Technical Corrections Notice

Long-Term Services and Supports (LTSS) Quality Measures Technical Specifications and Resource Manual

Original Publication Date: April 2024

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This document provides technical corrections to the Long-Term Services and Supports (LTSS) Quality Measures Technical Specifications and Resource Manual, originally published in 2024, and serves as a companion document to the published manual. These revisions correct typographical errors, formatting issues, inaccurate references, and clarify terminology across all measures, including updates to ensure consistent use of measure-specific terminology. The corrections are technical in nature and do not change the policies, requirements, measure specifications, calculations, or intent of the guidance in the manual. Technical corrections are identified across applicable measures and identified by page number. The updated text associated with each technical correction is shown in [red font].

The CMS LTSS measures, include eight managed care (MLTSS) and seven fee-for service (FFS LTSS) quality measures for states and Medicaid managed care programs.

Use the following hyperlinks to quickly navigate to the technical corrections in this notice that apply to each measure: MLTSS-1, MLTSS-2, MLTSS-3, MLTSS-4, MLTSS-5, MLTSS-6, MLTSS-7, MLTSS-8, FFS LTSS-1, FFS LTSS-2, FFS LTSS-3, FFS LTSS-4, FFS LTSS-6, FFS LTSS-7, FFS LTSS-8.

For technical assistance with calculating and reporting the LTSS measures, contact the CMS technical assistance mailbox at HCBSQuality@cms.hhs.gov

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
All LTSS Measures		
Clarifying terminology.	All applicable	Where the manual refers to *a Medicaid MLTSS plan*, the term M*edicaid managed care plan that covers LTSS* should be used. Where the manual refers to the LTSS participant characteristic *gender*, the term *sex* should be used. Where the manual refers to a participant "expiring" it should be interpreted as referring to a participant who has died. The terms *die*, *died*, or *dying* should be used in place of *expire*, *expired*, or *expiring*.
MLTSS-1: MLTSS Comprehensive Assessment and Update		
Clarifying the continuous enrollment definition.	Page 10	**Continuous enrollment** A participant must be enrolled in a Medicaid [managed care plan that covers LTSS] for at least 150 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods in the plan during the measurement year, use [the most recent or last] assessment completed during the last continuous enrollment period of 150 days or more occurring during the measurement year.
Clarifying the denominator.	Page 11	**Denominator** [A statistically valid random sample drawn from Medicaid MLTSS participants aged 18 years or older who have at least 150 days of continuous enrollment between August 1 of the year prior to and December 31 of the measurement year.]
MLTSS-2: MLTSS Comprehensive Person-Centered Plan and Update		
Clarifying the continuous enrollment definition.	Page 19, continued 20	**Continuous enrollment** A participant must be enrolled in a Medicaid [managed care plan that covers LTSS] for at least 150 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods in the plan during the measurement year, use [the most recent or last] person-centered plan completed during the last continuous enrollment period of 150 days or more occurring during the measurement year.
Clarifying the denominator.	Page 21	**Denominator** [A statistically valid random sample drawn from Medicaid MLTSS participants aged 18 years or older who have at least 150 days of continuous enrollment between August 1 of the year prior to and December 31 of the measurement year.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
MLTSS-3: MLTSS Shared Person-Centered Plan with Primary Care Provider		
Clarifying the continuous enrollment element definition.	Page 26	**Continuous enrollment** A participant must be enrolled in a Medicaid [managed care plan that covers LTSS] for at least 150 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods in the plan during the measurement year, use [the most recent or last] assessment [or person-centered plan] completed during the last continuous enrollment period of 150 days or more occurring during the measurement year.
Clarifying the denominator.	Page 27	**Denominator** [A statistically valid random sample drawn from Medicaid MLTSS participants aged 18 years or older who have at least 150 days of continuous enrollment between August 1 of the year prior to and December 31 of the measurement year.]
MLTSS-4: MLTSS Reassessment and Person-Centered-Plan Update after Inpatient Discharge		
Clarifying the denominator.	Page 31	**Denominator** [This measure is based on a review of Medicaid MLTSS participant case management records, selected via a statistically valid random sample of acute or non-acute inpatient discharges for an unplanned admission between January 1 and December 1 of the measurement year. Participants with multiple discharges may appear more than once in the sample.]
MLTSS-5: MLTSS Screening, Risk Assessment, and Plan of Care to Prevent Future Falls		
Clarifying the continuous enrollment element definition.	Page 36, continued 37, & 39	**Continuous enrollment** A participant must be enrolled in a Medicaid [managed care plan that covers LTSS] for at least 150 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods in the plan during the measurement year, use the screening completed during the last continuous enrollment period of 150 days or more occurring during the measurement year.
Clarifying the denominator.	Page 37 and 39	**Denominator** [A statistically valid random sample drawn from Medicaid MLTSS participants aged 18 years or older who have at least 150 days of continuous enrollment between August 1 of the year prior to and December 31 of the measurement year.]
Removing the term "ever" which was inadvertently included, by reverting to the previous wording in the MLTSS-5 Falls Part 2, description, and eligible population; event/diagnosis.	Page 38, continued & 39	*A. Description*. The percentage of Medicaid MLTSS participants, aged 18 and older, with a documented history of falls (i.e., [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. *C. Eligible Population;* Event/diagnosis**:** A documented history of falls ([at least two falls or one fall with injury in the past year]). Documentation of the participant's self-reported history of falls is sufficient.

