety risks (e.g., home fall risks, bathroom safety, chemical hazards, food preparation safety, crime). A standardized tool is not required. Documentation that there are no home safety risks meets this element.
7. Confirm living arrangements (e.g., nursing facility, institution, assisted living, adult foster care, general community, other setting).
8. Confirm current and future family/friend caregiver availability. Documentation of family/friend caregivers (paid or unpaid) who assist the member (with ADL, instrumental activities of daily living, health care tasks, emotional support), their availability and contact information. Documentation that no family/friend caregiver is available meets this element.
9. Documentation of current providers (e.g., primary care practitioner; individual or company providing home health, personal aide assistance, physical therapy, occupational therapy, adult day care, respite care, meal delivery, transportation services, primary care, specialty care).

Rate 2: Assessment of Supplemental Elements

The number of MLTSS plan members who had either of the following:

- *For new members: A comprehensive LTSS assessment completed within 90 days of enrollment with nine (9) core and at least twelve (12) supplemental elements documented, or*
- *For established members: A comprehensive LTSS assessment completed during the measurement year with nine (9) core and at least twelve (12) supplemental elements documented.*

Assessment must be a face-to-face discussion with the member in the member's home. Assessment by phone or video conference, or in another location that is not the member's home, is not permitted except in the following circumstances:

- The member was offered an in-home assessment and refused the in-home assessment (either refused to allow the care manager into the home or request a telephone assessment instead of an in-home assessment),
- The member is residing in an acute facility (hospital, skilled nursing facility, other post-acute care facility) during the assessment time period, OR
- The state policy, regulation, or other state guidance excludes the member from a requirement for in-home assessment.

The member's assessment must document evidence of 9 core elements defined above and evidence of at least 12 supplemental elements, and the date of the assessment.

Supplemental elements include the following:

1. Documentation that Instrumental ADL were assessed, or that at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
2. Documentation of the current use of assistive device or technology to maintain or improve mobility; for example, wheelchair, walker, scooter, cane, crutches, prostheses. Documentation that the member does not use an assistive device or technology meets the element.
3. Assessment of the member's self-reported health status using a standardized tool or question; for example:
   - A single question, "In general, would you say that your health is excellent, very good, good, fair, or poor?"
   - The Short-Form Survey—12 (SF-12).
   - Patient-Reported Outcome Measurement Information System (PROMIS) Global 10.

   Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.
4. Assessment of behavior abnormalities that can result from a cognitive or psychological condition; for example, sleep disturbances, wandering, aggression, urinary incontinence, disinhibition, binge eating, hyperorality, agitation (physical or verbal outbursts, general emotional distress, restlessness, pacing, shredding paper or tissues, yelling), delusions (firmly held belief in things that are not real) or hallucinations (seeing, hearing or feeling things that are not there). Documentation that the member has no behavior difficulties meets the element.
5. Assessment of the member's self-reported activation or self-efficacy using a standardized tool; for example, the Patient Activation Measure (PAM), the Stanford Chronic Disease Self-Efficacy Scale (CDSM). Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.
6. Documentation of vision needs, including whether the member has impaired vision and uses a device (corrective lenses, visual aids, specialized computer software and hardware) to address that need. Documenting that the member does not have impaired vision meets this element.

7. Documentation of hearing needs, including whether the member has impaired hearing and uses a device (e.g., hearing aid, specialized computer software and hardware that increase hearing or communication capacities) to address that need. Documenting that the member does not have impaired hearing meets the element.
8. Documentation of speech needs, including whether the member has a speech impairment and uses a device (e.g., specialized computer software or hardware that increase communication capacities) to address that need. Documenting that the member does not have impaired hearing meets the element.
9. Documentation of physical/occupational therapy needs, including whether the member needs physical or occupational therapy. Documenting that the member does not have physical/occupational therapy needs meets the element.
10. Screening for history of falls and/or problems with balance or gait. Documenting that the member has no history of falls, no fall risk or no problem with gait or balance meets the element.
11. Assessment of the member's alcohol or other drug use using a standardized tool (either current alcohol use or current illicit drug use); for example, the
    - The Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument.
    - The Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Screening Instrument.
    - Single Question Screening, "How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?"
    - The NIDA Drug Screening Tool.

    Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.
12. Documentation of smoking status, including whether the member is a current smoker.
13. Documentation of the current or planned use of community, public or plan resources to address social risk factors; for example, eligibility for Medicare, Medicaid, Supplemental Security Income, transportation services, food subsidies, electric/gas subsidies, housing subsidies.
14. Assessment of the member's social support in community; for example, from friends and family, faith-based community, senior center or other nonmedical facility for group activity, or other community-based groups (arts, volunteer, theater, education, support group).
15. Assessment of member's self-reported social isolation or loneliness using a standardized tool; for example:
    - The UCLA Loneliness Scale.
    - The Three Item Loneliness Scale.

- The PROMIS Social Isolation scale.
- The PROMIS Companionship scale
- The Duke Social Support Index.

Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.

16. Documentation of cultural and linguistic preferences; for example, preferred language, need for interpreter services.
17. Documentation of the existence of an advance care plan; for example:
    - Preferences for life-sustaining treatment and end-of-life care or documented surrogate decision maker.
    - Advance directive. Directive about treatment preferences or the designation of a surrogate who can make medical decisions for a member who is unable to make them (e.g., living will, health care power of attorney, health care proxy).
    - Actionable medical orders. Written instructions regarding initiating, continuing, withholding or withdrawing specific forms of life-sustaining treatment (e.g., Physician Orders for Life Sustaining Treatment [POLST], Five Wishes).
    - Living will. Legal document denoting preferences for life-sustaining treatment and end-of-life care.
    - Surrogate decision maker. A written document designating someone other than the member to make medical treatment choices.
    - Notation in the medical record of a discussion with a provider or initiation of a discussion by a provider during the measurement year.
    - Documentation that a provider asked the member if an advance care plan was in place and the member indicated that he or she did not wish to discuss it is considered sufficient evidence of a discussion.
    - Documentation that a provider asked the member if an advance care plan was in place and the member indicated a plan was not in place is <u>not</u> considered a discussion or initiation of a discussion.
    - Conversations with relatives or friends about life-sustaining treatment and end-of-life care, documented in the medical record. Member designation of an individual who can make decisions on behalf of the member. Evidence of oral statements must be documented.
18. Documentation of current participation or preference for participating in work or volunteer activities. Documenting the member's current work or volunteer status meets the element.
19. Documentation of recent use of medical services, which can include the ED, hospitalization, home health, skilled nursing facility, paid home health care.

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LONG-TERM SERVICES AND SUPPORTS (LTSS) COMPREHENSIVE CARE PLAN AND UPDATE

A. DESCRIPTION

The percentage MLTSS plan members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified timeframe that includes documentation of core elements. The following rates are reported:

1. *Care Plan with Core Elements.* MLTSS plan members who had a comprehensive LTSS care plan with nine core elements documented within 120 days of enrollment (for new members) or annually.
2. *Care Plan with Supplemental Elements*. MLTSS plan members who had a comprehensive LTSS care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new members) or annually.

Data Collection Method: Case Management Record Review

Guidance for Reporting:

- This measure applies to Medicaid MLTSS plan members ages 18 and older.
- Two performance rates should be reported for this measure: (1) Care Plan with Core Elements and (2) Care Plan with Supplemental Elements.
- The rates of required exclusions should also be reported: (1) Member could not be contacted for care planning and (2) Member refused to participate in care planning.

B. DEFINITIONS

LTSS care plan	A document or electronic tool which identifies member needs, preferences and risks, and contains a list of the services and supports planned to meet those needs while reducing risks. The document must include evidence that a member agreed to the care plan. A care plan may be called a "service plan" in certain MLTSS plans. There must be documentation that the care plan was discussed during a face-to-face encounter between the care manager and the member. The care plan may be discussed during the same encounter as the assessment. Discussion of the care plan may not be done by phone except in the following circumstances: • The member was offered a face-to-face discussion and refused (either refused face-to-face encounter or requested a telephone discussion instead of a face-to-face discussion), OR • The state policy, regulation, or other state guidance excludes the member from a requirement for face-to-face discussion of a care plan. **Note:** If multiple care plans are documented in the measurement year, use the most recently updated plan.
Care Manager	The person responsible for conducting an assessment and care plan with a member. The LTSS organization may designate an organization employee or a contracted employee; the care manager is not required to have a specific type of professional license.
New Member	A member who was newly enrolled in the organization between August 1 of the year prior to the measurement year and July 31 of the measurement year.
Established Member	A member who was enrolled prior to August 1 of the year prior to the measurement year.

