Medicaid Managed Long-Term Services and Supports (MLTSS) Measures Technical Specifications and Resource Manual

2022

ACKNOWLEDGMENTS

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Table of Contents

I. Medicaid Managed Long-Term Services and Supports Measures

Background

Medicaid Managed Long-Term Services and Supports (MLTSS) refers to the delivery of long-term services and supports through capitated managed care programs. The measures for Medicaid MLTSS, developed and tested by the Center for Medicare & Medicaid Services (CMS), for participants age 18 and older, address critical gaps in quality for managed care plans that provide Medicaid MLTSS for

- Older adults,
- Persons with physical disabilities,
- Persons with intellectual or developmental disabilities,
- Persons with acquired brain injury, and
- Persons with mental health or substance use disorders or both.

The MLTSS measures assess the experience of participants enrolled in MLTSS programs. These measures provide information that can be used by states, managed care plans, and other stakeholders for quality improvement purposes, to allow for comparison of performance of MLTSS programs within and across states. The MLTSS measures in **Exhibit 1** offer nationally standardized measures meeting importance, usability, feasibility, and scientific validity and reliability standards for use across Medicaid MLTSS plans and state Medicaid programs, to fill key gaps in MLTSS measure domains.

Exhibit 1: Medicaid MLTSS Measures

Measure Steward		Measure Name	Data Collection Method	Measure Type
Assessment and Care Planning	CMS	Long-Term Services and Supports Comprehensive Assessment and Update (MLTSS-1) This measure is aligned with HEDIS measure Long-Term Services and Supports-CAU.	Case Management Record Review	Process
	CMS	Long-Term Services and Supports Comprehensive Care Plan[1] and Update (MLTSS-2) This measure is aligned with HEDIS measure Long-Term Services and Supports-CPU.	Case Management Record Review	Process
	CMS	Long-Term Services and Supports Shared Care Plan with Primary Care Provider (MLTSS-3) This measure is aligned with HEDIS measure Long-Term Services and Supports-SCP.	Case Management Record Review	Process
	CMS	Long-Term Services and Supports Reassessment/Care Plan Update after Inpatient Discharge (MLTSS-4) This measure is aligned with HEDIS measure Long-Term Services and Supports-RAU.	Case Management Record Review	Process
	NCQA	Screening, Risk Assessment, and Plan of Care to Prevent Future Falls (MLTSS-5)	Case Management Record Review	Process
Rebalancing Long-Term Services and Supports	CMS	Long-Term Services and Supports Admission to a Facility from the Community (MLTSS-6)	Administrative[2]	Outcome
	CMS	Long-Term Services and Supports Minimizing Facility Length of Stay (MLTSS-7)	Administrative	Process
	CMS	Long-Term Services and Supports Successful Transition after Long-Term Facility Stay (MLTSS-8)	Administrative	Outcome

The technical specifications in **Section III: Technical Specifications** of this manual provide additional details for each Medicaid MLTSS measure.

The Medicaid MLTSS Measures Technical Specifications and Resource Manual with updates is available at https://www.medicaid.gov/medicaid/managed-care/ltss/index.html.

Updates include the following.

- Adding a new link to updated value sets for MLTSS-4, MLTSS-6, MLTSS-7, and MLTSS-8 that incorporate refinements since the 2019 version, such as changes in terminology (e.g., Current Procedural Terminology [CPT]) to add codes to align with advancements in technology

[1] In this manual, care plan refers to documentation of needs and planned services that addresses multiple potential items while plan of care refers to a single area to address (e.g., potential falls).
[2] Administrative data include claims, encounters, vital records, and registries.

- Changing the MLTSS-3 measure name to Medicaid Managed Long-Term Services and Supports Shared Care Plan with Primary Care Provider (formerly Long-Term Services and Supports Shared Care Plan with Primary Care Practitioner)
- Changing the MLTSS-6 measure name to Medicaid Managed Long-Term Services and Supports Admission to a Facility from the Community (formerly Long-Term Services and Supports Admission to an Institution from the Community)
- Changing the MLTSS-7 measure name to Medicaid Managed Long-Term Services and Supports Minimizing Facility Length of Stay (formerly Medicaid Managed Long-Term Services and Supports Minimizing Institutional Length of Stay)
- Changing the MLTSS-8 measure name to Medicaid Managed Long-Term Services and Supports Successful Transition after Long Term Facility Stay (formerly Medicaid Managed Long-Term Services and Supports Successful Transition after Long Term Institutional Stay)
- Clarifying that use of one of the standardized assessment tools identified in each of the assessment core (4 and 5) and supplemental (3, 11, and 15) elements provided for MLTSS-1 and MLTSS-4 is sufficient for demonstrating numerator compliance for a given element (e.g., use of the interRAI Cognitive Performance Scale *or* the Mini Mental State Examination© is sufficient for meeting assessment core element 4)
- Expanding the definition of participant representative in MLTSS-2 and MLTSS-4 beyond the single example of power of attorney to "anyone who has been authorized to make decisions on behalf of the participant, including, but not limited to, power of attorney, spouse, parent, or other family member"
- Clarifying that the state, or its representative, is responsible for care plan transmission to a participant's primary care provider in MLTSS-3, not the participant
- Minor clarifications consistent with CMS responses to frequently asked questions, the quality measure set for Medicaid-funded home and community-based services request for information feedback, and the NCQA specifications for the HEDIS aligned measures[3]
- Adding an appendix to denote copyright and trademark ownership of standardized tool examples provided in MLTSS-1, MLTSS-4, and MLTSS-5

[3] The HEDIS specifications are available from the NCQA Store website.

II. Data Collection and Preparation for Reporting

To support consistency in reporting the Medicaid MLTSS measures, this section provides general guidelines for data collection, preparation, and reporting. Presented in **Section III**, the technical specifications and detailed information on how to calculate each measure are provided. For technical assistance with calculating and reporting these measures, contact the technical assistance mailbox at MLTSSMeasures@cms.hhs.gov.

Version of specifications – This manual includes the most current version of the measure specifications as of June 2022. For HEDIS aligned measures (i.e., Long-Term Services and Supports-CAU, Long-Term Services and Supports-CPU, Long-Term Services and Supports-SCP, and Long-Term Services and Supports-RAU), this manual follows HEDIS 2022 specifications (2021 measurement year). Additional updates to this manual are anticipated in 2023 to introduce corresponding measures for Medicaid fee-for-service long-term services and supports programs and further align the CMS Medicaid MLTSS measures and their HEDIS equivalents.

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. The long-term services and supports value set directory (VSD) is available at https://www.medicaid.gov/medicaid/managed-care/ltss/index.html.

Data collection timeframes for measures – States should adhere to the measurement years identified in the technical specifications for each measure. All measures are collected by calendar year (i.e., January 1 through December 31) but may require examining data in the year prior to the measurement year. Data collection timeframes should align with the calendar year prior to the reporting year; for example, calendar year 2021 data should be reported for the 2022 reporting period. For some measures, the denominator measurement year for the 2022 reporting period corresponds to calendar year 2021 (January 1, 2021 to December 31, 2021).

Continuous enrollment – This term refers to the timeframe during which a participant must be eligible for benefits to be included in the measure denominator. To be considered continuously enrolled, a participant must also be continuously enrolled with the benefit specified for each measure (e.g., long-term services and supports, 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 to December 31) and allows one gap in enrollment of up to 45 days, a participant who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as no other gaps in enrollment occur throughout the remainder of the measurement year because this participant has one 38-day gap (January 1 to February 7).

Retroactive eligibility – This term refers to the time between the actual date when Medicaid became financially responsible for a participant and the date when it received notification of the new participant's eligibility. For measures with a continuous enrollment requirement, participants may be excluded if the retroactive eligibility exceeds the allowable gap.

Anchor date – Some measures include an anchor date, the date by which a participant must be enrolled and be eligible for the required benefits to be eligible for the measure. For example, if an enrollment gap includes the anchor date, the participant is ineligible for the measure. For these measures, the anchor date is the last day of the measure's measurement year for the current reporting period (e.g., the 2022 reporting period anchor date for the measurement year is December 31, 2021). 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 – Documentation of a date must be specific enough to determine that an event occurred during the timeframe in the measure. Instances occur 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 unacceptable.