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
MLTSS-6: MLTSS Admission to a Facility from the Community		
Adding a new URL for an updated value set.	Page 3	• **Value set directory** for MLTSS-6, FFS LTSS-6, MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 is available at https://www.medicaid.gov/license/form/8586/141126.
Adding a new URL for an updated value set directory.	Page 8	The value set directory for the LTSS Admission to a Facility from the Community (MLTSS-6 and FFS LTSS-6), LTSS Minimizing Facility Length of Stay (MLTSS-7 and FFS LTSS-7), and LTSS Successful Transition after Long-Term Facility Stay (MLTSS-8 and FFS LTSS-8) measures is available at https://www.medicaid.gov/license/form/8586/141126.
Clarifying the administrative data source.	Page 41	**Data source: Administrative.** [The eligible population includes participants that are eligible for Medicaid only and participants that are dually eligible for Medicare and Medicaid. Medicare and Medicaid claims, encounters, and enrollment data are needed to calculate this measure for the eligible population.]
Clarifying the definition of facility.	Page 42	**Facility**: [Nursing facilities, ICFs/IID, hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, and services in an IMD for individuals ages 65 and older.]
Clarifying in the eligible population, by replacing benefit with service utilization to reflect the identification of HCBS participants using the administrative data source more accurately.	Page 42	[**Service utilization**: The participant must have at least one Medicaid managed care HCBS claim between August 1 of the year prior to the measurement year through July 31 of the measurement year.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying the numerator definition to include facility admissions that occur during or in the month following an eligible month of HCBS use and by revising language describing how to implement the updated facility value set to identify eligible facility admissions.	Page 44	**Numerator** The number of facility admissions from a community residence [during or in the month following an eligible month of HCBS use] from August 1 of the year prior to the measurement year through July 31 of the measurement year. Facility admissions are reported in three categories: 1) short-term stays (i.e., 1 to 20 days), 2) medium-term stays (i.e., 21 to 100 days), and 3) long-term stays (i.e., greater than or equal to 101 days). Use the steps below to identify numerator events. **Step 1** Identify all facility admissions [during or in the month following an eligible month of HCBS use] between August 1 of the year prior to the measurement year and July 31 of the measurement year [(using codes from the *LTSS Facility Value Set* workbook)]. • For the NF, ICF_IID, IMD, and PSYCH_UNDER21 tabs in the *LTSS Facility Value Set* workbook (representing eligible facilities), limit to claims that have at least one of the code values where Code_Type = UBREV and at least one of the code values where Code_Type = UBTOB • The IMD and PSYCH_UNDER21 tabs have an additional age restriction: o Only keep claims identified based on the IMD tab to those where the person receiving the service was age 65 or older at the time of admission. o Only keep claims identified based on the PSYCH_UNDER21 tab to those where the person receiving the service was under age 21 at the time of admission. • A HOSPITAL tab is included in the *LTSS Facility Value Set* workbook to identify hospitals in cases where there was a transfer to or from an eligible facility. • Note that because of the overlap in the UBREV and UBTOB codes used to define IMDs and hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, there will be claims/encounters that are classified as both facility types. This will need to be accounted for when implementing the age restriction to ensure that all eligible records are retained. For example, a two-step drop may need to be implemented where 1) records that are flagged as IMDs and hospitals furnishing inpatient psychiatric hospital services with no other facility flags are dropped where the admission age is between 21-64, and 2) records that are flagged as IMDs with no other facility flags are dropped where the admission age is less than 65. • Note: Medicare institutional claims do not store UB Type of Bill (TOB) codes as a single field. Instead, TOB components (e.g., facility type and service classification) are stored in separate fields and need to be combined to derive the corresponding UB TOB codes.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the numerator, Step 2 the language describing how to treat transfers from one facility to another and between facilities and hospitals.	Page 44	**Step 2** [Treat transfers from one eligible facility to another (for example, from nursing facility A to nursing facility B) and transfers between eligible facilities and hospitals (for example, from an ICF/IID to a hospital or vice versa) as a single continuous stay when those stays have contiguous or overlapping admission/discharge dates. Treat inpatient psychiatric hospital stays for individuals under age 21 as stays, even if they do not have contiguous or overlapping admission/discharge dates with another facility, since they are eligible facilities; drop hospital stays that are (1) not psychiatric hospital stays for individuals under age 21 or (2) not connected to a transfer to or from another eligible facility. Combine two (or more) records into a stay when the following criteria are met: • Records have the same admission date or have the same discharge date OR • One record's admission date is equal to or one day after the discharge date of another record OR • One record's admission date and discharge date are in between another record's admission and discharge date OR • One record's discharge date is in between another record's admission date and discharge date OR • One record's admission date is in between another record's admission date and discharge date. Keep the earliest non-missing admission date and the latest non-missing discharge date.]
Clarifying the length of stay calculation in Step 5 of the numerator. Removing unnecessary language related to accounting for discharges to or from a hospital or facility, as these steps are no longer needed following the technical correction to the numerator, Step 2.	Page 44	**Step 5** [Calculate length of stay for each facility admission: • If the participant is discharged to the community, calculate length of stay. • as the date of facility discharge minus the admission date. • If there is no discharge, calculate the length of stay as the date of the last day of the measurement year minus the admission date. • When counting the duration of each facility admission 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 one.]
MLTSS-7: MLTSS Minimizing Facility Length of Stay		
Clarifying the measure type.	Page 2	**Measure Type:** [Outcome]
Adding new URLs for an updated value set directory and the risk-adjustment tables.	Page 3	• Value set directory for MLTSS-6, FFS LTSS-6, MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 is available at https://www.medicaid.gov/license/form/8586/141126. • Risk-adjustment tables for MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 are available at https://www.medicaid.gov/media/3296.