C. ELIGIBLE POPULATION

Age	18 years and older as of the first day of the measurement year.
Continuous enrollment	Member must be enrolled in a Medicaid MLTSS plan for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For individuals with multiple distinct continuous enrollment periods during the measurement year, look at the assessment completed in the last continuous enrollment period of 150 days or more during the measurement year. **Note:** 150 days continuous enrollment allows a single sample to be used across the suite of LTSS measures: LTSS Comprehensive Assessment and Update, which looks for assessment to be conducted within 90 days of enrollment; LTSS Comprehensive Care Plan and Update, which looks for a care plan to be developed within 30 days of assessment or 120 days of enrollment; LTSS Shared Care Plan with Primary Care Practitioner, which looks for a care plan to be shared within 30 days of development; and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measure, which looks for screening for fall risk.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care).
Event/diagnosis	None.

Required Exclusions	Required exclusions are reported with the measure rates. (1) Could Not Be Contacted for Care Planning: New plan members who could not be contacted to create an LTSS comprehensive care plan within 120 days of enrollment. Established plan members who could not be contacted to create an LTSS comprehensive care plan during the measurement year. MLTSS plans use their own process for identifying members who cannot be contacted for care planning, and document that at least three attempts were made to contact the member. To calculate the rate of individuals who could not be reached for care planning divide the number of individuals meeting this exclusion criterion by the number of people meeting the continuous enrollment criteria. (2) Refusal of Care Planning: Plan members who refused a comprehensive care plan. Document that the member was contacted and refused to participate in a care plan. To calculate the rate of individuals who refused care planning divide the number of individuals meeting this exclusion criterion by the number of people meeting the continuous enrollment criteria.

D. CASE MANAGEMENT RECORD REVIEW SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Note: the same systematic sample may be used to calculate the LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, LTSS Shared Care Plan with Primary Care Practitioner, and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measures.

Numerator

The measure reports two numerators.

Rate 1: Care Plan with Core Elements

The number of MLTSS plan members who had either of the following:

- *For new members:* A comprehensive LTSS care plan completed within 120 days of enrollment, with all nine (9) core elements documented, ***or***
- *For established members:* A comprehensive LTSS care plan completed at least once during the measurement year with all nine (9) elements documented.

Care plans must be discussed during a face-to-face encounter between the care manager and the member, unless exceptions apply. The care plan is not required to

be created in the member's home. Video conferencing is allowable as evidence of a face-to-face discussion. The care plan may be discussed during the same encounter as the assessment. Discussion of the care plan may not be done by phone except in the following circumstances:

- The member was offered a face-to-face discussion and refused (either refused face-to-face encounter or request a telephone discussion instead of a face-to-face discussion), OR
- The state policy, regulation, or other state guidance excludes the member from a requirement for face-to-face discussion of a care plan.

Assessment of the member and development of the care plan may be done during the same encounter or during different encounters.

The initial care plan or care plan update must include documentation of following nine (9) core elements and the date of the care plan:

1. At least one individualized member goal (medical or non-medical outcome important to the member, such as losing weight, reducing specific symptoms, staying out of the hospital, engaging in a hobby, pursuing an interest, seeking out social contact, taking a special trip, living to see a relative's life milestone). Documentation that member is too cognitively impaired to provide a goal and has no family members is sufficient to meet this element.

   Note: Goals that are determined solely by the provider without member input, or automatically generated based on patient conditions or risk factors, do not count as a member goal.

2. A plan of care to meet the member's medical needs. Documentation that the plan addresses the member's needs or that the member does not have medical needs.
3. A plan of care to meet the member's functional needs. Documentation that the plan addresses the member's needs or that the member does not have functional needs.
4. A plan of care to meet the member's needs due to cognitive impairment; for example, support for behavioral difficulties, caregiver support or education to address cognitive impairment, support for engaging the member in activities. Document that the plan addresses the member's needs or that the member does not have needs resulting from cognitive impairment.
5. A list of all LTSS services and supports the member receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings (e.g., adult day health center, nursing facility), including the amount (e.g., hours, days) and frequency (e.g., every day, once a week). Documentation that the member does not receive LTSS meets the numerator criteria.
6. A plan for the care manager to follow up and communicate with the member (e.g., a follow-up and communication schedule).

7. A plan to ensure that the member's needs are met in an emergency (e.g., the care assistant or home health aide cannot get to the member's home, natural disaster). At a minimum, the plan must include the name of LTSS organization staff or a contracted provider to contact in an emergency.
8. Documentation of the family/friend caregivers who were involved in development of the care plan, and their contact information. Documentation of no family/friend caregiver involvement meets the element. Documentation that family/friend caregivers were invited but declined to participate in care planning meets the element.
9. Documentation that the member or the member's representative (i.e., power of attorney) agrees to the completed care plan, or appeals the care plan. Documentation includes the member/ representative's verbal agreement received by the case manager by telephone or in person, or a written agreement by the member/representative mailed to the case manager mail (e.g., a signature). Documentation that a care plan was discussed or reviewed does not meet the measure. Agreement or appeal by the member/representative must be documented.

Rate 2: Care Plan with Supplemental Elements Documented

The number of MLTSS plan members who had either of the following:

- *For new members:* A comprehensive LTSS care plan completed within 120 days of enrollment with nine (9) core elements and at least four (4) supplemental elements documented, ***or***
- *For established members:* A comprehensive LTSS care plan created during the measurement year with nine (9) core elements and at least four (4) supplemental elements documented.

The care plan must be completed within 120 days of enrollment and updated annually thereafter.

Care plans must be discussed during a face-to-face encounter between the care manager and the member, unless exceptions apply. The care plan is not required to be created in the member's home. Video conferencing is allowable as evidence of a face-to-face discussion. The care plan may be discussed during the same encounter as the assessment. Discussion of the care plan may not be done by phone except in the following circumstances:

- The member was offered a face-to-face discussion and refused (either refused face-to-face encounter or requested a telephone discussion instead of a face-to-face discussion), OR
- The state policy, regulation, or other state guidance excludes the member from a requirement for face-to-face discussion of a care plan.

The member's care plan must document evidence of 9 core elements defined above and evidence of at least 4 supplemental elements, and the date of the care plan.

Supplemental elements include the following:

1. A plan of care to meet the member's mental health needs (e.g., depression, anxiety). Documentation that either the plan addresses the member's needs or that the member does not have mental health needs.
2. A plan of care to meet the member's social or community integration needs; for example, through planned social activities with friends and family, participation in community based activities, participation in work or volunteer activities. Documentation that the member does not have social or community integration needs meets the numerator criteria.
3. The duration (how long services will be provided or when need for services will be assessed) of all LTSS the member receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings (e.g., adult day health center, nursing facility), or the time (date) when services will be reassessed. Documentation that the member does not receive LTSS meets the numerator criteria.
4. Contact information for the member's LTSS providers. Documentation that the member does not receive LTSS meets the numerator criteria.
5. A plan to assess the member's progress toward meeting established goals, including a time frame for reassessment and follow-up.
6. Documentation of barriers to the member meeting defined goals; for example, life, community or health factors that may make it difficult for the member to meet goals.
7. The member's first point of contact. The care manager's contact information meets this element if it is provided to the member.
8. Contact information for member's primary care practitioner (PCP), or a plan for connecting the member to a PCP if the member does not currently have one.

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LONG-TERM SERVICES AND SUPPORTS (LTSS) SHARED CARE PLAN WITH PRIMARY CARE PRACTITIONER

A. DESCRIPTION

The percentage of MLTSS plan members 18 years of age and older with a care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner identified by the plan member within 30 days its development.