Reporting unit – Individual states should determine the appropriate reporting unit at the state, plan, or organizational 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, anchor date).

Eligibility for benefits – The technical specifications for each measure have guidance regarding the benefits for which the participant must be eligible to be included. Some measures require only that the participant be eligible for long-term services and supports benefits to be included, although others require that participants be eligible for both long-term services and supports and medical care benefits through the Medicaid MLTSS plan.

Aggregating information for state-level reporting – To obtain a state-level rate for a measure developed from the rates of multiple units of measurement (such as multiple Medicaid MLTSS plans), the state should calculate a weighted average of the individual rates. The amount any one entity (e.g., individual Medicaid MLTSS plans) will contribute to the weighted average is based on the size of its eligible population for the measure, meaning that reporting units with larger eligible populations will contribute more toward the rate than units with smaller eligible populations.

Representativeness of data – For measures based on a sampling methodology, plans, states, or both 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 case management record review. Each measure specifies the data collection method or methods that must be used. The administrative method uses transaction data (e.g., claims, encounters, vital records, registries) 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.

Sampling – For measures that use the case management record review method, sampling should be systematic to ensure all eligible cases have an equal chance of inclusion. The sample size should

be 411 for such measures, unless special circumstances apply. Regardless of the selected sample size, CMS recommends an oversample to allow for substitution should cases in the original sample prove ineligible for the measure.

Small numbers – For non-risk-adjusted measures, the managed care plan or state may choose not to report a measure with a denominator less than 30 because of risk of identification. For risk-adjusted measures (i.e., Long-Term Services and Supports Minimizing Facility Length of Stay and Long-Term Services and Supports Successful Transition after Long-Term Facility Stay), the managed care plan or state may choose not to report a measure with a denominator less than 150 because of small numbers.

III. Technical Specifications

This section presents the technical specifications for each measure, including a description of the measure and information about the eligible population, key definitions, data collection method or methods, instructions for calculating the measure, and any other relevant measure information. These 2022 specifications represent the current version of the MLTSS measures.

MLTSS-1: Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update

A. Description

The percentage of Medicaid MLTSS plan participants age 18 and older who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core elements

Two performance rates and two exclusions rates are reported for this measure.

Performance Rates

1. *Assessment of Core Elements*. Medicaid MLTSS plan participants who had a long-term services and supports comprehensive assessment with nine core elements documented within 90 days of enrollment (for new participants) or during the measurement year (for established participants)
2. *Assessment of Supplemental Elements*. Medicaid MLTSS plan participants who had a long-term services and supports comprehensive assessment with nine core elements and at least 12 supplemental elements documented within 90 days of enrollment (for new participants) or during the measurement year (for established participants)

Exclusion Rates[4]

1. *Participant Could Not Be Contacted*. Medicaid MLTSS plan participants who could not be contacted for long-term services and supports comprehensive assessment within 90 days of enrollment (for new participants) or during the measurement year (for established participants)
2. *Participant Refused Assessment*. Medicaid MLTSS plan participants who refused a comprehensive assessment

Data Collection Method: Case Management Record Review

[4] Exclusion rates are reported to illustrate portions of the intended measure population uncaptured in the performance rate. Medicaid MLTSS plan participants have the right to refuse an assessment, and plans may have difficulty contacting some participants.

B. Definitions

Long-term services and supports assessment – A face-to-face discussion with the participant in the home using a structured or semi-structured tool that addresses the participant's health status and needs and includes a minimum of nine core elements and may include supplemental elements.

New participant – A participant who was newly enrolled in the Medicaid MLTSS plan between August 1 of the year prior to the measurement year and July 31 of the measurement year.

Established participant – A participant who was enrolled prior to August 1 of the year prior to the measurement year.

Home – The location where the participant lives, which may be the participant's residence, a caregiver's residence, an assisted living facility, an adult-foster care residence, a temporary residence, or a long-term care facility.

Standardized tool – A set of structured questions that elicit participant information, which may include person-reported outcome measures, screening or assessment tools, or standardized questionnaires developed by the state, by the Medicaid MLTSS plan, or by another organization to assess risks and needs.

C. Eligible Population

Age – Age 18 and older as of the first day of the measurement year.

Continuous Enrollment – A participant must be enrolled in a Medicaid MLTSS plan for at least 150 continuous days 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, look at the assessment completed in the last continuous enrollment period of 150 days or more during the measurement year.

Note: One hundred fifty days' continuous enrollment allows a single sample to be used across the set of MLTSS measures: Long-Term Services and Supports Comprehensive Assessment and Update, which looks for assessment to be conducted within 90 days of enrollment; Long-Term Services and Supports Comprehensive Care Plan and Update, which looks for a care plan to be developed within 30 days of assessment or 120 days of enrollment; Long-Term Services and Supports 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, Facility Care, or both).

Event/Diagnosis – None.

Required Exclusions – Required exclusions are reported with the measure performance rate.

1. *Participant Could Not Be Contacted*
    - New Medicaid MLTSS plan participants who could not be contacted for long-term services and supports comprehensive assessment within 90 days of enrollment
    - Established participants who could not be contacted for long-term services and supports comprehensive assessment during the measurement year
    - Medicaid MLTSS plans use their own process for identifying participants who cannot be contacted for assessment and document that at least three attempts were made to contact the participant.
    - To calculate the rate of participants who could not be contacted for assessment, divide the number of participants meeting this exclusion criterion by the number of participants meeting the continuous enrollment criteria.
2. *Participant Refused Assessment*
    - Medicaid MLTSS plan participants who refused a comprehensive assessment
    - Document in the case management record that the participant was contacted, and the participant refused to participate in an assessment.
    - To calculate the rate of participants who refused assessment, divide the number of participants who meet this exclusion criterion by the number of participants meeting the continuous enrollment criteria.

D. Case Management Record Review Specification

Denominator

This measure is based on review of Medicaid MLTSS participant long-term services and supports case management records from a systematic sample drawn from the eligible population.

Note: The same systematic sample may be used to calculate the Long-Term Services and Supports Comprehensive Assessment and Update, the Long-Term Services and Supports Comprehensive Care Plan and Update, the Long-Term Services and Supports Shared Care Plan with Primary Care Provider, and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measures. Obtain a separate (or supplemental) sample for MLTSS-4 Reassessment and Care Plan Update after In-Patient Admission.

Numerator

The MLTSS-1 measure reports two numerators:1) assessment of core elements and 2) assessment of supplemental elements.

Rate 1: *Assessment of Core Elements*

The number of Medicaid MLTSS participants who had either of the following

- **New participants.** A long-term services and supports comprehensive assessment completed within 90 days of enrollment with all nine core elements documented *or*

- **Established participants.** A long-term services and supports comprehensive assessment completed at least once during the measurement year with all nine core elements documented

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

- The participant was offered and refused the in-home assessment (either refused to allow the care manager into the home or requested a phone assessment instead of an in-home assessment);
- The participant is residing in an acute facility (e.g., 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 participant from a requirement for in-home assessment.

Assessment Core Elements

The Medicaid MLTSS plan participant's assessment must include documentation of the following nine core elements and the assessment date.

1. At least five of the following activities of daily living (ADL): bathing, dressing, eating, transferring (e.g., getting in and out of a chair), using the toilet, walking
2. Acute and chronic health conditions (may document condition names only)
3. Current medications (may document medication names only)
4. Cognitive function using a standardized tool, such as one of the following
    - 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)
    - St. Louis University Mental Status Exam (SLUMS)
    - Eight-Item Informant Interview to Differentiate Aging and Dementia (AD8™)

    Documentation that the participant is too cognitively impaired to self-report on a standardized tool meets the element.
5. Mental health status using a standardized tool, such as one of the following
    - 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 participant is too cognitively impaired to self-report on a standardized tool meets the element.

6. Home safety risks (e.g., home fall risks, bathroom safety, chemical hazards, food preparation safety, crime)

   A standardized tool is not required. Documentation that no home safety risks exist meets the element.