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Adding a new URL for an updated value set directory.	Page 8	The value set directory for the LTSS Admission to a Facility from the Community (MLTSS-6 and FFS LTSS-6), LTSS Minimizing Facility Length of Stay (MLTSS-7 and FFS LTSS-7), and LTSS Successful Transition after Long-Term Facility Stay (MLTSS-8 and FFS LTSS-8) measures is available at https://www.medicaid.gov/license/form/8586/141126.
Clarifying the administrative data source.	Page 46	**Data source: Administrative.** [The eligible population includes participants that are eligible for Medicaid only and participants that are dually eligible for Medicare and Medicaid. Medicare and Medicaid claims, encounters, and enrollment data are needed to calculate this measure for the eligible population.]
Clarifying the definition of facility.	Page 46	**Facility:** [Nursing facilities, ICFs/IID, hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, and services in an IMD for individuals ages 65 and older.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the denominator Step 1, by revising the language describing how to implement the updated facility value set to identify eligible facility admissions.	Page 48	Identify all admissions to facilities between July 1 of the year prior to the measurement year and June 30 of the measurement year [(using codes from the *LTSS Facility Value Set* workbook). • For the NF, ICF_IID, IMD, and PSYCH_UNDER21 tabs in the *LTSS Facility Value Set* workbook (representing eligible facilities), limit to claims that have at least one of the code values where Code_Type = UBREV and at least one of the code values where Code_Type = UBTOB • The IMD and PSYCH_UNDER21 tabs have an additional age restriction: o Only keep claims identified based on the IMD tab to those where the person receiving the service was age 65 or older at the time of admission. o Only keep claims identified based on the PSYCH_UNDER21 tab to those where the person receiving the service was under age 21 at the time of admission. • A HOSPITAL tab is included in the *LTSS Facility Value Set* workbook to identify hospitals in cases where there was a transfer to or from an eligible facility. • Note that because of the overlap in the UBREV and UBTOB codes used to define IMDs and hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, there will be claims/encounters that are classified as both facility types. This will need to be accounted for when implementing the age restriction to ensure that all eligible records are retained. For example, a two-step drop may need to be implemented where 1) records that are flagged as IMDs and hospitals furnishing inpatient psychiatric hospital services with no other facility flags are dropped where the admission age is between 21-64, and 2) records that are flagged as IMDs with no other facility flags are dropped where the admission age is less than 65. Note: Medicare institutional claims do not store UB Type of Bill (TOB) codes as a single field. Instead, TOB components (e.g., facility type and service classification) are stored in separate fields and need to be combined to derive the corresponding UB TOB codes.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the numerator, Step 2 the language describing how to treat transfers from one facility to another and between facilities and hospitals.	Page 48	**Step 2** [Treat transfers from one eligible facility to another (for example, from nursing facility A to nursing facility B) and transfers between eligible facilities and hospitals (for example, from an ICF/IID to a hospital or vice versa) as a single continuous stay when those stays have contiguous or overlapping admission/discharge dates. Treat inpatient psychiatric hospital stays for individuals under age 21 as stays, even if they don't have contiguous or overlapping admission/discharge dates with another facility, since they are eligible facilities; drop hospital stays that are (1) not psychiatric hospital stays for individuals under age 21 or (2) not connected to a transfer to or from another eligible facility. Combine two (or more) records into a stay when the following criteria are met: • Records have the same admission date or have the same discharge date OR • One record's admission date is equal to or one day after the discharge date of another record OR • One record's admission date and discharge date are in between another record's admission and discharge date OR • One record's discharge date is in between another record's admission date and discharge date OR • One record's admission date is in between another record's admission date and discharge date. Keep the earliest non-missing admission date and the latest non-missing discharge date.]
Clarifying the number of prior hospital stays in the classification period (180 days prior to and including the facility admission date).	Page 49	**Number of prior hospital stays.** Determine whether the participant had any acute care hospitalizations [in the classification period (180 days prior to and including the facility admission date).] Classify the total acute hospitalizations as zero, one, or two or more.
Clarifying in the diagnoses codes table that chronic conditions used for risk adjustment are based on diagnoses listed on claims during the classification period.	Page 49	**Diagnoses.** [Filter the *Diagnosis codes* table (within the *LTSS Risk Adjustment Tables* workbook) to the LTSS-7 rows indicated in column A and assign risk adjustment condition categories to the facility admission based on diagnoses listed on claims during the classification period (180 days prior to and including the facility admission date).]
Clarifying the number of prior hospital stays in the classification period (180 days prior to and including the facility admission date).	Page 49	**Days of enrollment [in a Medicaid managed care plan that covers LTSS]**. Determine the number of days the participant was enrolled [in a Medicaid managed care plan that covers LTSS during the classification period (180 days prior to and including the facility admission date).] Classify the total days of enrollment as fewer than 180 days or equal to 180 days.