Data Collection Method: Case Management Record Review

Guidance for Reporting:

- This measure applies to Medicaid MLTSS plan members ages 18 and older.
- Only one rate is reported for this measure.
- The rate of required exclusions should also be reported: (1) Member refused to have their care plan shared with a PCP or other medical care provider.

B. DEFINITIONS

LTSS care plan	A document or electronic tool which identifies member needs, preferences and risks, and contains a list of the services and supports planned to meet those needs while reducing risks. The document must include evidence that a member agreed to the care plan. A care plan may be called a "service plan" in certain MLTSS plans.
Transmitted	Dissemination of the care plan to providers via mail, fax, secure email or mutual access to an electronic portal or EHR. **Note:** It is not necessary to transmit the entire care plan to meet the numerator criteria. Plans may select the most relevant parts of the care plan or provide a summary.
Primary Care Provider (PCP)	A physician, non-physician (e.g., nurse practitioner, physician assistant), or group of providers who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.
Other documented medical care practitioner	A medical care practitioner identified by the member as the primary point of contact for medical care. This practitioner does not need to be a PCP.

C. ELIGIBLE POPULATION

Age	18 years and older as of the first day of the measurement year.
Continuous enrollment	Member must be enrolled in a Medicaid MLTSS plan for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For individuals with multiple distinct continuous enrollment periods during the measurement year, look at the assessment completed in the last continuous enrollment period of 150 days or more during the measurement year. **Note:** 150 days continuous enrollment allows a single sample to be used across the suite of LTSS measures: LTSS Comprehensive Assessment and Update, which looks for assessment to be conducted within 90 days of enrollment; LTSS Comprehensive Care Plan and Update, which looks for a care plan to be developed within 30 days of assessment or 120 days of enrollment; LTSS Shared Care Plan with Primary Care Practitioner, which looks for a care plan to be shared within 30 days of development; and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measure, which looks for screening for fall risk.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care).
Event/diagnosis	Documentation of a Care Plan with core elements as specified in *Long Term Services and Supports Comprehensive Care Plan and Update* measure. If multiple care plans are documented or updated in the measurement year, the numerator event can be identified after any of these events.
Required Exclusions	Required exclusions are reported with the measure rate. (1) Refusal to share care plan: Members who refuse to allow the care plan to be shared. There must be documentation in the record that the member refused to allow the care plan to be shared. Notation of verbal refusal is sufficient. To calculate the rate of individuals who refused care plan sharing, divide the number of individuals meeting this exclusion criterion by the number of people meeting the continuous enrollment criteria.

D. CASE MANAGEMENT RECORD REVIEW SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Note: the same systematic sample may be used to calculate the LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, LTSS Shared Care Plan with Primary Care Practitioner, and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measures.

Numerator

The number of members whose care plan was transmitted to their PCP or other documented medical care practitioner identified by the plan member within 30 days of the date when the member agreed to the care plan. The documentation must show transmission at least once between August 1 of the year prior to the measurement year and December 31 of the measurement year. If multiple care plans are documented or updated in the measurement year, evidence of one transmission within 30 days of the member's agreement to the care plan is sufficient to meet the numerator.

Evidence of care plan transmission includes:

- To whom the care plan was transmitted.
- The date of transmission.
- A copy of the transmitted plan or plan sections.

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LONG-TERM SERVICES AND SUPPORTS (LTSS) REASSESSMENT/ CARE PLAN UPDATE AFTER INPATIENT DISCHARGE

A. DESCRIPTION

The percentage of discharges from inpatient facilities for MLTSS plan members 18 years of age and older for whom a reassessment and care plan update occurred within 30 days of discharge. The following rates are reported

1. *Reassessment after Inpatient Discharge*. The percentage of discharges from inpatient facilities resulting in a LTSS reassessment within 30 days of discharge.
2. *Reassessment and Care Plan Update after Inpatient Discharge*. The percentage of discharges from inpatient facilities resulting in a LTSS reassessment and care plan update within 30 days of discharge.

Data Collection Method: Case Management Record Review

Guidance for Reporting:

- This measure applies to MLTSS plan members ages 18 and older.
- Two performance rates should be reported for this measure: (1) Reassessment after Inpatient Discharge and (2) Reassessment and Care Plan Update after Inpatient Discharge.
- The rates of required exclusions should also be reported: (1) Member could not be contacted for assessment and/or care planning and (2) Member refused to participate in assessment and/or care planning.

The following coding systems are used in this measure: ICD-10-CM, ICD-10-PCS, CPT, HCPCS and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

LTSS reassessment	A face-to-face discussion with between a member and the case manager that addresses the member's health status and needs. The assessment must include nine core elements and may also include supplemental elements. The assessment must be conducted during a face-to-face encounter between the care manager and the member unless there is documentation that the member refused a face-to-face encounter. Assessment in the inpatient facility on the day of discharge meets the requirement.

LTSS care plan	A document or electronic tool that identifies member needs, preferences and risks, and contains a list of services and supports planned to meet those needs while reducing risks. The document must include evidence that a member agreed to the care plan. The care plan may be called a “service plan” in certain MLTSS plans. The care plan must include nine core elements and may also include supplemental elements. The care plan must be conducted during a face-to-face encounter between the care manager and the member unless there is documentation that the member refused a face-to-face encounter. A care plan developed in the inpatient facility on the day of discharge meets the requirement.
Standardized tool	A set of structured questions that elicit member information. May include person-reported outcome measures, screening or assessment tools or standardized questionnaires developed by the LTSS organization or state to assess risks and needs.
Care manager	The person responsible for conducting an assessment and care plan with a member. The LTSS organization may designate an organization employee or a contracted employee; the care manager is not required to have a specific type of professional license.

C. ELIGIBLE POPULATION

Age	18 years and older as of the first day of the measurement year.
Continuous enrollment	Enrollment in the LTSS organization on the date of discharge through 30 days after the date of discharge.
Allowable gap	None.
Anchor date	The date of discharge.
Benefit	Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care) **AND** Benefit for medical care and services. Benefits should be determined at the individual level. Any individual receiving a benefit for both LTSS and medical care through the MLTSS plan is eligible for this measure.

Event/ diagnosis	An acute or nonacute inpatient discharge from an unplanned admission between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Readmission or direct transfer	If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 total days), count only the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharges if the last discharge occurs after December 1 of the measurement year. **Note:** If a member remains in an acute or nonacute care setting through December 1 of the measurement year, a discharge is not included in the measure for this member, but the organization must have a method for identifying the member's status for the remainder of the measurement year, and may not assume the member remained admitted based only on the absence of a discharge before December 1. If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.

Required Exclusions	(1) Discharges for planned admissions: Exclude planned hospital admissions from the measure denominator. A hospital stay is considered planned if it meets any of the following criteria: • Hospital stays with a principal diagnosis of pregnancy or a condition originating in the perinatal period. • A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set). • A principal diagnosis of rehabilitation (Rehabilitation Value Set). • An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set). • A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set). The exclusion for planned admissions is not reported with the measure performance rates. The exclusions listed below (Could not be contacted and Refusal) are reported with the measure rates. (2) Could not be contacted for assessment and care plan update: Members who could not be reached for assessment and care plan update following inpatient discharge. Organizations use their own process for identifying members who cannot be contacted for assessment, and document that at least three attempts were made to contact the member. To calculate the rate of individuals who could not be reached divide the number of individuals meeting this exclusion criterion by the number of people meeting the continuous enrollment criteria. (3) Refusal of assessment or care planning: Members who refused to participate in an assessment or development of a comprehensive LTSS care plan following inpatient discharge. To calculate the rate of individuals who refused, divide the number of individuals meeting this exclusion criterion by the number of people meeting the continuous enrollment criteria.

D. CASE MANAGEMENT RECORD REVIEW SPECIFICATION

Denominator

A systematic sample of inpatient discharges drawn from the eligible population. The denominator is based on discharges, not on members. Members may appear more than once in the sample.

Numerator

The measure reports two numerators.

Rate 1: Reassessment after Inpatient Discharge

LTSS reassessment on the date of discharge or within 30 days after discharge.

Reassessment must document evidence of the nine core elements and the reassessment date. Documentation of “no change” does not meet numerator criteria.