7. Confirmation of living arrangements (e.g., nursing facility, assisted living, adult foster care, general community, other setting)

8. Confirmation of current and future family or friend caregiver (or both) availability with name and contact information for caregivers (paid or unpaid)

   Caregivers include individuals who assist the participant with ADLs and instrumental activities of daily living (IADL), health care tasks, and emotional support. Documentation that no family or friend caregiver is available meets the element.

9. Name and contact information for the participant's current known providers (e.g., primary care provider [PCP]; 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 Medicaid MLTSS plan participants who had either of the following

- **New participants.** A long-term services and supports comprehensive assessment completed within 90 days of enrollment with nine core elements and at least 12 supplemental elements documented *or*
- **Established participants.** A long-term services and supports comprehensive assessment completed during the measurement year with nine core elements and at least 12 supplemental elements documented

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

- The participant was offered and refused the in-home assessment (either refused to allow the care manager into the home or requested a phone or video conference assessment instead of an in-home assessment);
- The participant is residing in an acute facility (e.g., 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 participant from a requirement for in-home assessment.

The participant's assessment must document evidence of the nine core elements defined above as well as evidence of at least 12 of 19 supplemental elements and the assessment date.

Assessment Supplemental Elements

Supplemental elements include the following.

1. Assessment of IADLs for at least four of the following activities: shopping for groceries, driving or using public transportation, using the phone, cooking or meal preparation, doing housework, making home repairs, doing laundry, taking medications, handling finances
2. Current use of an assistive device or technology to maintain or improve mobility (e.g., wheelchair, walker, scooter, cane, crutches, prostheses)

   Documentation that the participant does not use an assistive device or technology meets the element.
3. Assessment of the participant's self-reported health status using a question or a standardized tool, for example

   - Single question, "In general, would you say that your health is excellent, very good, good, fair, or poor?"
   - Short-Form Health Survey-12® (SF-12)
   - Patient-Reported Outcome Measurement Information System (PROMIS) Global 10

   Documentation that the participant is too cognitively impaired to self-report on a standardized tool meets the element.
4. Assessment of behavior abnormalities that can result from a cognitive or psychological condition (e.g., 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], hallucinations [seeing, hearing, or feeling things that are not there])

   Documentation that the participant has no behavioral difficulties meets the element.

5. Assessment of the participant's self-reported levels of activation or self-efficacy behaviors using a standardized tool (e.g., Patient Activation Measure® [PAM], Stanford Chronic Disease Self-Efficacy Scale [CDSM])

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

6. Vision needs, including whether the participant has impaired vision and uses a device (e.g., corrective lenses, visual aids, specialized computer software and hardware) to address that need

   Documentation that the participant's vision is not impaired meets the element.

7. Hearing needs, including whether the participant 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

   Documentation that the participant does not have impaired hearing meets the element.

8. Speech needs, including whether the participant has a speech impairment and uses a device (e.g., specialized computer software or hardware that increase communication capacities) to address that need

   Documentation that the participant does not have impaired speech meets the element.

9. Physical or occupational therapy needs or both, including whether the participant needs physical or occupational therapy

   Documentation that the participant has no physical or occupational therapy needs meets the element.

10. Screen for falls risk, including whether the participant has a history of falls or a problem with balance or gait

    Documentation that the participant has no history of falls, no fall risk, or no problem with balance or gait meets the element.

11. Assessment of the participant's current alcohol or other illicit substance use or both using a standardized tool

    - Single question, "How many times in the past year have you had five (5) (for men) or four (4) (for women and all adults older than 65 years) or more drinks in a day?"
    - Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument
    - Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Screening Instrument
    - National Institute of Drug Abuse (NIDA) Drug Screening Tool

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

12. Smoking status, including whether the participant is a current smoker or tobacco user

13. Assessment of the participant's current or planned use of community, public, or managed care plan resources to address social risk factors (e.g., eligibility for Medicare, Medicaid, Supplemental Security Income, transportation services, food subsidies, electric or gas subsidies or both, housing subsidies)
14. Assessment of the participant's social support in the community (e.g., friends and family, faith-based community, senior center or other nonmedical facility for group activity, other community-based groups [arts, volunteer, theater, education, support group])
15. Assessment of participant's self-reported social isolation or loneliness using a standardized tool, for example
    - University of California, Los Angeles (UCLA) Loneliness Scale
    - Three Item Loneliness Scale
    - PROMIS Social Isolation scale
    - PROMIS Companionship scale
    - Duke Social Support Index

    Documentation that the participant is too cognitively impaired to self-report on a standardized tool meets the element.
16. Cultural and linguistic preferences (e.g., participant's culture, preferred language, need for interpreter services)
17. Existence of an advance care plan, for example
    - Preferences for life-sustaining treatment and end-of-life care or documented surrogate decisionmaker
    - Surrogate decisionmaker, a written document designating someone other than the participant to make medical treatment choices
    - Advance directive, a legal document about treatment preferences or the designation of a surrogate who can make medical decisions for a participant 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, a legal document denoting preferences for life-sustaining treatment and end-of-life care
    - Notation in the medical record documenting a discussion with a provider or initiation of a discussion by a provider during the measurement year

    Documentation that a provider asked the participant whether an advance care plan is in place
    - The participant's indicating that he or she does not wish to discuss it is considered sufficient evidence of a discussion.

- The participant's indicating that a plan is not in place is not considered a discussion or an initiation of a discussion.
- Notation in the medical record, documenting conversations with relatives or friends about life-sustaining treatment and end-of-life care and including the participant's designation of an individual to make decisions on his or her behalf
- Oral statements must be documented.

18. Current engagement or preference for engaging in work or volunteer activities

    Documentation of the participant's current work or volunteer status meets the element.

19. Recent use of medical services, which can include the emergency department, hospitalization, home health, skilled nursing facility, paid home healthcare

MLTSS-2: Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update

A. Description

The percentage of Medicaid MLTSS participants age 18 and older who have documentation of a long-term services and supports comprehensive care plan in a specified timeframe that includes documentation of core elements

Two performance rates and two exclusion rates are reported for this measure.

Performance Rates

1. *Care Plan with Core Elements*. Medicaid MLTSS participants who had a long-term services and supports comprehensive care plan with nine core elements documented within 120 days of enrollment (for new participants) or during the measurement year (for established participants)
2. *Care Plan with Supplemental Elements*. Medicaid MLTSS participants who had a long-term services and supports comprehensive care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new participants) or during the measurement year (for established participants)

Exclusion Rates[5]

1. *Participant Could Not Be Contacted*. Medicaid MLTSS plan participants who could not be contacted to create a long-term services and supports comprehensive care plan within 120 days of enrollment (for new participants) or during the measurement year (for established participants)
2. *Participant Refused Care Planning.* Medicaid MLTSS plan participants who refused a comprehensive care plan

Data Collection Method: Case Management Record Review

[5] Exclusion rates are reported to illustrate portions of the intended measure population uncaptured in the performance rate. Medicaid MLTSS plan participants have the right to refuse to participate in care planning, and managed care plans may have difficulty contacting some participants.

B. Definitions

Long-term services and supports care plan – A document or electronic tool that identifies participant 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 participant agreed to the care plan. A care plan may also be called a "service plan."

Care manager – The person responsible for conducting an assessment and care plan with a participant; The Medicaid MLTSS plan may designate an organization employee or a contracted employee. The care manager is not required to have a specific type of professional license.

New participant – A participant who was newly enrolled in the Medicaid MLTSS plan between August 1 of the year prior to the measurement year and July 31 of the measurement year.

Established participant – A participant who was enrolled prior to August 1 of the year prior to the measurement year.

C. Eligible Population

Age – Age 18 and older as of the first day of the measurement year.

Continuous enrollment – A participant must be enrolled in a Medicaid MLTSS plan for at least 150 continuous days 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 assessment completed in the last continuous enrollment period of 150 days or more during the measurement year.

Note: One hundred fifty days' continuous enrollment allows a single sample to be used across the set of MLTSS measures: Long-Term Services and Supports Comprehensive Assessment and Update, which looks for assessment to be conducted within 90 days of enrollment; Long-Term Services and Supports Comprehensive Care Plan and Update, which looks for a care plan to be developed within 30 days of assessment or 120 days of enrollment.