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the numerator, Step 1, language describing how to identify eligible facility stays with a discharge to the community. Clarifying in the numerator, Step 2, by revising the length of stay calculation to align with the updated guidance in the denominator, Step 2, for facility-to-facility and facility-to-hospital transfers.	Page 51	**Numerator** **Step 1** [Using the denominator, limit to stays where there was a discharge to the community between July 1 of the year prior to the measurement year and October 31 of the measurement year.] **Step 2** [Calculate length of stay: • If the participant is discharged to the community, calculate length of stay as the date of facility discharge minus the admission date. 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 one.]
Clarifying in the numerator, Step 4 risk adjustment reporting of observed and risk-adjusted performance rates, by replacing the term plan with state to reflect that rates are reported by the state.	Page 52	States or 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 a lower-than-expected rate of successful discharges. Reporting of a risk-adjusted rate requires standardization of the O/E ratio using a multi-[state] population rate. States should calculate the multi-[state] population rate Y by taking the sum of all observed numerator events and dividing it by the sum of all observed denominator events. The risk-adjusted rate (rk) for the [LTSS measure] for each [state], k, is equal to the O/E ratio multiplied by the multi-[state] population rate, Y.
MLTSS-8: MLTSS Successful Transition after Long-Term Facility Stay		
Adding new URLs for an updated value set directory and the risk-adjustment tables.	Page 3	• Value set directory for MLTSS-6, FFS LTSS-6, MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 is available at https://www.medicaid.gov/license/form/8586/141126. • Risk-adjustment tables for MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 are available at https://www.medicaid.gov/media/3296.
Adding a new URL for an updated value set directory.	Page 8	The value set directory for the LTSS Admission to a Facility from the Community (MLTSS-6 and FFS LTSS-6), LTSS Minimizing Facility Length of Stay (MLTSS-7 and FFS LTSS-7), and LTSS Successful Transition after Long-Term Facility Stay (MLTSS-8 and FFS LTSS-8) measures is available at https://www.medicaid.gov/license/form/8586/141126.
Clarifying the administrative data source eligible population.	Page 53	**Administrative:** [The eligible population includes participants who are eligible for Medicaid only and participants who are dually eligible for Medicare and Medicaid. Medicare and Medicaid claims, encounters, and enrollment data are needed to calculate this measure for the eligible population.]
Clarifying the definition of facility.	Page 53	**Facility:** [Nursing facilities, ICFs/IID, hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, and services in an IMD for individuals ages 65 and older.]

Technical Correction Description	Page Number	Updated Text
Clarifying in the denominator, by adding Step 2 instructions for using the LTSS Facility Value Set workbook to identify eligible facility admissions.	Page 55	Using codes from the *LTSS Facility Value Set* workbook, identify [1) participants residing in a facility on July 1 of the year prior to the measurement year and who were residing in the facility for at least 101 days inclusive of July 1 of the year prior to the measurement year [and 2) new admissions to facilities from July 1 of the year prior to the measurement year through June 30 of the measurement year. • For the NF, ICF_IID, IMD, and PSYCH_UNDER21 tabs in the *LTSS Facility Value Set* workbook (representing eligible facilities), limit to claims that have at least 1 of the code values where Code_Type = UBREV and at least one of the code values where Code_Type = UBTOB • The IMD and PSYCH_UNDER21 tabs have an additional age restriction: o Only keep claims identified based on the IMD tab to those where the person receiving the service was age 65 or older at the time of admission. o Only keep claims identified based on the PSYCH_UNDER21 tab to those where the person receiving the service was under age 21 at the time of admission. • A HOSPITAL tab is included in the *LTSS Facility Value Set* workbook to identify hospitals in cases where there was a transfer to or from an eligible facility. • Note that because of the overlap in the UBREV and UBTOB codes used to define IMDs and hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, there will be claims/encounters that are classified as both facility types. This will need to be accounted for when implementing the age restriction to ensure that all eligible records are retained. For example, a two-step drop may need to be implemented where 1) records that are flagged as IMDs and hospitals furnishing inpatient psychiatric hospital services with no other facility flags are dropped where the admission age is between 21-64, and 2) records that are flagged as IMDs with no other facility flags are dropped where the admission age is less than 65. • Note: Medicare institutional claims do not store UB Type of Bill (TOB) codes as a single field. Instead, TOB components (e.g., facility type and service classification) are stored in separate fields and need to be combined to derive the corresponding UB TOB codes.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the denominator, Step 3 how to treat transfers from one facility to another and between facilities and hospitals.	Page 55	**Step 3** [Treat transfers from one eligible facility to another (for example, from nursing facility A to nursing facility B) and transfers between eligible facilities and hospitals (for example, from an ICF/IID to a hospital or vice versa) as a single continuous stay when those stays have contiguous or overlapping admission/discharge dates. Treat inpatient psychiatric hospital stays for individuals under age 21 as stays, even if they do not have contiguous or overlapping admission/discharge dates with another facility, since they are eligible facilities; drop hospital stays that are (1) not psychiatric hospital stays for individuals under age 21 or (2) not connected to a transfer to or from another eligible facility. Combine two (or more) records into a stay when the following criteria are met: • Records have the same admission date or have the same discharge date OR • One record's admission date is equal to or one day after the discharge date of another record OR • One record's admission date and discharge date are in between another record's admission and discharge date OR • One record's discharge date is in between another record's admission date and discharge date OR • One record's admission date is in between another record's admission date and discharge date. Keep the earliest non-missing admission date and the latest non-missing discharge date.]
Clarifying the length of stay calculation by removing unnecessary language related to discharges to or from a hospital or facility that is addressed in Step 2.	Page 55	**Step 6** [Calculate length of stay for each eligible admission: • If the participant is discharged to the community, calculate length of stay as the date of facility discharge minus the admission date. • If there is no discharge, calculate the length of stay as the date of the last day of the measurement year minus the admission date or July 1 of the year prior to the measurement year if there is no admission date.]
Clarifying in the diagnoses codes table that chronic conditions used for risk adjustment are based on diagnoses listed on claims during the classification period.	Page 56	**Diagnoses**. [Filter the *Diagnosis codes* table (within the LTSS Risk Adjustment Tables workbook) to the LTSS-8 rows indicated in column B and assign risk adjustment condition categories to the facility admission based on diagnoses listed on claims during the classification period (180 days prior to and including the facility admission date).]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying age and sex are determined on the facility admission date.	Page 56	For each long-term facility stay, use the following steps to identify risk-adjustment categories based on dual eligibility for Medicare and Medicaid, age, [sex], diagnoses from the long-term facility stay, number of hospital stays, and months of enrollment in the measurement period. **Age and [sex].** Determine the participant's age and [sex on the facility admission date] and assign to the following categories: female, aged 18 to 44 years; female, aged 45 to 64 years; female, aged 65 to 74 years; female, aged 75 to 84 years; female, aged 85 years and older; male, aged 18 to 44 years; male, aged 45 to 64 years; male, aged 65 to74 years; male, aged 75 to 84 years; and male, aged 85 years and older.
Clarifying the number of prior hospital stays in the classification period (180 days prior to and including the facility admission date).	Page 57	**Days of enrollment [in a Medicaid managed care plan that covers LTSS]**. Determine the number of days the participant was enrolled in [a Medicaid managed care plan that covers LTSS during the classification period (180 days prior to and including the facility admission date).] Classify the total days of enrollment as fewer than 180 days or equal to 180 days.
Clarifying the number of prior hospital stays.	Page 57	**Number of prior hospital stays.** Determine whether the participant had any acute care hospitalizations in the classification period. [(180 days prior to and including the facility admission date).] Classify the total acute hospitalizations as zero, one, or two or more
Clarifying the numerator Step 1 and removing Step 2.	Page 59	**Step 1** [Using the denominator, limit to stays where there was a discharge to the community between July 1 of the year prior to the measurement year and October 31 of the measurement year.]
Clarifying in the numerator, Step 4 risk adjustment reporting of observed and risk-adjusted performance rates, by replacing the term plan with state to reflect that rates are reported by the state.	Page 60	States or 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 a lower-than-expected rate of successful discharges. Reporting of a risk-adjusted rate requires standardization of the O/E ratio using a multi-[state] population rate. States should calculate the multi-[state] population rate Y by taking the sum of all observed numerator events and dividing it by the sum of all observed denominator events. The risk-adjusted rate (rk) for the [LTSS measure] for each [state], k, is equal to the O/E ratio multiplied by the multi-[state] population rate, Y.
FFS LTSS-1: FFS LTSS Comprehensive Assessment and Update		
Clarifying continuous element definition.	Page 61	**Continuous enrollment:** A participant must be enrolled in Medicaid FFS LTSS for at least 150 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use [the most recent or last] assessment or person-centered plan completed during the last continuous enrollment period of 150 days or more occurring during the measurement year.