Reassessment must be a face-to-face discussion between the member and care manager. Reassessment may not be conducted over the telephone unless there is documentation that the member refused a face-to-face encounter. Reassessment in the inpatient facility on the day of discharge meets the requirement.

The member’s reassessment must include documentation of the following nine (9) core elements and the date of the reassessment:

1. Documentation that Activities of Daily Living (ADL) were assessed, or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
2. Documentation of acute and chronic health conditions (may document condition names only).
3. Documentation of current medications (may document medication names only).
4. Assessment of cognitive function using a standardized tool; for example:
    - General Practitioner Assessment of Cognition (GPCOG).
    - Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE).
    - interRAI Cognitive Performance Scale.
    - Memory Impairment Screen (MIS)
    - Mini-Cog© Screening for Cognitive Impairment in Older Adults.
    - Mini Mental State Examination© (MMSE).
    - Montreal Cognitive Assessment (MoCA).
    - Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE).
    - St. Louis University Mental Status Exam (SLUMS).
    - The Eight-Item Informant Interview to Differentiate Aging and Dementia (AD8™).

Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.

5. Assessment of mental health status using a standardized tool; for example:
    - Patient Health Questionnaire 2-item or 9-item (PHQ2, PHQ9).
    - Beck Depression Inventory (BDI or BDI-II).
    - Center for Epidemiologic Studies Depression Scale (CES-D).
    - Depression Scale (DEPS).
    - Duke Anxiety-Depression Scale (DADS).
    - Geriatric Depression Scale (GDS).
    - Cornell Scale Screening.
    - PRIME MD-PHQ2, Generalized Anxiety Disorder 7-Item Scale (GAD7).
    - interRAI Depression Scale

    Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.

6. Assessment of home safety risks (e.g., home fall risks, bathroom safety, chemical hazards, food preparation safety, crime). A standardized tool is not required. Documentation that there are no home safety risks meets this element.
7. Confirm living arrangements (e.g., nursing facility, institution, assisted living, adult foster care, general community, other setting).
8. Confirm current and future family/friend caregiver availability. Documentation of family/friend caregivers (paid or unpaid) who assist the member (with ADL, instrumental activities of daily living, health care tasks, emotional support), their availability and contact information. Documentation that no family/friend caregiver is available meets this element.
9. Documentation of current providers (e.g., primary care practitioner; individual or company providing home health, personal aide assistance, physical therapy, occupational therapy, adult day care, respite care, meal delivery, transportation services, primary care, specialty care).

Rate 2: Reassessment and Care Plan Update after Inpatient Discharge

LTSS reassessment and care plan update on the date of discharge or within 30 days after discharge.

Reassessment must document evidence of the nine core elements described above and the reassessment date.

Care plan update must document evidence of nine core elements described below. Documentation of “no change” does not meet numerator criteria.

The care plan must be conducted during a face-to-face encounter between the care manager and the member unless there is documentation that the member refused a

face-to-face encounter. A care plan developed in the inpatient facility on the day of discharge meets the requirement.

The care plan update must include documentation of following nine (9) core elements and the date of the care plan:

1. At least one individualized member goal (medical or non-medical outcome important to the member, such as losing weight, reducing specific symptoms, staying out of the hospital, engaging in a hobby, pursuing an interest, seeking out social contact, taking a special trip, living to see a relative's life milestone). Documentation that member is too cognitively impaired to provide a goal and has no family members is sufficient to meet this element.

   Note: Goals that are determined solely by the provider without member input, or automatically generated based on patient conditions or risk factors, do not count as a member goal.

2. A plan of care to meet the member's medical needs. Documentation that the plan addresses the member's needs or that the member does not have medical needs.

3. A plan of care to meet the member's functional needs. Documentation that the plan addresses the member's needs or that the member does not have functional needs.

4. A plan of care to meet the member's needs due to cognitive impairment; for example, support for behavioral difficulties, caregiver support or education to address cognitive impairment, support for engaging the member in activities. Document that the plan addresses the member's needs or that the member does not have needs resulting from cognitive impairment.

5. A list of all LTSS services and supports the member receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings (e.g., adult day health center, nursing facility), including the amount (e.g., hours, days) and frequency (e.g., every day, once a week). Documentation that the member does not receive LTSS meets the numerator criteria.

6. A plan for the care manager to follow up and communicate with the member (e.g., a follow-up and communication schedule).

7. A plan to ensure that the member's needs are met in an emergency (e.g., the care assistant or home health aide cannot get to the member's home, natural disaster). At a minimum, the plan must include the name of LTSS organization staff or a contracted provider to contact in an emergency.

8. Documentation of the family/friend caregivers who were involved in development of the care plan, and their contact information. Documentation of no family/friend caregiver involvement meets the element. Documentation that family/friend caregivers were invited but declined to participate in care planning meets the element.

9. Documentation that the member or the member's representative (i.e., power of attorney) agrees to the completed care plan, or appeals the care plan. Documentation includes the member/ representative's verbal agreement received by the case manager by telephone or in person, or a written agreement by the member/representative mailed to the case manager mail (e.g., a signature). Documentation that a care plan was discussed or reviewed does not meet the measure. Agreement or appeal by the member/representative must be documented.

SCREENING, RISK ASSESSMENT, AND PLAN OF CARE TO PREVENT FUTURE FALLS

FALLS PART 1: SCREENING

A. DESCRIPTION

The percentage of MLTSS plan members 18 years of age and older who have documentation of screening for history of falls and/or problems with balance or gait.

Data Collection Method: Case Management Record Review

Guidance for Reporting:
• This measure applies to Medicaid MLTSS plan members ages 18 and older. • Only one rate is reported for this measure

B. DEFINITIONS

Fall	A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.
Screening	Any evaluation of whether an enrollee has experienced a history of falls and/or problems with balance or gait.

C. ELIGIBLE POPULATION

Age	18 years and older as of the first day of the measurement year.
Continuous enrollment	Member must be enrolled in a Medicaid MLTSS plan for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For individuals with multiple distinct continuous enrollment periods during the measurement year, look at the screening completed in the last continuous enrollment period of 150 days or more during the measurement year. **Note:** 150 days continuous enrollment allows a single sample to be used across the suite of LTSS measures: LTSS Comprehensive Assessment and Update, which looks for assessment to be conducted within 90 days of enrollment; LTSS Comprehensive Care Plan and Update, which looks for a care plan to be developed within 30 days of assessment or 120 days of enrollment; LTSS Shared Care Plan with Primary Care Practitioner, which looks for a care plan to be shared within 30 days of development; and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measure, which looks for screening for history of falls and/or problems with balance or gait.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care).
Event/diagnosis	None.
Required Exclusions	Required exclusions are NOT reported with the measure rate. (1) Plan members who are not ambulatory: Plan members who are not ambulatory, bed ridden, immobile, confined to chair, wheelchair users who are dependent on helper pushing wheelchair, are independent in wheelchair, or require minimal help in wheelchair are excluded from this rate.

D. CASE MANAGEMENT RECORD REVIEW SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Note: the same systematic sample may be used to calculate the LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, LTSS Shared Care Plan with Primary Care Practitioner, and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measures.

Numerator

The number of MLTSS plan members who have documentation of an evaluation of whether the member has experienced a fall or problems with balance or gait. The evaluation must be completed between August 1 of the year prior to the measurement year and December 31 of the measurement year. A specific screening tool is not required for this measure however potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test.

Note: The same tool may be used for screening and assessment if it meets the definition specified in each measure.

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FALLS PART 2: RISK ASSESSMENT AND PLAN OF CARE

A. DESCRIPTION

The percentage of MLTSS plan members 18 years of age and older with a documented history of falls (at least two falls or one fall with injury in the past year), who have documentation of a falls risk assessment and plan of care to prevent future falls. The following rates are reported.

1. *Falls Risk Assessment*. MLTSS plan members at risk for future falls who had a risk assessment for falls completed
2. *Plan of Care for Falls*. MLTSS plan members at risk for future falls who had a plan of care to prevent future falls documented

Data Collection Method: Case Management Record Review

Guidance for Reporting:

- This measure applies to Medicaid MLTSS plan members ages 18 and older.
- Two performance rates should be reported for this measure: (1) Falls Risk Assessment and (2) Plan of Care for Falls.
- One rate of required exclusions should also be reported: (1) Member refused risk assessment and/or plan of care.