Allowable gap – None.

Anchor date – December 31 of the measurement year.

Benefit – Long-Term Services and Supports (Home and Community-Based Services, Facility Care, or both).

Event/diagnosis – None.

Required exclusions – Required exclusions are reported with the measure rates.

1. *Participant Could Not Be Contacted*
    - New Medicaid MLTSS plan participants who could not be contacted to create a long-term services and supports comprehensive care plan within 120 days of enrollment

- Established Medicaid MLTSS plan participants who could not be contacted to create a long-term services and supports comprehensive care plan during the measurement year
- Medicaid MLTSS plans use their own process for identifying participants who cannot be contacted for care planning and document that at least three attempts were made to contact the participant.
- To calculate the rate of participants who could not be reached for care planning divide the number of participants meeting this exclusion criterion by the number of participants meeting the continuous enrollment criteria.

2. *Participant Refused Care Planning*

- Participants who refused a comprehensive care plan
- Document that the participant was contacted and that the participant refused to participate in a care plan.
- To calculate the rate of participants who refused care planning divide the number of participants who meet this exclusion criterion by the number of participants meeting the continuous enrollment criteria.

D. Case Management Record Review Specification

Denominator

This measure is based on review of Medicaid MLTSS plan case management records from a systematic sample drawn from the eligible population.

Note: The same systematic sample may be used to calculate the Long-Term Services and Supports Comprehensive Assessment and Update, the Long-Term Services and Supports Comprehensive Care Plan and Update, the Long-Term Services and Supports Shared Care Plan with Primary Care Provider, and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measures. Obtain a separate (or supplemental) sample for MLTSS-4 Reassessment and Care Plan Update after In-Patient Admission.

Numerator

Rate 1: *Care Plan with Core Elements*

The number of Medicaid MLTSS participants who had either of the following

- **New participants.** A long-term services and supports comprehensive care plan completed within 120 days of enrollment with all nine core elements documented *or*
- **Established participants.** A long-term services and supports comprehensive care plan completed at least once during the measurement year with all nine elements documented

Care plans must be discussed during a face-to-face encounter between the care manager and the participant, unless exceptions apply. The care plan is not required to be created in the participant'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 participant was offered a face-to-face discussion and refused (either refused a face-to-face encounter or requested a phone or video discussion instead of a face-to-face discussion) *or*
- The state policy, regulation, or other state guidance excludes the participant from a requirement for face-to-face discussion of a care plan.

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

Care Plan Core Elements

The initial care plan or care plan update must include documentation of the following nine core elements and the care plan date.

1. At least one individualized participant goal (medical or nonmedical outcome important to the participant, such as losing weight, reducing specific symptoms, staying out of the hospital, engaging in a hobby, pursuing an interest, seeking social contact, taking a special trip, living to see a relative's life milestone)

   Documentation that the participant is too cognitively impaired to provide a goal and has no family caregivers meets the element.

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

2. A plan of care to meet the participant's medical needs

   Documentation that either the plan addresses the participant's medical needs or the participant has no medical needs meets the element.

3. A plan of care to meet the participant's functional needs

   Documentation that either the plan addresses the participant's functional needs or the participant has no functional needs meets the element.

4. A plan of care to meet the participant's needs because of cognitive impairment (e.g., support for behavioral difficulties, support or education for a caregiver to address cognitive impairment, support for engaging the participant in activities)

   Documentation that either the plan addresses the participant's needs or the participant has no needs resulting from cognitive impairment meets the element.

5. A list of all long-term services and supports the participant 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 participant receives no long-term services and supports meets the numerator criteria.

6. A plan for the care manager to follow up and communicate with the participant (e.g., follow-up and communication schedule)
7. A plan to ensure the participant's needs are met in an emergency (e.g., care assistant or home health aide cannot get to the participant's home, natural disaster)

   Note: At a minimum, the plan must include the name of Medicaid MLTSS plan staff or a contracted provider to contact in an emergency.
8. Name and contact information for family or friend caregivers who were involved in the participant's care plan development

   Documentation of no family or friend caregiver involvement meets the element.

   Documentation that family or friend caregivers were invited but declined to participate in care planning meets the element.
9. Agreement of the participant or representative to the completed care plan or disagreement and intention to appeal the care plan

   Documentation includes participant or representative verbal agreement by phone or in person or written agreement (e.g., with signature) sent by U.S. mail to the case manager. A participant's "representative" is anyone who has been authorized to make decisions on behalf of the participant, including, but not limited to, power of attorney, spouse, parent, or other family member.

   Documentation that a care plan was discussed or reviewed does not meet the measure; agreement or appeal by the participant or the representative must be documented.

Rate 2: *Care Plan with Supplemental Elements Documented*

The number of Medicaid MLTSS participants who had either of the following

- **New participants.** A long-term services and supports comprehensive care plan completed within 120 days of enrollment with nine core elements and at least four supplemental elements documented *or*
- **Established participants.** A long-term services and supports comprehensive care plan created during the measurement year with nine core elements and at least four supplemental elements documented

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

Care plans must be discussed during a face-to-face encounter between the care manager and the participant, unless exceptions apply. The care plan is not required to be created in the participant'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 participant was offered a face-to-face discussion and refused (either refused face-to-face encounter or requested a phone discussion instead of a face- to-face discussion) *or*

- The state policy, regulation, or other state guidance excludes the participant from a requirement for face-to-face discussion of a care plan.

The participant's care plan must document evidence of the nine core elements defined above, evidence of at least four of eight supplemental elements, and the care plan date.

Care Plan Supplemental Elements

Supplemental elements include the following.

1. A plan of care to meet the participant's mental health needs (e.g., depression, anxiety)

   Documentation that either the plan addresses the participant's mental health needs or that the participant has no mental health needs meets the element.

2. A plan of care to meet the participant's social or community integration needs (e.g., through planned social activities with friends and family, participation in community-based activities, participation in work or volunteer activities)

   Documentation that the participant has no 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 long-term services and supports that the participant 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 participant receives no long-term services and supports meets the numerator criteria.

4. Contact information for the participant's long-term services and supports providers

   Documentation that the participant receives no long-term services and supports meets the numerator criteria.

5. A plan to assess the participant's progress toward meeting established goals, including a timeframe for reassessment and follow-up

6. Documentation of barriers to the participant's meeting defined goals (e.g., life, community, or health factors that may make meeting goals difficult for the participant)

7. The participant's first point-of-contact

   The care manager's contact information, if provided to the participant, meets the element.

8. Contact information for the participant's PCP[6] or a plan for connecting the participant to a PCP if the participant has none currently.

[6] In some environments, PCP is referred to as a primary care practitioner or clinician.

MLTSS-3: Medicaid Managed Long-Term Services and Supports Shared Care Plan with Primary Care Provider

A. Description

The percentage of Medicaid MLTSS plan participants age 18 and older with a care plan that was transmitted to their PCP or other documented medical care provider identified by the participant within 30 days of its development

One performance rate and one exclusion rate are reported for this measure.

Performance Rate

1. *Participant with Care Plan Transmitted to PCP*. Medicaid MLTSS participants whose care plan was transmitted to the PCP or other documented medical care provider identified by the participant within 30 days of the date when the participant agreed to the care plan

Exclusion Rate[7]

1. *Participant Refused to Share Care Plan.* Medicaid MLTSS participants who refused to have the care plan shared with a PCP or other medical care provider

Data Collection Method: Case Management Record Review

B. Definitions

Long-term services and supports care plan – A document or electronic tool that identifies participant needs, preferences, and risks and contains a list of the services and supports planned to meet those needs while reducing risks; The care plan must include nine core elements and may also include supplemental elements. The document must include evidence that a participant agreed to the care plan. A care plan may also be called a "service plan."

Transmitted – Dissemination of the care plan to providers via U.S. mail, fax, secure email, or mutual access to an electronic portal or electronic health record.

Note: Transmitting the entire care plan is unnecessary to meet the numerator criteria. Plans may select the most relevant parts of the care plan or may provide a summary.