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying the denominator.	Page 62	**Denominator** [A statistically valid random sample drawn from Medicaid FFS LTSS participants aged 18 years or older who have at least 150 days of continuous enrollment between August 1 of the year prior to and December 31 of the measurement year.]
FFS LTSS-2: FFS LTSS Comprehensive Person-Centered Plan and Update		
Clarifying the continuous enrollment definition.	Page 71	**Continuous enrollment:** A participant must be enrolled in Medicaid FFS LTSS for at least 150 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use [the most recent or last] person-centered plan completed during the last continuous enrollment period of 150 days or more occurring during the measurement year.
Clarifying the denominator.	Page 72	**Denominator** [A statistically valid random sample drawn from Medicaid FFS LTSS participants aged 18 years or older who have at least 150 days of continuous enrollment between August 1 of the year prior to and December 31 of the measurement year.]
FFS LTSS-3: FFS LTSS Shared Person-Centered Plan with Primary Care Provider		
Clarifying the continuous enrollment definition.	Page 77	**Continuous Enrollment:** A participant must be enrolled in Medicaid FFS LTSS for at least 150 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use [the most recent or last] assessment or person-centered plan completed during the last continuous enrollment period of 150 days or more occurring during the measurement year.
Clarifying the denominator.	Page 78	**Denominator** [A statistically valid random sample drawn from Medicaid FFS LTSS participants aged 18 years or older who have at least 150 days of continuous enrollment between August 1 of the year prior to and December 31 of the measurement year.]
FFS LTSS-4: FFS LTSS Reassessment and Person-Centered-Plan Update after Inpatient Discharge		
Clarifying the denominator.	Page 82	**Denominator** [This measure is based on a review of Medicaid FFS LTSS participant case management records, selected via a statistically valid random sample of acute or non-acute inpatient discharges for an unplanned admission between January 1 and December 1 of the measurement year. Participants with multiple discharges may appear more than once in the sample.]
FFS LTSS-6: FFS LTSS Admission to a Facility from the Community		
Adding a new URL for an updated value set directory.	Page 3	• Value set directory for MLTSS-6, FFS LTSS-6, MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 is available at https://www.medicaid.gov/license/form/8586/141126.