B. DEFINITIONS

Fall	A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.
Falls Risk Assessment	An assessment for fall risk. The falls risk assessment must include at a minimum balance/gait assessment AND one or more of the following assessments: postural blood pressure, vision, home fall hazards, and documentation on whether or not medications are a contributing factor to falls.
Plan of Care for Falls	A plan of care to prevent future falls. The plan of care must include at a minimum exercise therapy or referral to exercise.

C. ELIGIBLE POPULATION

Age	18 years and older as of the first day of the measurement year.
Continuous enrollment	Member must be enrolled in a Medicaid MLTSS plan for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For members with multiple distinct continuous enrollment periods during the measurement year, look at the last continuous enrollment period of 150 days or more during the measurement year.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care)
Event/diagnosis	A documented history of falls (at least two falls or one fall with injury in the past year). Documentation of plan member self-reported history of falls is sufficient.
Required Exclusions	(1) Plan members who are not ambulatory: Plan members who are not ambulatory, bed ridden, immobile, confined to chair, wheelchair users who are dependent on helper pushing wheelchair, are independent in wheelchair, or require minimal help in wheelchair are excluded from all rates of this measure. The exclusion for members who are not ambulatory is NOT reported with the measure performance rates. (2) Refusal of risk assessment and/or plan of care: Plan members who refused a risk assessment and/or plan of care. Document that the member was contacted and refused to participate in an assessment and/or development of plan of care. The exclusion for members who refused assessment and/or a plan of care IS reported with the measure rates. To calculate the rate of individuals who refused, divide the number of individuals meeting this exclusion criterion by the number of people meeting the continuous enrollment criteria.

D. CASE MANAGEMENT RECORD REVIEW SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Numerator

The measure reports two numerators

Rate 1: Risk Assessment

The number of MLTSS plan members who have documentation of a falls risk assessment completed between August 1 of the year prior to the measurement year and December 31 of the measurement year. Falls risk assessment must include a balance/gait assessment AND at least one of the following assessments: postural blood pressure, vision, home fall hazards, and medications. A standardized tool is not required for assessment of balance/gait. All components do not need to be completed during a single encounter but should be documented in the member record as having been performed between August 1 of the year prior to the measurement year and December 31 of the measurement year.

- Balance/gait assessment. Comprises at least one of the following three elements:
  (1) Documentation of observed transfer and walking,
  (2) Documented use of a standardized scale for assessment of balance/gait (e.g., Get Up & Go, Berg, Tinetti), and/or
  (3) Documentation of assessment with no standardized tool.
- Postural blood pressure assessment. Comprises documentation of blood pressure values in standing and supine positions.
- Vision Assessment. Comprises at least one of the following two elements during an in-person assessment:
  (1) Documentation that patient is functioning well with vision, or not functioning well with vision based on discussion with the patient, or
  (2) Documented use of a standardized scale or vision assessment tool (e.g., Snellen).
- Home fall hazards assessment. Comprises documentation of inquiry of home fall hazards.
- Medication assessment. Comprises documentation of whether the member's current medications may or may not be contributing to falls.

Note: The same standardized tool may be used to conduct screening (Falls Part 1) and risk assessment (Falls Part 2). For example, a tool which asks about balance and gait AND home fall hazards would meet the definition of a screening tool and the definition of risk assessment.

Rate 2: Plan of Care

The number of MLTSS plan members who have documentation of a plan of care to prevent future falls completed between August 1 of the year prior to the measurement year and December 31 of the measurement year, which includes at a minimum exercise therapy or referral to exercise. Documentation of exercise therapy may include any of the following:

1. Documentation of exercise provided or referral to an exercise program
2. Balance/gait training or instructions provided or referral for balance/gait training
3. Physical therapy provided or referral to physical therapy
4. Occupational therapy provided or referral for occupational therapy

LONG-TERM SERVICES AND SUPPORTS (LTSS) ADMISSION TO AN INSTITUTION FROM THE COMMUNITY

A. DESCRIPTION

The number of MLTSS plan member admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) from the community that result in a short-term, medium-term, or long-term stay during the measurement year per 1,000 member months.

The following rates are reported across four age groups, 18-64, 65-74, 75-84, and 85 and older:

1. *Short-Term Stay*. The rate of admissions resulting in a short-term (1 to 20 days) stay per 1,000 MLTSS member months.
2. *Medium-Term Stay*. The rate of admissions resulting in a medium-term (21 to 100 days) stay per 1,000 MLTSS member months.
3. *Long-Term Stay.* The rate of admissions resulting in a long-term (greater than or equal to 101 days) stay per 1,000 MLTSS member months.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid MLTSS plan members ages 18 and older.
- Twelve performance rates should be reported for this measure: (1) Short-Term Stay, (2) Medium-Term Stay, and (3) Long-Term Stay stratified across four age groups: 18-64, 65-74, 75-84, and 85 and older. Age stratification guidelines for this measure are provided in the administrative specification.
- Include paid claims only.

The following coding systems are used in this measure: UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Institutional Facility	Medicaid- or Medicare- certified nursing facilities providing skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as “custodial care”) or Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
Community Residence	Any residence that is not an institutional facility (see definition above). **Note**: community residence may include assisted living, adult foster care, or other care in another setting that is not defined as an institution.

Member months	A MLTSS plan member's "contribution" to the total yearly enrollment. Member months are calculated by summing the total number of months each member is enrolled in the MLTSS plan and residing in the community for at least one day of the month during the measurement year.
Institutional Facility Admission (IFA)	Admissions to an institutional facility from the community or from the hospital (where the hospital admission originated in the community) between August 1 of the year prior to the measurement year and July 31 of the measurement year.

C. ELIGIBLE POPULATION

Age	18 years and older as of the first day of the measurement year
Continuous enrollment	Member must be enrolled in a Medicaid MLTSS plan for at least 30 days between August 1 of the year prior to the measurement year and December 31 of the measurement year.
Allowable gap	None.
Anchor date	None.
Benefit	Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care) **AND** Benefit for medical care and services. Benefits should be determined at the individual level. Any individual receiving a benefit for both LTSS and medical care through the MLTSS plan is eligible for this measure.
Event/diagnosis	None.
Required Exclusions	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Number of member months where the member was residing in the community for at least one day of the month.

Step 1

Identify the eligible population above.

Step 2

Determine member months between August 1 of the year prior to the measurement year and July 31 of the measurement year using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the plan's administrative processes. The day selected must be consistent from person to person, month to month, and year to year. For example, if the plan tallies enrollment on the 15th of the month and a member is enrolled in the MLTSS program on January 15, the member contributes one member month in January.

Step 3

Identify the months where the MLTSS plan member was residing in an institutional facility for the entire month (i.e., there were no days in the month spent residing in the community). Remove these months from the denominator.

Step 4

Exclude the month that a member dies, and any subsequent months of enrollment, from the measure denominator.

Step 5

Divide population into age stratification groups - Use the member's age on the specified day of each month to determine to which age group the member months will be attributed. For example, if the plan tallies members on the 15th of each month and a member turns 65 on April 3 and is enrolled for the entire year, then the member contributes three member months to the 18-64 age group category and nine member months to the 65-74 age category.

Numerator

The number of IFA (nursing facility or ICF/IID) from a community residence during the measurement year between August 1 of the year prior to the measurement year and July 31 of the measurement year. Admissions are reported in three categories: 1) short-term stay (1 to 20 days), 2) medium-term stay (21 to 100 days), 3) long-term stay (greater than or equal to 101 days).

Use the steps below to identify numerator events.

Step 1

Identify all admissions to institutions between August 1 of the year prior to the measurement year and July 31 of the measurement year (Institutional Facility Value Set).

Step 2

Remove admissions that are direct transfers from another institution. Keep the original admission date at the date of new institutional facility admission. A direct transfer is when the discharge date from the first institutional facility setting precedes the admission date to a second institutional facility setting by one calendar day or less. For example:

- An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 1, is a direct transfer.