Primary Care Provider – A clinician, 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 participant as the primary point-of-contact for medical care; This practitioner need not be a PCP.

[7] Exclusion rates are reported to illustrate portions of the intended measure population uncaptured in the performance rate. Medicaid MLTSS plan participants have the right to refuse to have their care plan shared with a PCP.

C. Eligible Population

Age – Age 18 and older as of the first day of the measurement year.

Continuous enrollment – A participant must be enrolled in a Medicaid MLTSS plan for at least 150 continuous days 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, look at the assessment completed in the last continuous enrollment period of 150 days or more during the measurement year.

Note: One hundred fifty days' continuous enrollment allows a single sample to be used across the suite of MLTSS measures: Long-Term Services and Supports Comprehensive Assessment and Update, which looks for assessment to be conducted within 90 days of enrollment; Long-Term Services and Supports Comprehensive Care Plan and Update, which looks for a care plan to be developed within 30 days of assessment or 120 days of enrollment; Long-Term Services and Supports Shared Care Plan with Primary Care Provider, 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, Facility Care, or both).

Event/diagnosis – Documentation of a care plan with core elements as specified in the 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. *Participant Refused to Share Care Plan*
    - Participants who refuse to allow the care plan to be shared
    - There must be documentation in the record that the participant refused to allow the care plan to be shared. Notation of verbal refusal is sufficient.
    - To calculate the rate of participants who refused care plan sharing, divide the number of participants who meet this exclusion criterion by the number of participants meeting the continuous enrollment criteria.

D. Case Management Record Review Specification

Denominator

This measure is based on review of long-term services and supports case management records from a systematic sample drawn from the eligible population.

Note: The same systematic sample may be used to calculate the Long-Term Services and Supports Comprehensive Assessment and Update, the Long-Term Services and Supports Comprehensive

Care Plan and Update, the Long-Term Services and Supports Shared Care Plan with Primary Care Provider, and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measures. Obtain a separate (or supplemental) sample for MLTSS-4 Reassessment and Care Plan Update after In-Patient Admission.

Numerator

The number of participants whose care plan was transmitted to their PCP or other documented medical care provider identified by the participant within 30 days of the date when the participant agreed to the care plan (31 days total).

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 participant's agreement to the care plan is sufficient to meet the numerator. *Transmission of care plans to participants' PCPs is the responsibility of the managed care plan or the state, not the participant.*

Evidence of care plan transmission includes 1) to whom the care plan was transmitted, 2) the transmission date, and 3) a copy of the transmitted plan or plan sections.

MLTSS-4: Medicaid Managed Long-Term Services and Supports Reassessment/ Care Plan Update after Inpatient Discharge

A. Description

The percentage of discharges from inpatient facilities for Medicaid MLTSS participants age 18 and older for whom a reassessment and care plan update occurred within 30 days of discharge

Two performance rates and three exclusion rates are reported for this measure.

Performance Rates

1. *Reassessment after Inpatient Discharge*. The percentage of discharges from inpatient facilities resulting in a long-term services and supports 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 long-term services and supports reassessment and care plan update within 30 days of discharge

Exclusion Rates[8]

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.
2. *Participant Could Not Be Contacted*. Participants who could not be contacted for assessment and care plan update following inpatient discharge. At least three attempts to contact the participant were made and documented, including the date and mode of each contact (e.g., phone call, letter, email), and all were unsuccessful.
3. *Participant Refused Assessment or Care Planning.* Participants who refused an assessment or development of a long-term services and supports comprehensive care plan following inpatient discharge

Data Collection Method: Case Management Record Review

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.

[8] Exclusion rates are reported to illustrate portions of the intended measure population uncaptured in the performance rate. Medicaid MLTSS plan participants have the right to refuse to participate in reassessment or care planning, and plans may have difficulty contacting some participants.

B. Definitions

Long-term services and supports reassessment – A face-to-face discussion between a participant and the case manager that addresses the participant's health status and needs; The assessment must include nine core elements and may also include supplemental elements.

Long-term services and supports care plan – A document or electronic tool that identifies participant 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 participant agreed to the care plan. The care plan may also be called a "service plan." The care plan must include nine core elements and may also include supplemental elements.

Standardized tool – A set of structured questions that elicit participant information, which may include person-reported outcome measures, screening or assessment tools, or standardized questionnaires developed by the state, the Medicaid MLTSS plan, or another organization to assess risks and needs.

Care manager – The person responsible for assessing, and developing a care plan for, a participant; The Medicaid MLTSS plan 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 – Age 18 and older as of the first day of the measurement year.

Continuous enrollment – Enrollment in the Medicaid MLTSS plan on the date of discharge through 30 days after the date of discharge.

Allowable gap – None.

Anchor date – Date of discharge.

Benefit – Long-Term Services and Supports (Home and Community-Based Services, Facility Care, or both) *and* Benefit for medical care and services; Benefits should be determined at the individual level. Any participant receiving a benefit for both long-term services and supports and medical care through the Medicaid 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, identify

1. Acute and nonacute inpatient stays (MLTSS-4 Value Sets, Inpatient Stay Revenue Codes) and
2. Date of discharge for the stay.

The denominator for this measure is based on discharges, not on participants. If participants 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, identify

1. All acute and nonacute inpatient stays (MLTSS-4 Value Sets, Inpatient Stay Revenue Codes),
2. Stay admission date (admission date must occur during the 31-day period), and
3. Date of discharge for the stay (date of discharge 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 participant 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 participant, but the organization must have a method for identifying the participant's status for the remainder of the measurement year and may not assume the participant remained admitted based only on the absence of a discharge before December 1. If the organization is unable to confirm the participant 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 (MLTSS-4 Value Sets Perinatal Conditions Diagnosis Codes)
   - Principal diagnosis of maintenance chemotherapy (MLTSS-4 Value Sets Chemotherapy Encounter Diagnosis Codes)
   - Principal diagnosis of rehabilitation (MLTSS-4 Value Sets Rehabilitation Diagnosis Codes)
   - Organ transplant (MLTSS-4 Value Sets Kidney Transplant Procedure Codes, Bone Marrow Transplant Procedure Codes, Organ Transplant Other Than Kidney Procedure Codes, Introduction of Autologous Pancreatic Cells Procedure Codes)
   - Potentially planned procedure (MLTSS-4 Value Sets Potentially Planned Procedures Procedure Codes) without a principal acute diagnosis (Acute Condition Diagnosis Codes)

   The exclusion for planned admissions is not reported with the measure performance rates.

2. *Participant Could Not Be Contacted*

   Participants who could not be contacted for assessment and care planning update following inpatient discharge.

At least three attempts were made to contact the participant, including the date and mode of each contact (e.g., phone call, letter, email), but the participant could not be reached.

To calculate the rate of participants who could not be reached divide the number of participants meeting this exclusion criterion by the number of participants meeting the continuous enrollment criteria.

3. *Participant Refused Assessment or Care Planning*

   Participants who refused to participate in an assessment or development of a long-term services and supports comprehensive care plan following inpatient discharge.

   To calculate the rate of participants who refused, divide the number of participants who meet this exclusion criterion by the number of participants meeting the continuous enrollment criteria.

D. Case Management Record Review Specification

Denominator

A systematic sample of inpatient discharges from the eligible population

The denominator is based on discharges, not on participants. Participants may appear more than once in the sample.

Numerator

Rate 1: *Reassessment after Inpatient Discharge*

Long-term services and supports reassessment on the date of discharge or within 30 days after discharge

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

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

Reassessment Core Elements

1. At least five of the following ADLs: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using toilet, walking
2. Acute and chronic health conditions (may document condition names only)
3. Current medications (may document medication names only)
4. Cognitive function using a standardized tool, such as one of the following
   - 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)
- St. Louis University Mental Status Exam (SLUMS)
- Eight-Item Informant Interview to Differentiate Aging and Dementia (AD8™)

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

5. Assessment of mental health status using a standardized tool, such as one of the following
    - 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 participant is too cognitively impaired to 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 no home safety risks exist meets the element.
7. Confirmation of living arrangements (e.g., nursing facility, assisted living, adult foster care, general community, other setting)
8. Confirmation of current and future family or friend caregiver (or both) availability with name and contact information for caregivers (paid or unpaid)

    Caregivers include individuals who assist the participant with ADLs, IADLs, health care tasks, and emotional support.