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Adding a new URL for an updated value set directory.	Page 8	The value set directory for the LTSS Admission to a Facility from the Community (MLTSS-6 and FFS LTSS-6), LTSS Minimizing Facility Length of Stay (MLTSS-7 and FFS LTSS-7), and LTSS Successful Transition after Long-Term Facility Stay (MLTSS-8 and FFS LTSS-8) measures is available at https://www.medicaid.gov/license/form/8586/141126.
Clarifying the administrative data source.	Page 87	**Data source: Administrative.** [The eligible population includes participants that are eligible for Medicaid only and participants that are dually eligible for Medicare and Medicaid. Medicare and Medicaid claims, encounters, and enrollment data are needed to calculate this measure for the eligible population.]
Clarifying the definition of facility.	87	**Facility:** [Nursing facilities, ICFs/IID, hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, and services in an IMD for individuals ages 65 and older.]
Clarifying in the eligible population, by replacing benefit with service utilization to reflect the identification of HCBS participants using the administrative data source more accurately.	Page 88	**[Service utilization:** The participant must have at least one Medicaid FFS LTSS HCBS claim between August 1 of the year prior to the measurement year through July 31 of the measurement year.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying the numerator definition to include facility admissions that occur during or in the month following an eligible month of HCBS use and by revising language describing how to implement the updated facility value set to identify eligible facility admissions.	Page 90	**Numerator** The number of facility admissions from a community residence [during or in the month following an eligible month of HCBS use] from August 1 of the year prior to the measurement year through July 31 of the measurement year. Facility admissions are reported in three categories: 1) short-term stays (i.e., 1 to 20 days), 2) medium-term stays (i.e., 21 to 100 days), and 3) long-term stays (i.e., greater than or equal to 101 days). Use the steps below to identify numerator events. **Step 1** Identify all admissions to facilities [during or in the month following an eligible month of HCBS use] between August 1 of the year prior to the measurement year and July 31 of the measurement year [(using codes from the *LTSS Facility Value Set* workbook). • For the NF, ICF_IID, IMD, and PSYCH_UNDER21 tabs in the *LTSS Facility Value Set* workbook (representing eligible facilities), limit to claims that have at least one of the code values where Code_Type = UBREV and at least one of the code values where Code_Type = UBTOB • The IMD and PSYCH_UNDER21 tabs have an additional age restriction: o Only keep claims identified based on the IMD tab to those where the person receiving the service was age 65 or older at the time of admission. o Only keep claims identified based on the PSYCH_UNDER21 tab to those where the person receiving the service was under age 21 at the time of admission. • A HOSPITAL tab is included in the *LTSS Facility Value Set* workbook to identify hospitals in cases where there was a transfer to or from an eligible facility. • Note that because of the overlap in the UBREV and UBTOB codes used to define IMDs and hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, there will be claims/encounters that are classified as both facility types. This will need to be accounted for when implementing the age restriction to ensure that all eligible records are retained. For example, a two-step drop may need to be implemented where 1) records that are flagged as IMDs and hospitals furnishing inpatient psychiatric hospital services with no other facility flags are dropped where the admission age is between 21-64, and 2) records that are flagged as IMDs with no other facility flags are dropped where the admission age is less than 65. • Note: Medicare institutional claims do not store UB Type of Bill (TOB) codes as a single field. Instead, TOB components (e.g., facility type and service classification) are stored in separate fields and need to be combined to derive the corresponding UB TOB codes.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the numerator, Step 2, language describing how to treat transfers from one facility to another and between facilities and hospitals.	Page 90	**Step 2:** [Treat transfers from one eligible facility to another (for example, from nursing facility A to nursing facility B) and transfers between eligible facilities and hospitals (for example, from an ICF/IID to a hospital or vice versa) as a single continuous stay when those stays have contiguous or overlapping admission/discharge dates. Treat inpatient psychiatric hospital stays for individuals under age 21 as stays, even if they do not have contiguous or overlapping admission/discharge dates with another facility, since they are eligible facilities; drop hospital stays that are (1) not psychiatric hospital stays for individuals under age 21 or (2) not connected to a transfer to or from another eligible facility. Combine two (or more) records into a stay when the following criteria are met: • Records have the same admission date or have the same discharge date OR • One record's admission date is equal to or one day after the discharge date of another record OR • One record's admission date and discharge date are in between another record's admission and discharge date OR • One record's discharge date is in between another record's admission date and discharge date OR • One record's admission date is in between another record's admission date and discharge date. Keep the earliest non-missing admission date and the latest non-missing discharge date.]
Clarifying the length of stay calculation in Step 5 of the numerator. Removing unnecessary language related to accounting for discharges to or from a hospital or facility, as these steps are no longer needed following the technical correction to the numerator, Step 2.	Page 90	**Step 5** [Calculate length of stay for each facility admission: • If the participant is discharged to the community, calculate length of stay as the date of facility discharge minus the admission date. • If there is no discharge, calculate the length of stay as the date of the last day of the measurement year minus the admission date. • When counting the duration of each facility admission 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 one.]
FFS LTSS-7: FFS LTSS Minimizing Facility Length of Stay		
Clarifying measure type.	Page 2	**Measure type:** [Outcome]
Adding new URLs for an updated value set directory and risk-adjustment tables.	Page 3	• Value set directory for MLTSS-6, FFS LTSS-6, MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 is available at https://www.medicaid.gov/license/form/8586/141126. • Risk-adjustment tables for MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 are available at https://www.medicaid.gov/media/3296.