- An institutional facility discharge on June 1, followed by an admission to an institutional facility setting on June 2, is a direct transfer.
- An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 3, is not a direct transfer; these are two distinct new institutional facility stays.

Step 3

Remove admissions from the hospital that originated from an institution. Keep the original institutional facility admission date (that preceded the admission to the hospital) as the date of new institutional facility admission.

Step 4

Remove admissions that result in death in the institution or death within 1 day of discharge from the institution.

Step 5

Calculate the continuous enrollment. Remove admissions for individuals how do not meet the continuous enrollment criteria. All resulting admissions directly from the community and from the hospital that originated in the community make up the numerator

Step 6

For all IFA, look for location of the first discharge in the measurement year.

- If the member is discharged to the community, calculate length of stay (LOS) as the date of institution discharge minus the index admission date.
- If there is no discharge, calculate LOS as the date of the last day of the measurement year minus index admission date.
- If the member is discharged to the hospital, look for the hospital discharge and location of discharge. If the member is discharged from the hospital to the community, calculate LOS as the date of institution discharge minus the IFA date.
- If the member is discharged from the hospital to the institution, repeat until there is a discharge to the community or the end of the measurement year.
- If the member is discharged to a different institution (i.e. a transfer), repeat until there is a discharge to the community or the end of the measurement year.
- When counting the duration of each stay within a measurement year, include the day of entry (admission) but not the day of discharge unless the admission and discharge occurred on the same day in which case the number of days in the stay is equal to 1.

Step 7

Classify LOS for each IFA as short-term, medium-term, or long-term.

- Short-term stay: The LOS is 1 – 20 days.
- Medium-term stay: The LOS is 21 – 100 days.
- Long-term stay: The LOS is ≥101 days.

Step 8

Determine the member's age at the time of admission and assign to either the 18 – 64, 65 – 74, 75 – 84, or 85+ age strata as appropriate.

Reporting Performance Rate

Calculate the admission rate for each type of stay and age strata by dividing the number of admissions by the number of member months and multiplying by 1,000 as follows:

- Short-term Admission Rate = (Number of short-term admissions/number of member months) x 1,000
- Medium-term Admission Rate = (Number of medium-term admissions/number of member months) x 1,000
- Long-term Admission Rate = (Number of long-term admissions/number of member months) x 1,000

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LONG-TERM SERVICES AND SUPPORTS (LTSS) MINIMIZING INSTITUTIONAL LENGTH OF STAY

A. DESCRIPTION

The proportion of admissions to an institutional facility (e.g., nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID]) for MLTSS plan members that result in successful discharge to the community (community residence for 60 or more days) within 100 days of admission. This measure is reported as an observed rate and a risk-adjusted rate.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid MLTSS plan members ages 18 and older.
- This measure is reported as an observed rate and a risk-adjusted rate. Risk adjustment guidelines for this measure are provided in the administrative specification.
- Include paid claims only

The following coding systems are used in this measure: UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Institutional facility admission (IFA)	An admission to the institutional setting directly from the community between July 1 of the year prior to the measurement year and June 30 of the measurement year. Include admissions to the institutional setting from the hospital setting only if the MLTSS plan member lived in the community prior to the hospital admission.
Discharge to the community	A discharge to the community from the institutional facility for all IFA between July 1 of the year prior to the measurement year and October 31 of the measurement year. Include discharges to the hospital setting only if the MLTSS plan member was discharged from the hospital to the community between July 1 of the year prior to the measurement year and October 31 of the measurement year.
Institutional facility	Medicaid- or Medicare- certified nursing facilities providing skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as “custodial care”) or Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Community residence	Any residence that is not an institutional facility (see definition above). **Note:** Community residence may include assisted living, adult foster care, or other care in another setting that is not defined as an institution.
Classification period	180 days prior to and including the IFA date.

Risk Adjustment Tables*

LTSS-CCW	ICD-10 codes for Chronic Conditions Warehouse (CCW) classification
MinInstit-RAW	Weights for risk adjustment weighting

*__Note__: Risk adjustment tables are provided in the attached Excel workbook: LTSS Risk Adjustment Tables.

C. ELIGIBLE POPULATION

Age	18 years and older as of the first day of the measurement year.
Continuous enrollment	Enrollment in the MLTSS plan on the date of IFA through 160 days following the IFA date.
Allowable gap	None.
Anchor date	IFA date.
Benefit	Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care) **AND** Benefit for medical care and services. Benefits should be determined at the individual level. Any individual receiving a benefit for both LTSS and medical care through the MLTSS plan is eligible for this measure.
Event/diagnosis	New admissions to an institutional facility between July 1 of the year prior to the measurement year and June 30 of the measurement year. The denominator for this measure is based on discharges, not members. MLTSS plans should follow the steps below to identify new institutional facility admissions.
Exclusions	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Step 1

Identify all admissions to institutional facilities between July 1 of the year prior to the measurement year and June 30 of the measurement year (Institutional Facility Value Set).

Step 2

Remove admissions that are direct transfers from another institution. Keep the original admission date at the date of new institutional facility admission. A direct transfer is when the discharge date from the first institutional facility setting precedes the admission date to a second institutional facility setting by one calendar day or less. For example:

- An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 1, is a direct transfer.
- An institutional facility discharge on June 1, followed by an admission to an institutional facility setting on June 2, is a direct transfer.
- An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 3, is not a direct transfer; these are two distinct new institutional facility stays.

Step 3

Remove admissions to the institutional facility from the hospital that originated from an institution. Keep the original institutional facility admission date (that preceded the admission to the hospital) as the date of new institutional facility admission.

Step 4

Remove admissions that result in death in the institution or death within 1 day of discharge from the institution.

Step 5

Calculate continuous enrollment. Remove admissions for individuals who do not meet the continuous enrollment criteria.

Risk Adjustment Determination

For each IFA, use the following steps to identify risk adjustment categories based on dual eligibility, age and gender, diagnoses from the IFA, and number of hospital stays and months of enrollment in the classification period.

Age and gender	Determine the member's age and gender on the date of IFA and assign to the following categories: Female age 18-44, Female age 45-64, Female age 65-74, Female age 75-84, Female age 85+, Male age 18-44, Male age 45-64, Male age 65-74, Male age 75-84, Male age 85+
Dual eligibility	Determine the member's dual eligibility status on the date of IFA. If the member received full Medicaid and Medicare benefits classify them as a dual eligible member. All other members are not considered dual eligible.
Diagnoses	Assign a chronic condition's warehouse (CCW) code to the IFA based on its diagnoses using table LTSS-CCW. For direct transfers, use the all diagnoses that occurred during the episode (i.e., original admission diagnoses and direct transfer's diagnoses.) Exclude diagnoses that cannot be mapped to Table MinInstit-RAW.
Number of hospital stays	Determine if the member had any acute hospitalizations in the 6 months prior to the measurement year. Classify the total count of acute hospitalizations as 0, 1, or 2 or more.
Days of enrollment in MTLSS plan	Determine the number of days the member has been enrolled in the MLTSS plan prior to the IFA date. Classify the total days of enrollment as less than 180 days or greater than or equal to 180 days.

Risk Adjustment Weighting

For each IFA, use the following steps to identify risk adjustment weights based on dual eligibility, age and gender, diagnoses from the IFA, and number of hospital stays and months of enrollment in the classification period. Risk adjustment weights are listed in table MinInstit-RAW.

Step 1

Identify the base weight

Step 2

Link the age and gender weights for each IFA

Step 3

For each IFA with dual eligibility, link the dual eligibility weight.

Step 4

For each IFA with an admission CCW category, link the CCW category weight.

Step 5

For each IFA with 1 or more hospitalizations prior to IFA, link the number of hospitalizations weight.

Step 6

For each IFA with six months or more of enrollment prior to the IFA, link the six months enrollment weight.

Step 7

Sum all weights associated with the IFA (i.e., base, age and gender, dual eligibility, qualified CCW categories, number of hospitalizations, and six months enrollment weight) to calculate the expected estimated probability of Successful Discharge to the Community for each IFA.

Expected Discharge Probability = [exp (sum of weights for IFA)]/[1+exp(sum of weights for IFA)]

Note: “Exp” refers to the exponential or antilog function.