    Documentation that no family or friend caregiver is available meets the element.
9. Name and contact information for the participant's current known providers (e.g., PCP; 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*

Long-term services and supports 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.

The care plan update must be conducted during a face-to-face encounter between the care manager and the participant unless there is documentation that the participant refused a face-to-face encounter. A care plan developed in the inpatient facility on the day of discharge meets the requirement.

Care plan update must document evidence of the nine core elements described below and the care plan date. Documentation of "no change" does not meet numerator criteria.

Care Plan Core Elements

1. At least one individualized participant goal (medical or nonmedical outcome important to the participant, such as losing weight, reducing specific symptoms, staying out of the hospital, engaging in a hobby, pursuing an interest, seeking social contact, taking a special trip, living to see a relative's life milestone)

   Documentation that the participant is too cognitively impaired to provide a goal and has no family caregivers is sufficient to meet the element.

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

2. A plan of care to meet the participant's medical needs

   Documentation that either the plan addresses the participant's medical needs or the participant has no medical needs meets the element.

3. A plan of care to meet the participant's functional needs

   Documentation that either the plan addresses the participant's functional needs or the participant has no functional needs meets the element.

4. A plan of care to meet the participant's needs because of cognitive impairment (e.g., support for behavioral difficulties, support or education for a caregiver to address cognitive impairment, support for engaging the participant in activities)

   Documentation that either the plan addresses the participant's needs or the participant has no needs resulting from cognitive impairment meets the element.

5. A list of all long-term services and supports the participant 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 participant receives no long-term services and supports meets the numerator criteria.

6. A plan for the care manager to follow up and communicate with the participant (e.g., follow-up and communication schedule)
7. A plan to ensure the participant's needs are met in an emergency (e.g., the care assistant or home health aide cannot get to the participant's home, natural disaster)

   Note: At a minimum, the plan must include the name of Medicaid MLTSS plan staff or a contracted provider to contact in an emergency.
8. Name and contact information for family or friend caregivers who were involved in the participant's care plan development

   Documentation of no family or friend caregiver involvement meets the element. Documentation that family or friend caregivers were invited but declined to participate in care planning meets the element.
9. Agreement of the participant or participant's representative to the completed care plan or disagreement and intention to appeal the care plan

   Documentation includes participant or representative verbal agreement by phone or in person or written agreement (e.g., with signature) sent by U.S. mail to the case manager. A "participant representative" is anyone who has been authorized to make decisions on behalf of the participant, including, but not limited to, power of attorney, spouse, parent, or other family member.

   Documentation that a care plan was discussed or reviewed does not meet the measure; agreement or disagreement and appeal by the participant or participant's representative must be documented.

MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls

This measure includes two parts: 1) screening and 2) risk assessment and plan of care.

Falls Part 1: Screening

A. Description

The percentage of Medicaid MLTSS participants age 18 and older who have documentation of screening for history of falls, problems with balance or gait, or both.

The following rate is reported.

Performance Rate

1. *Fall or Problems with Balance or Gait Evaluation*. Medicaid MLTSS participants who have documentation of an evaluation of whether the participant has experienced a fall or problems with balance or gait

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 a participant has experienced a history of falls, problems with balance or gait, or both.

C. Eligible Population

Age – Aged 18 and older as of the first day of the measurement year.

Continuous enrollment – Participant must be enrolled in a Medicaid MLTSS plan for at least 150 continuous days 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, look at the screening completed in the last continuous enrollment period of 150 days or more during the measurement year.

Note: One hundred fifty days' continuous enrollment allows a single sample to be used across the suite of MLTSS measures: Long-Term Services and Supports Comprehensive Assessment and Update, which looks for assessment to be conducted within 90 days of enrollment; Long-Term Services and Supports Comprehensive Care Plan and Update, which looks for a care plan to be developed within 30 days of assessment or 120 days of enrollment; Long-Term Services and Supports Shared Care Plan with Primary Care Provider, 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, problems with balance or gait, or both.

Allowable gap – None.

Anchor date – December 31 of the measurement year.

Benefit – Long-Term Services and Supports (Home and Community-Based Services, Facility Care, or both).

Event/diagnosis – None.

Required exclusions – Required exclusions are *not* reported with the measure rate.

1. *Participants Who Are Not Ambulatory*

   Excluded from this rate are participants who are bedridden, immobile, or confined to a chair and wheelchair users who depend on a helper to push their wheelchair, who require minimal help in their wheelchair, or who are independent in their wheelchair.

D. Case Management Record Review Specification

Denominator

A systematic sample from the eligible population.

Note: The same systematic sample may be used to calculate the Long-Term Services and Supports Comprehensive Assessment and Update, the Long-Term Services and Supports Comprehensive Care Plan and Update, the Long-Term Services and Supports Shared Care Plan with Primary Care Provider, and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measures. Obtain a separate (or supplemental) sample for MLTSS-4 Reassessment and Care Plan Update after In-Patient Admission.

Numerator

The number of Medicaid MLTSS participants who have documentation of an evaluation of whether the participant 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.

Falls Part 2: Risk Assessment and Plan of Care

A. Description

The percentage of Medicaid MLTSS participants age 18 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.

Performance Rates

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

Exclusion Rate

1. *Participant Refused Risk Assessment, Plan of Care for Falls, or Both*

Data Collection Method: Case Management Record Review

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 and 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 – Age 18 and older as of the first day of the measurement year.

Continuous enrollment – Participant must be enrolled in a Medicaid MLTSS plan for at least 150 continuous days 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, 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, Facility Care, or both).

Event/diagnosis – A documented history of falls (at least two falls or one fall with injury in the past year); Documentation of participant self-reported history of falls is sufficient.

Required exclusions –

1. *Participant Refused Risk Assessment, Plan of Care for Falls, or Both*

   Participants who refused a risk assessment, a plan of care, or both

   Document that the participant was contacted and refused to participate in an assessment, plan of care development, or both.

   The exclusion for participants who refused assessment, plan of care development, or both *is* reported with the measure rates. To calculate the rate of participants who refused,

divide the number of participants who meet this exclusion criterion by the number of participants meeting the continuous enrollment criteria.

2. *Participants Who Are Not Ambulatory*

   Excluded from all rates of this measure are participants who are bedridden, immobile, or confined to a chair and wheelchair users who depend on a helper to push their wheelchair, who require minimal help in their wheelchair, or who are independent in their wheelchair.

   The exclusion for participants who are not ambulatory is *not* reported with the measure performance rates.

D. Case Management Record Review Specification

Denominator

A systematic sample drawn from the eligible population

Numerator

The measure reports two numerators: 1) assessment of core elements and 2) assessment of supplemental elements.

Rate 1: *Risk Assessment*

The number of Medicaid MLTSS participants 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 and gait assessment *and* at least one of the following assessments: postural blood pressure, vision, home fall hazards, or medications. A standardized tool is not required for balance and gait assessment. All components need not be completed during a single encounter but should be documented in the participant record as having been performed between August 1 of the year prior to the measurement year and December 31 of the measurement year.

- **Balance and gait assessment** comprises at least one of the following elements.
  - Documentation of observed transfer and walking
  - Documented use of a standardized scale for assessment ofbalance and gait (e.g., Get-Up-and-Go test, Berg Functional Balance Scale, Tinetti Gait and Balance Test)
  - 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 elements during an in-person assessment.
  - Documentation that a participant is functioning well with vision based on discussion with the participant

    - Documented use of a standardized scale or vision assessment tool (e.g., Snellen eye charts)
- **Home fall hazards assessment** comprises documentation of inquiry of home fall hazards.
- **Medication assessment** comprises documentation of whether the participant's current medications may 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 that 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 Medicaid MLTSS participants 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.