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Adding a new URL for an updated value set directory.	Page 8	The value set directory for the LTSS Admission to a Facility from the Community (MLTSS-6 and FFS LTSS-6), LTSS Minimizing Facility Length of Stay (MLTSS-7 and FFS LTSS-7), and LTSS Successful Transition after Long-Term Facility Stay (MLTSS-8 and FFS LTSS-8) measures is available at https://www.medicaid.gov/license/form/8586/141126.
Clarifying the administrative data source.	Page 92	**Data source: Administrative** [The eligible population includes participants that are eligible for Medicaid only and participants that are dually eligible for Medicare and Medicaid. Medicare and Medicaid claims, encounters, and enrollment data are needed to calculate this measure for the eligible population.]
Clarifying the facility definition.	Page 92	**Facility:** [Nursing facilities, ICFs/IID, hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, and services in an IMD for individuals ages 65 and older.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the denominator Step 1, by revising the language describing how to implement the updated facility value set to identify eligible facility admissions.	Page 94	Identify all admissions to facilities between July 1 of the year prior to the measurement year and June 30 of the measurement year [(using codes from the *LTSS Facility Value Set* workbook). • For the NF, ICF_IID, IMD, and PSYCH_UNDER21 tabs in the *LTSS Facility Value Set* workbook (representing eligible facilities), limit to claims that have at least one of the code values where Code_Type = UBREV and at least one of the code values where Code_Type = UBTOB • The IMD and PSYCH_UNDER21 tabs have an additional age restriction: o Only keep claims identified based on the IMD tab to those where the person receiving the service was age 65 or older at the time of admission. o Only keep claims identified based on the PSYCH_UNDER21 tab to those where the person receiving the service was under age 21 at the time of admission. • A HOSPITAL tab is included in the *LTSS Facility Value Set* workbook to identify hospitals in cases where there was a transfer to or from an eligible facility. • Note that because of the overlap in the UBREV and UBTOB codes used to define IMDs and hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, there will be claims/encounters that are classified as both facility types. This will need to be accounted for when implementing the age restriction to ensure that all eligible records are retained. For example, a two-step drop may need to be implemented where 1) records that are flagged as IMDs and hospitals furnishing inpatient psychiatric hospital services with no other facility flags are dropped where the admission age is between 21-64, and 2) records that are flagged as IMDs with no other facility flags are dropped where the admission age is less than 65. • Note: Medicare institutional claims do not store UB Type of Bill (TOB) codes as a single field. Instead, TOB components (e.g., facility type and service classification) are stored in separate fields and need to be combined to derive the corresponding UB TOB codes.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the numerator, Step 2, language describing how to treat transfers from one facility to another and between facilities and hospitals.	Page 94	**Step 2** [Treat transfers from one eligible facility to another (for example, from nursing facility A to nursing facility B) and transfers between eligible facilities and hospitals (for example, from an ICF/IID to a hospital or vice versa) as a single continuous stay when those stays have contiguous or overlapping admission/discharge dates. Treat inpatient psychiatric hospital stays for individuals under age 21 as stays, even if they do not have contiguous or overlapping admission/discharge dates with another facility, since they are eligible facilities; drop hospital stays that are (1) not psychiatric hospital stays for individuals under age 21 or (2) not connected to a transfer to or from another eligible facility. Combine two (or more) records into a stay when the following criteria are met: • Records have the same admission date or have the same discharge date OR • One record's admission date is equal to or one day after the discharge date of another record OR • One record's admission date and discharge date are in between another record's admission and discharge date OR • One record's discharge date is in between another record's admission date and discharge date OR • One record's admission date is in between another record's admission date and discharge date. Keep the earliest non-missing admission date and the latest non-missing discharge date.]
Clarifying the number of prior hospital stays in the classification period (180 days prior to and including the facility admission date).	Page 95	**Number of prior hospital stays.** Determine whether the participant had any acute care hospitalizations in the classification period [(180 days prior to and including the facility admission date).] Classify the total acute hospitalizations as zero, one, or two or more.
Clarifying in the diagnoses codes table that chronic conditions used for risk adjustment are based on diagnoses listed on claims during the classification period.	Page 95	**Diagnoses.** [Filter the *Diagnosis codes* table (within the *LTSS Risk Adjustment Tables* workbook) to the LTSS-7 rows indicated in column A and assign risk adjustment condition categories to the facility admission based on diagnoses listed on claims during the classification period (180 days prior to and including the facility admission date).]
Clarifying the days during the classification period (180 days prior to and including the facility admission date).	Page 95	**Days of enrollment in Medicaid FFS LTSS.** Determine the number of days the participant was enrolled in Medicaid FFS LTSS [during the classification period (180 days prior to and including the facility admission date).] Classify the total days of enrollment as fewer than 180 days or equal to 180 days.

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the numerator, Step 1, language describing how to identify eligible facility stays with a discharge to the community. Clarifying in the numerator, Step 2, by revising the length of stay calculation to align with the updated guidance in the denominator, Step 2, for facility-to-facility and facility-to-hospital transfers.	Page 97	**Step 1** [Using the denominator, limit to stays where there was a discharge to the community between July 1 of the year prior to the measurement year and October 31 of the measurement year.] **Step 2** [Calculate length of stay: • If the participant is discharged to the community, calculate length of stay as the date of facility discharge minus the admission date. 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 one.]
Clarifying in the numerator, Step 4 risk adjustment reporting of observed and risk-adjusted performance rates, by replacing the term plan with state to reflect that rates are reported by the state.	Page 98	States or 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 a lower-than-expected rate of successful discharges. Reporting of a risk-adjusted rate requires standardization of the O/E ratio using a multi-[state] population rate. States should calculate the multi-[state] population rate Y by taking the sum of all observed numerator events and dividing it by the sum of all observed denominator events. The risk-adjusted rate (rk) for the [LTSS measure] for each [state], k, is equal to the O/E ratio multiplied by the multi-[state] population rate, Y..
FFS LTSS-8		
Adding new URLs for the updated value set directory and risk-adjustment tables.	Page 3	• Value set directory for MLTSS-6, FFS LTSS-6, MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 is available at https://www.medicaid.gov/license/form/8586/141126. • Risk-adjustment tables for MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 are available at https://www.medicaid.gov/media/3296.
Adding a new URL for the updated value set directory.	Page 8	The value set directory for the LTSS Admission to a Facility from the Community (MLTSS-6 and FFS LTSS-6), LTSS Minimizing Facility Length of Stay (MLTSS-7 and FFS LTSS-7), and LTSS Successful Transition after Long-Term Facility Stay (MLTSS-8 and FFS LTSS-8) measures is available at https://www.medicaid.gov/license/form/8586/141126.
Clarifying the administrative data source.	Page 98	**Data source: Administrative.** [The eligible population includes participants that are eligible for Medicaid only and participants that are dually eligible for Medicare and Medicaid. Medicare and Medicaid claims, encounters, and enrollment data are needed to calculate this measure for the eligible population.]
Clarifying the definition o facility.	Page 99	**Facility:** [Nursing facilities, ICFs/IID, hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, and services in an IMD for individuals ages 65 and older.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the denominator, by adding Step 2 instructions for using the LTSS Facility Value Set workbook to identify eligible facility admissions.	Page 101	[Using codes from the *LTSS Facility Value Set* workbook, identify [1)] participants residing in a facility on July 1 of the year prior to the measurement year and who were residing in the facility for at least 101 days inclusive of July 1 of the year prior to the measurement year [and 2) new admissions to facilities from July 1 of the year prior to the measurement year through June 30 of the measurement year. • For the NF, ICF_IID, IMD, and PSYCH_UNDER21 tabs in the *LTSS Facility Value Set* workbook (representing eligible facilities), limit to claims that have at least 1 of the code values where Code_Type = UBREV and at least one of the code values where Code_Type = UBTOB • The IMD and PSYCH_UNDER21 tabs have an additional age restriction: o Only keep claims identified based on the IMD tab to those where the person receiving the service was age 65 or older at the time of admission. o Only keep claims identified based on the PSYCH_UNDER21 tab to those where the person receiving the service was under age 21 at the time of admission. • A HOSPITAL tab is included in the *LTSS Facility Value Set* workbook to identify hospitals in cases where there was a transfer to or from an eligible facility. • Note that because of the overlap in the UBREV and UBTOB codes used to define IMDs and hospitals furnishing inpatient psychiatric hospital services for individuals under age 21, there will be claims/encounters that are classified as both facility types. This will need to be accounted for when implementing the age restriction to ensure that all eligible records are retained. For example, a two-step drop may need to be implemented where 1) records that are flagged as IMDs and hospitals furnishing inpatient psychiatric hospital services with no other facility flags are dropped where the admission age is between 21-64, and 2) records that are flagged as IMDs with no other facility flags are dropped where the admission age is less than 65. • Note: Medicare institutional claims do not store UB Type of Bill (TOB) codes as a single field. Instead, TOB components (e.g., facility type and service classification) are stored in separate fields and need to be combined to derive the corresponding UB TOB codes.]