Step 8

Calculate the count of successful discharges to the community. The count of expected discharges is the sum of the estimated discharge probability calculated in Step 7 for each IFA.

$$Count\ of\ \ Expected\ Discharges = \sum \left(\text{Estimated Discharge Probability} \right)$$

As an example, below we provide a sample calculation of expected discharge probability for a hypothetical member with the following characteristics: male; 88 years old; had two pre-period hospital stays; and had a stroke.

Base Risk Weight	Age	Gender	Age and Gender Weight	Dual eligibility weight	Number of hospital stays		IFA Admission Diagnosis			6+ Months of enrollment	Sum of weights	Expected discharge probability
					Number of hospital stays	Weight	ICD-10 Diagnosis Codes	CCW	Weight			
-0.9966	88	Male	0.4395	0	2	-.4930	G459	Stroke	-0.5140	0	-1.1565	0.315

In this example, the expected probability of having a successful discharge during the measure year for this member is:

$$Expected\ Discharge\ Probability = \exp\left(-0.9966 + 0.8471 - 0.4930 - 0.5140\right) = 0.315$$

Numerator

The count of discharges from an institutional facility to the community during the measurement year that occurred within 100 days or less of admission. Discharges that result in death, hospitalization or re-admission to the institution within 60 days of discharge from the institution do not meet the numerator criteria.

Step 1

Identify all IFA (see Denominator criteria above).

Step 2

Look for location of the first discharge for each IFA in between July 1 of the year prior to the measurement year and October 31 of the measurement year.

- If the member is discharged to the community, calculate length of stay (LOS) as the date of institution discharge minus the index admission date.
- If there is no discharge, calculate LOS as the date of the last day of the measurement year minus IFA date.
- If the member is discharged to the hospital, look for the hospital discharge and location of discharge. If the member is discharged from the hospital to the community, calculate LOS as the date of institution discharge minus the IFA date.
- If the member is discharged to the hospital and dies in the hospital, exclude the admission from the count of IFA.
- If the member is discharged to the hospital and remains in the hospital at the end of the measurement year, exclude the admission from the count of IFA.
- If the member is discharged from the hospital to the institution, repeat step 2 until there is a discharge to the community or the end of the measurement year.
- If the member is discharged to a different institution (i.e. a transfer), repeat step 2 until there is a discharge to the community or the end of the measurement year.
- When counting the duration of each stay within a measurement year, include the day of entry (admission) but not the day of discharge unless the admission and discharge occurred on the same day in which case the number of days in the stay is equal to 1.

Step 3

Using information from step 2, identify all IFA with length of stay of less than or equal to 100 days. This should include only discharges to the community (either directly from the institution or from the institution to the hospital to the community).

Step 4

Remove discharge if the MLTSS member was hospitalized, died or was re-admitted to the institution within 60 days of the day of discharge.

Reporting Observed and Risk-Adjusted Performance Rates

Calculate the observed discharge rate by dividing the numerator (count of successful discharges to the community) by the denominator (count of IFA). Report the observed discharge rate as the observed performance rate of Minimizing Institutional Length of Stay.

Calculate the expected discharge rate by dividing the expected count of successful discharges by the denominator (count of IFA). Report the expected discharge rate as the expected performance rate of Minimizing Institutional Length of Stay.

Plans can understand their results by calculating the ratio of their observed to expected (O/E) rates. A ratio of greater than 1 implies a higher than expected rate of successful discharges, whereas a ratio of less than 1 implies lower than expected rate of successful discharges.

Reporting of a risk-adjusted rate requires standardization of the O/E ratio using a multi-plan, population rate.

States should calculate the multi-plan population rate Y by taking the sum of all observed numerator events and dividing by the sum of all observed denominator events.

The risk-adjusted rate (r_k) of Minimizing Institutional Length of Stay for each plan *k* is equal to:

$$r_k = \left(\frac{Observed\ Rate_k}{Expected\ Rate_k} \right) \times Y$$

LONG-TERM SERVICES AND SUPPORTS (LTSS) SUCCESSFUL TRANSITION AFTER LONG-TERM INSTITUTIONAL STAY

A. DESCRIPTION

The proportion of MLTSS plan members who are long-term residents (101 days or more) of institutional facilities (e.g., nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities [ICD/IID]) who are successfully transitioned to the community (community residence for 60 or more days). This measure is reported as an observed rate and a risk adjusted rate.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid MLTSS plan members ages 18 and older.
- This measure is reported as an observed rate and a risk-adjusted rate. Risk adjustment guidelines for this measure are provided in the administrative specification.
- Include paid claims only

The following coding systems are used in this measure: UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

New Institutional facility admission (IFA)	An admission to the institutional setting directly from the community between July 1 of the year prior to the measurement year and June 30 of the measurement year. Include admissions to the institutional setting from the hospital setting only if the MLTSS plan member lived in the community prior to the hospital admission.
Prior institutional facility admission (PIFA)	The admission for MLTSS plan members who resided in the institutional facility on July 1 of the year prior to the measurement year.
Long-term institutional stay (LTIS)	IFA and PIFA that result in a continuous stay in the institutional facility of 101 days or more.

Discharge to the community	A discharge to the community from the institutional facility for all IFA and PIFA between July 1 of the year prior to the measurement year and October 31 of the measurement year. Include discharges to the hospital setting only if the MLTSS plan member was discharged from the hospital to the community between July 1 of the year prior to the measurement year and October 31 of the measurement year.
Institutional facility	Medicaid- or Medicare- certified nursing facilities providing skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as "custodial care") or Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
Community residence	Any residence that is not an institutional facility (see definition above). **Note:** Community residence may include assisted living, adult foster care, or other care in another setting that is not defined as an institution.
Classification period	180 days prior to January 1 of the measurement year.

Risk Adjustment Tables*

LTSS-CCW	ICD-10 codes for Chronic Conditions Warehouse (CCW) classification
LTTrans-RAW	Weights for risk adjustment weighting

*__Note__: Risk adjustment tables are provided in the attached Excel workbook: LTSS Risk Adjustment Tables.

C. ELIGIBLE POPULATION

Age	18 years and older as of July 1 of year prior to the measurement year.
Continuous enrollment	Continuously enrolled in the MLTSS plan for at least 365 days during the period between July 1 of the year prior to the measurement year and December 31 of the measurement year. If the enrollee dies after discharge to the community, the continuous enrollment period does not include the period after death.
Allowable gap	No more than one gap in enrollment of up to 45 days and no gap during the 60 days following the date of discharge to the community.
Anchor date	July 1 of year prior to the measurement year.

Benefit	Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care) **AND** Benefit for medical care and services. Benefits should be determined at the individual level. Any individual receiving a benefit for both LTSS and medical care through the MLTSS plan is eligible for this measure.
Event/diagnosis	IFA with a length of stay 101 days or more between July 1 of the year prior to the measurement year and June 30 of the measurement year, **OR** PIFA where the length of stay was at least 101 days inclusive of July 1 of the year prior to the measurement year. For example, a PIFA for a member identified as residing in an institutional facility on July 1 of the year prior to the measurement year, who was admitted to the facility on June 1 of the year prior to the measurement year and remained in the facility through September 15 of the year prior to the measurement year is considered a stay of at least 101 days. The denominator for this measure is based on discharges, not members. MLTSS plans should follow the steps below to identify new and prior institutional facility admissions.
Exclusions	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Step 1

Identify all members residing in an institution (NF and ICF/IID facilities) on July 1 of the year prior to the measurement year and were residing in the institution for at least 101 days inclusive of July 1 of the year prior to the measurement year. Plans may use their own method to identify individuals residing in institutions for at least 101 days inclusive of July 1 of the year prior to the measurement year. For example, an individual identified as residing in an institutional facility on July 1 of the year prior to the measurement year, who was admitted to the facility on June 1 of the year prior to the measurement year and remained in the facility through September 15 of the year prior to the measurement year is considered a stay of at least 101 days. These admissions are considered PIFA.

Step 2

Identify all new admissions to institutional facilities (NF and ICF/IID facilities) between July 1 of the year prior to the measurement year and June 30 of the measurement year (Institutional Facility Value Set). These are considered IFA.