- Documentation of exercise provided or referral to an exercise program
- Balance and gait training or instructions provided or referral for balance and gait training
- Physical therapy provided or referral to physical therapy
- Occupational therapy provided or referral for occupational therapy

MLTSS-6: Medicaid Managed Long-Term Services and Supports Admission to a Facility from the Community

A. Description

The number of admissions to a facility among Medicaid MLTSS participants age 18 and older residing in the community for at least one month

The number of short-term, medium-term, or long-term admissions is reported per 1,000 participant months. Participant months reflect the total number of months each participant is enrolled in the program and residing in the community for at least one day of the month.

The following three performance rates are reported across four age groups (18 to 64, 65 to 74, 75 to 84, and 85 and older.).

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

Data Collection Method: Administrative

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

B. Definitions

Facility – Medicaid- or Medicare-certified nursing facilities providing skilled nursing or medical care, or both; rehabilitation needed because of injury, illness, or disability; or long-term care (also referred to as "custodial care"); Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Community residence – Any residence that is not a facility (see definition above)

Note: Residence may include assisted living, adult foster care, or other care in another setting that is not defined as a facility.

Participant months – Participant months are a Medicaid MLTSS participant's "contribution" to the total yearly enrollment. Participant months are calculated by summing the total number of months each participant is enrolled in the Medicaid MLTSS plan and residing in the community for at least one day of the month from August 1 of the year prior to the measurement year through July 31 of the measurement year. Participant months do not include the month that aa participant dies or any subsequent months. See Subsection D for guidance on calculating participant months.

Facility admission – An admission to a facility from the community or from the hospital (where the hospital admission originated in the community) from August 1 of the year prior to the

measurement year through July 31 of the measurement year; Facility admission (FA) is based on paid claims only.

C. Eligible Population

Age – Age 18 and older as of the first day of the measurement year.

Continuous enrollment – Participant 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, Facility Care, or both) *and* Benefit for medical care and services; Benefits should be determined at the individual level. Any participant receiving a benefit for both long-term services and supports and medical care through the Medicaid MLTSS plan is eligible for this measure.

Event/diagnosis – None.

Required exclusions – None.

D. Administrative Specification

1. Denominator

Number of participant months where the participant was residing in the community for at least one day of the month[9]

Step 1

Identify the eligible population as defined above.

Step 2

Determine participant 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, the last day of the month) to be determined according to the plan's administrative processes. For example, if the plan tallies enrollment on the 15th of the month and a participant is enrolled in the Medicaid MLTSS program on January 15, the participant contributes one participant month in January. The day selected must be consistent from person to person, month to month, and year to year.

[9] For example, if a participant was admitted to a facility on February 12 and discharged on April 15, February and April would count in the denominator but March would not. States should count months only when there is an opportunity for an admission.

Step 3

Identify the months when the Medicaid MLTSS participant was residing in a facility for the entire month (i.e., no days in the month were spent residing in the community). Remove these months from the denominator.

Step 4

Remove from the measure denominator the month when a participant dies and any subsequent months.

Step 5

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

Step 6

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

Numerator

The number of facility admissions (FA) from a community residence from August 1 of the year prior to the measurement year through July 31 of the measurement year

FAs are reported in three categories: 1) short-term stay (1 to 20 days), 2) medium-term stay (21 to 100 days), and 3) long-term stay (greater than or equal to 101 days).

Use the steps below to identify numerator events.

Step 1

Identify all FAs between August 1 of the year prior to the measurement year and July 31 of the measurement year (MLTSS-6-8 Value Sets Facility Uniform Bill Codes).

Step 2

Remove FAs that are direct transfers from another facility. Keep the original admission date as the date of new FA. A direct transfer is when the discharge date from the first facility setting precedes the admission date to a second facility setting by one calendar day or less. For example,

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

Step 3

Remove admissions from the hospital that originated from a facility. Keep the original FA date (that preceded the admission to the hospital) as the new FA date.

Step 4

Remove admissions that result in death in the facility or death within one day of discharge from the facility.

Step 5

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

- If the participant is discharged to the community, calculate length of stay (LOS) as the date of facility 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.
- If the participant is discharged to the hospital, look for the hospital discharge and location of discharge. If the participant is discharged from the hospital to the community, calculate LOS as the date of hospital discharge minus the FA date.
- If the participant is discharged to the hospital and dies in the hospital, exclude the admission from the numerator.
- If the participant is discharged to the hospital and remains in the hospital at the end of the measurement year, exclude the admission from the numerator.
- If the participant is discharged to the hospital and then is admitted back to the facility, repeat Step 5 until there is a discharge to the community or until the end of the measurement year. When calculating the LOS, include all hospital days between the FA date and discharge to the community or the end of the measurement year.
- If the participant is discharged to a different facility (i.e., a transfer), repeat Step 5 until there is a discharge to the community or until the end of the measurement year. When calculating the LOS, include all facility days between the FA date and discharge to the community or until 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 one.

Step 6

Classify LOS for each FA as short-term (1 to 20 days), medium-term (21 to 100 days), or long-term (greater than or equal to101 days).

Step 7

Determine the participant's age at the time of admission and assign it to an age category: 18 to 64, 65 to 74, 75 to 84, or 85 or older.

Calculating Performance Rate

Calculate the admission rate for each type of stay and age category by dividing the number of admissions by the number of participant months and multiplying by 1,000, as follows.

- Short-term admission rate = (number of short-term admissions / number of participant months) x 1,000. Calculate the rate for each of the four age groups: 18 to 64, 65 to 74, 75 to 84, and 85 or older.
- Medium-term admission rate = (number of medium-term admissions / number of participant months) x 1,000. Calculate the rate for each of the four age groups: 18 to 64, 65 to 74, 75 to 84, and 85 or older.
- Long-term admission rate = (number of long-term admissions / number of participant months) x 1,000. Calculate the rate for each of the four age groups: 18 to 64, 65 to 74, 75 to 84, and 85 or older.

MLTSS-7: Medicaid Managed Long-Term Services and Supports Minimizing Facility Length of Stay

A. Description

The proportion of admissions to a facility among Medicaid MLTSS participants age 18 and older 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.

The measure focuses on discharges within 100 days because it is generally considered a cross-over point in long-term care. After that time, evidence shows that 1) a participant's residence in the facility becomes considered semipermanent, 2) participants dually eligible for Medicare and Medicaid lose Medicare coverage for their facility stay, and 3) participants may lose their community-based housing, limiting the probability they can easily return to reside in the community.

Data Collection Method: Administrative

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

B. Definitions

Facility – Medicaid- or Medicare-certified nursing facilities providing skilled nursing or medical care or both; rehabilitation needed because of injury, illness, or disability; or long-term care (also referred to as "custodial care"); Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Discharge to the community – A discharge to the community from the facility for all FAs 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 Medicaid MLTSS participant 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.

Facility admission – An admission to the facility 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 facility from the hospital setting only if the Medicaid MLTSS participant lived in the community prior to the hospital admission. FA is based on paid claims only.

Community residence – Any residence not a 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 a facility.

Classification period – 180 days prior to and including the FA date.

C. Risk Adjustment Tables*

Long-Term Services and Supports-CCW – ICD-10 codes for Chronic Conditions Warehouse (CCW) classification.

MinInstit- RAW – Weights for risk adjustment weighting.

**Note*: Long-Term Services and Supports Risk Adjustment Tables are available at https://www.medicaid.gov/Medicaid/downloads/ltss-risk-adjustment.xlsx.

D. Eligible Population

Age – Age 18 and older as of the first day of the measurement year.

Continuous enrollment – Enrollment in the Medicaid MLTSS plan on the FA date through 160 days following the FA date.

Allowable gap – None.

Anchor date – FA date.

Benefit – Long-Term Services and Supports (Home and Community-Based Services, Facility Care, or both) *and* Benefit for medical care and services; Benefits should be determined at the individual level. Any participant receiving a benefit for both long-term services and supports and medical care through the Medicaid MLTSS plan is eligible for this measure.

Event/diagnosis – New admissions to a 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 on participants. Medicaid MLTSS plans should follow the steps below in Subsection E to identify new FAs.

Required exclusions – None.

E. Administrative Specification

Denominator

The eligible population

Step 1

Identify all admissions to facilities between July 1 of the year prior to the measurement year and June 30 of the measurement year (MLTSS-6-8 Value Sets Facility Uniform Bill Codes).