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying in the denominator, Step 3 how to treat transfers from one facility to another and between facilities and hospitals.	Page 101	[Treat transfers from one eligible facility to another (for example, from nursing facility A to nursing facility B) and transfers between eligible facilities and hospitals (for example, from an ICF/IID to a hospital or vice versa) as a single continuous stay when those stays have contiguous or overlapping admission/discharge dates. Treat inpatient psychiatric hospital stays for individuals under age 21 as stays, even if they do not have contiguous or overlapping admission/discharge dates with another facility, since they are eligible facilities; drop hospital stays that are (1) not psychiatric hospital stays for individuals under age 21 or (2) not connected to a transfer to or from another eligible facility. Combine two (or more) records into a stay when the following criteria are met: • Records have the same admission date or have the same discharge date OR • One record's admission date is equal to or one day after the discharge date of another record OR • One record's admission date and discharge date are in between another record's admission and discharge date OR • One record's discharge date is in between another record's admission date and discharge date OR • One record's admission date is in between another record's admission date and discharge date. Keep the earliest non-missing admission date and the latest non-missing discharge date.]
Clarifying the length of stay calculation by removing unnecessary language related to discharges to or from a hospital or facility that is addressed in Step 2.	Page 101	**Step 6** [Calculate length of stay for each eligible admission: • If the participant is discharged to the community, calculate length of stay as the date of facility discharge minus the admission date. • If there is no discharge, calculate the length of stay as the date of the last day of the measurement year minus the admission date or July 1 of the year prior to the measurement year if there is no admission date.]
Clarifying in the diagnoses codes table that chronic conditions used for risk adjustment are based on diagnoses listed on claims during the classification period.	Page 102	**Diagnoses.** [Filter the *Diagnosis codes* table (within the LTSS Risk Adjustment Tables workbook) to the LTSS-8 rows indicated in column B and assign risk adjustment condition categories to the facility admission based on diagnoses listed on claims during the classification period (180 days prior to and including the facility admission date).]
Clarifying age and sex are determined on the facility admission date.	Page 102	**Age [and sex].** Determine the participant's age and [sex on the facility admission date] and assign to the following categories: female, aged 18 to 44 years; female, aged 45 to 64 years; female, aged 65 to 74 years; female, aged 75 to 84 years; female, aged 85 years and older; male, aged 18 to 44 years; male, aged 45 to 64 years; male, aged 65 to74 years; male, aged 75 to 84 years; and male, aged 85 years and older.

LTSS Quality Measures Technical Specifications and Resource Manual Corrections

Technical Correction Description	Page Number	Updated Text
Clarifying the days during the classification period (180 days prior to and including the facility admission date).	Page 103	**Days of enrollment in Medicaid FFS LTSS.** Determine the number of days the participant was enrolled in Medicaid FFS LTSS [during the classification period (180 days prior to and including the facility admission date).] Classify the total days of enrollment as fewer than 180 days or equal to 180 days.
Clarifying the number of prior hospital stays in the classification period (180 days prior to and including the facility admission date).	Page 103	**Number of prior hospital stays.** Determine whether the participant had any acute care hospitalizations in the classification period [(180 days prior to and including the facility admission date).] Classify the total acute hospitalizations as zero, one, or two or more.
Clarifying the numerator Step 1 and removing Step 2.	Page 105	**Step 1** [Using the denominator, limit to stays where there was a discharge to the community between July 1 of the year prior to the measurement year and October 31 of the measurement year.]
Clarifying in the numerator, Step 4 risk adjustment reporting of observed and risk-adjusted performance rates, by replacing the term plan with state to reflect that rates are reported by the state.	Page 106	States or 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 a lower-than-expected rate of successful discharges. Reporting of a risk-adjusted rate requires standardization of the O/E ratio using a multi-[state] population rate. States should calculate the multi-[state] population rate Y by taking the sum of all observed numerator events and dividing it by the sum of all observed denominator events. The risk-adjusted rate (rk) for the [LTSS measure] for each [state], k, is equal to the O/E ratio multiplied by the multi-[state] population rate, Y.