Step 3

Remove admissions that are direct transfers from another institution. Keep the original admission date at the date of new institutional facility admission. A direct transfer is when the discharge date from the first institutional facility setting precedes the admission date to a second institutional facility setting by one calendar day or less. For example:

- An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 1, is a direct transfer.
- An institutional facility discharge on June 1, followed by an admission to an institutional facility setting on June 2, is a direct transfer.
- An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 3, is not a direct transfer; these are two distinct new institutional facility stays.

Step 4

Remove admissions from the hospital that originated from an institution. Keep the original institutional facility admission date (that preceded the admission to the hospital) as the date of new institutional facility admission.

Step 5

Remove admissions that result in death in the institution or death within 1 day of discharge from the institution.

Step 6

Look for location of the first discharge between July 1 of the year prior to the measurement year and October 31 of the measurement year for all new admissions and prior admissions.

- If the member is discharged to the community, calculate length of stay (LOS) as the date of institution discharge minus the index admission date.
- If there is no discharge, calculate LOS as the date of the last day of the measurement year minus the index admission date or July 1 of the year prior to the measurement year if there is no admission date.
- If the member is discharged to the hospital, look for the hospital discharge and location of discharge. If the member is discharged from the hospital to the community, calculate LOS as the date of institution discharge minus the IFA date. If the member is discharged from the hospital to the institution, repeat step 2-6 until there is a discharge to the community or the end of the measurement year.
- If the member is discharged to a different institution (i.e. a transfer), repeat step 2-6 until there is a discharge to the community or the end of the measurement year.

Step 7

Remove all admissions where the LOS is less than or equal to 100 days

Step 8

Calculate the continuous enrollment. Remove admissions for individuals who do not meet the continuous enrollment criteria. The resulting admissions (both new that originated in the community and prior that were residing in the institutional facility on July 1 of the year prior to the measurement year) that lasted 101 days or longer make up the denominator for the observed rate. These admissions are called LTIS.

Risk Adjustment Determination

For each LTIS, use the following steps to identify risk adjustment categories based on dual eligibility, age and gender, diagnoses from the LTIS, and number of hospital stays and months of enrollment in the classification period.

Age and gender	Determine the member's age and gender on July 1 of the year prior to the measurement year and assign to the following categories: Female age 18-44, Female age 45-64, Female age 65-74, Female age 75-84, Female age 85+, Male age 18-44, Male age 45-64, Male age 65-74, Male age 75-84, Male age 85+
Dual eligibility	Determine the member's dual eligibility status on the date of July 1 of the year prior to the measurement year. If the member received full Medicaid and Medicare benefits classify them as a dual eligible member. All other members are not considered dual eligible.
Diagnoses	Assign a chronic condition's warehouse (CCW) code to the LTIS based on all diagnoses for the LTIS episode (e.g., admission diagnoses, transfer diagnoses, interim claim diagnoses) using table LTSS-CCW. For direct transfers, use the direct transfer's discharge diagnoses. Exclude diagnoses that cannot be mapped to Table LTTrans-RAW.
Number of hospital stays	Determine if the member had any acute hospitalizations in the classification period. Classify the total count of acute hospitalizations as 0, 1, or 2 or more.
Days of enrollment in MTLSS plan	Determine the number of days the member was enrolled in the MLTSS plan during the classification period. Classify the total months of enrollment as less than 180 days or greater than or equal to 180 days.

Risk Adjustment Weighting

For each LTIS, use the following steps to identify risk adjustment weights based on dual eligibility, age and gender, and diagnoses from the LTIS, and number of hospital stays and months of enrollment in the classification period. Risk adjustment weights are listed in table LTTrans-RAW.

Step 1

Identify the base weight

Step 2

Link the age and gender weights for each LTIS

Step 3

For each LTIS with dual eligibility on July 1 of the year prior to the measurement year, link the dual eligibility weight.

Step 4

For each LTIS with a CCW category, link the LTIS CCW category weight. Use all diagnoses that occurred across the LTIS episode.

Step 5

For each LTIS with 1 or more hospitalizations in the classification period, link the number of hospitalizations weight.

Step 6

For each LTIS with six months or more of enrollment prior to the classification period, link the six months enrollment weight.

Step 7

Sum all weights associated with the LTIS (i.e., base, age and gender, dual eligibility, LTIS diagnoses, number of hospitalizations, and six months enrollment weight) to calculate the expected estimated probability of Successful Transition to the Community for each LTIS.

Expected Discharge Probability = [exp (sum of weights for LTIS)]/[1+exp(sum of weights for LTIS)]

Note: “Exp” refers to the exponential or antilog function.

Step 8

Calculate the count of successful transitions to the community. The count of expected discharges is the sum of the estimated discharge probability calculated in Step 7 for each LTIS.

$$Count\ of\ \ Expected\ Transitions = \sum \left(\text{Estimated Transistion Probability} \right)$$

As an example, below we provide a sample calculation of expected discharge probability for a hypothetical member with the following characteristics: male; 88 years old; had two pre-period hospital stays; and had an ulcer.

Base Risk Weight	Age	Gender	Age and Gender Weight	Dual eligibility weight	Number of hospital stays		LTIS Diagnosis			6+ Months of enrollment	Sum of weights	Expected discharge probability
					Number of hospital stays	Weight	ICD-10 Diagnosis Code	CCW	Weight			
0.0496	88	Male	1.2319	0	2	-1.1997	I70231	Ulcer	-0.8866	0	0.3949	1.4842

In this example, the expected probability of having a successful transition for this member during the measure year is:

$$\textit{Expected transition probability} = \exp\left(0.0496 + 1.2319 - 1.1997 - 0.8866\right) = 0.309$$

Numerator

The count of discharges from an intuitional facility to the community between July 1 of the year prior to the measurement year and October 31 of the measurement year that result in successful transition to the community for 60 consecutive days. Discharges that result in death, hospitalization or re-admission to the institution within 60 days of discharge from the institution do not meet the numerator criteria.

Step 1

Identify all LTIS (see denominator criteria above).

Step 2

Look for location of the first discharge between July 1 of the year prior to the measurement year and October 31 of the measurement year.

- If the member is discharged to the community, classify as a discharge to the community.
- If the member is discharged to the hospital, look for the hospital discharge and location of discharge. If the member is discharged from the hospital to the community, classify as a discharge to the community.
- All other discharges do not count as discharges to the community (i.e., transfer to an institution, discharge to the hospital followed by readmission the institution). Continue looking for subsequent discharges to the community in the measurement year.

Step 3

Remove discharges to the community if the member was hospitalized or admitted to an institution in the 60 days after discharge from the LTIS.

Step 4

Remove discharges to the community if the member died between day 2 and 60 in the 60 days after discharge from the LTIS.

Step 5

The resulting discharges to the community that were not re-admitted to the hospital, a facility or ended in death within 60 days of discharge make up the numerator for the observed rate and are classified as successful transitions to the community.

Reporting Observed and Risk-Adjusted Performance Rates

Calculate the observed successful discharge rate by dividing the numerator (count of successful transitions to the community) by the denominator (count of LTIS). Report the observed discharge rate as the observed performance rate of Successful Transition to the Community after Long-Term Institutional Stay.

Calculate the expected discharge rate by dividing the expected count of successful transitions by the denominator (count of LTIS). Report the expected transition rate

as the expected performance rate of Successful Transition to the Community after Long-Term Institutional Stay.

Plans can understand their results by calculating the ratio of their observed to expected (O/E) rates. A ratio of greater than 1 implies a higher than expected rate of successful transitions, whereas a ratio of less than 1 implies lower than expected rate of successful transitions.

Reporting of a risk-adjusted rate requires standardization of the O/E ratio using a multi-plan, population rate.

States should calculate the multi-plan population rate Y by taking the sum of all observed numerator events and dividing by the sum of all observed denominator events.

The risk-adjusted rate (r_k) of Successful Transition to the Community after Long Term Institutional Stay for each plan *k* is equal to:

$$r_k = \frac{ObservedRate_k}{ExpectedRate_k} \times Y \ .$$