Step 2

Remove FAs that are direct transfers from another facility. Keep the original FA date as the date of the new FA. A direct transfer is when the discharge date from the first facility setting precedes the admission date to a second facility setting by one calendar day or less. For example,

- Facility discharge on June 1, followed by an admission to another facility setting on June 1, is a direct transfer;

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

Step 3

Remove admissions from the hospital that originated from a facility. Keep the original FA date (that preceded the admission to the hospital) as the new FA date.

Step 4

Remove admissions that result in death in the facility or death within one day of discharge from the facility.

Step 5

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

Risk Adjustment Determination

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

Age and gender – Determine the participant's age and gender on the FA date and assign it to the following categories: female, age 18 to 44; female, age 45 to 64; female, age 65 to 74; female, age 75 to 84; female, age 85 or older; male, age 18 to 44; male, age 45 to 64; male, age 65 to74; male, age 75 to 84; male, age 85 or older.

Dual eligibility – Determine the participant's dual eligibility status for Medicare and Medicaid on the FA date. If the participant received full Medicaid and Medicare benefits, classify the participant as dually eligible. All other participants are not considered dually eligible.

Diagnoses – Using Table Long-Term Services and Supports-CCW, assign a CCW code to the FA based on its diagnoses. For direct transfers, use 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. Table Long-Term Services and Supports-CCW and Table MinInstit-RAW are available at https://www.medicaid.gov/Medicaid/downloads/ltss-risk-adjustment.xlsx.

Number of hospital stays – Determine whether the participant had any acute hospitalizations in the six 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 participant was enrolled in the Medicaid MLTSS plan prior to the FA date. Classify the total days of enrollment as fewer than 180 days or greater than or equal to 180 days.

Risk Adjustment Weighting

For each FA, use the following steps to identify risk adjustment weights based on dual eligibility for Medicare and Medicaid, age and gender, diagnoses from the FA, 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 FA.

Step 3

For each FA with dual eligibility for Medicare and Medicaid, link the dual eligibility weight.

Step 4

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

Step 5

For each FA with one or more hospitalizations prior to FA, link the number of hospitalizations weight.

Step 6

For each FA with six months' or more enrollment prior to the FA, link the six months enrollment weight.

Step 7

Sum all weights associated with the FA (i.e., base, age and gender, dual eligibility for Medicare and Medicaid, 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 FA.

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

Note: "Exp" refers to the exponential or antilog function. The formula above could also be written with superscripts: e (sum of weights for FA) / 1 + e (sum of weights for FA), where e represents the antilog of the natural logarithm (i.e., the inverse of the logarithmic transformation), which is a constant called Euler's number. Euler's number is irrational but begins with 2.718. In the Statistical Analysis System **(**SAS), the antilog can be obtained with the EXP function; in the Statistical Package for the Social Sciences (SPSS), the ANTILOG function may be used. It is also a function on many scientific calculators.

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 FA.

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

As an example, below is a sample calculation of expected discharge probability for a hypothetical participant with the following characteristics: male; 88 years old; two pre-period hospital stays; and stroke victim. The participant was not dually eligible and had only three months' enrollment prior to FA.

Base Risk Weight	Age	Gender	Age and Gender Weight	Number of Hospital Stays		FA Diagnosis			Sum of Weights	Expected Discharge Probability
				Number of Hospital Stays	Weight	ICD-10 Diagnosis Codes	CCW	Weight		
-0.9966	88	Male	0.4395	2	-0.4930	G459	Stroke	-0.5140	-1.5641	0.1731

In this example, the expected probability of having a successful discharge during the measure year for this participant is as follows.

$$Expected\ Discharge\ Probability = \frac{exp(-0.9966 + 0.4395 - 0.4930 - 0.5140)}{1 + exp(-0.9966 + 0.4395 - 0.4930 - 0.5140)} = 0.1731$$

Numerator

The count of discharges from a facility to the community during the measurement year that occurred within 100 days or fewer of admission

Discharges that result in death, hospitalization, or readmission to the facility within 60 days of discharge from the facility do not meet the numerator criteria.

Step 1

Identify all FAs (see Denominator criteria above).

Step 2

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

- If the participant is discharged to the community, calculate LOS as the date of facility 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 FA date.
- If the participant is discharged to the hospital, look for the hospital discharge and location of discharge. If the participant is discharged from the hospital to the community, calculate LOS as the date of hospital discharge minus the FA date.

- If the participant is discharged to the hospital and dies in the hospital, exclude the admission from the FA count.
- If the participant is discharged to the hospital and remains in the hospital at the end of the measurement year, exclude the admission from the FA count.
- If the participant is discharged from the hospital to the facility, repeat Step 2 until there is a discharge to the community or until the end of the measurement year.
- If the participant is discharged to a different facility (i.e., a transfer), repeat Step 2 until there is a discharge to the community or until 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 FAs with LOS of fewer than or equal to 100 days. This number should include only discharges to the community (either directly from the facility or from the facility to the hospital to the community).

Step 4

Remove the discharge if the Medicaid MLTSS participant was hospitalized, died, or was readmitted to the facility 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 (FA count). Report the observed discharge rate as the observed performance rate of Minimizing Length of Facility Stay.

Calculate the expected discharge rate by dividing the expected count of successful discharges by the denominator (FA count). Report the expected discharge rate as the expected performance rate of Minimizing Length of Facility 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 a 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 Facility LOS for each plan k is equal to the O/E ratio multiplied by the multi-plan population rate Y.

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

MLTSS-8: Medicaid Managed Long-Term Services and Supports Successful Transition after Long-Term Facility Stay

A. Description

The proportion of long-term facility stays among Medicaid MLTSS participants age 18 and older that result in successful transitions 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

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

B. Definitions

Facility – Medicaid- or Medicare-certified nursing facilities providing skilled nursing or medical care or both; rehabilitation needed because of injury, illness, or disability; or long-term care (also referred to as "custodial care"); Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Discharge to the community – A discharge to the community from the facility for all FAs and prior facility admissions (PFA) 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 Medicaid MLTSS participant 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.

Community residence – Any residence that is not a facility (see definition above)

Note: Community residence may include assisted living, adult foster care, or other care in another setting not defined as a facility.

*C. Risk Adjustment Tables**

Long-Term Services and Supports-CCW – ICD-10 codes for Chronic Conditions Warehouse (CCW) classification.

LTTrans- RAW – Weights for risk adjustment weighting.

**Note*: Long-Term Services and Supports Risk Adjustment Tables are available at https://www.medicaid.gov/Medicaid/downloads/ltss-risk-adjustment.xlsx.

D. Eligible Population

Age – Age 18 and older as of July 1 of the year prior to the measurement year.

Continuous enrollment – Continuously enrolled in the Medicaid MLTSS plan for at least 365 days from July 1 of the year prior to the measurement year through December 31 of the measurement year; If the participant 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, Facility Care, or both) *and* Benefit for medical care and services; Benefits should be determined at the individual level. Any participant receiving a benefit for both long-term services and supports and medical care services through the Medicaid MLTSS plan is eligible for this measure.

Event/diagnosis – FA 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* PFA 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 PFA is considered a stay of at least 101 days for a participant identified as residing in a 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. The denominator for this measure is based on discharges, not on participants. Medicaid MLTSS plans should follow the steps in Subsection D to identify new FAs and PFAs.

Required exclusions – None.

E. Administrative Specification

1. Denominator

The eligible population

Step 1

Identify all 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. Plans may use their own method to identify individuals residing in facilities for at least 101 days inclusive of July 1 of the year prior to the measurement year. For example, an admission is considered a stay of at least 101 days when an individual identified who was residing in a facility on July 1 of the year prior to the measurement year 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. These admissions are considered PFAs.

Step 2

Identify all new admissions to facilities (nursing and ICF/IID facilities) from July 1 of the year prior to the measurement year through June 30 of the measurement year (MLTSS-6-8 Value Sets Facility Uniform Bill Codes). These admissions are considered FAs.

Step 3

Remove admissions that are direct transfers from another facility. Keep the original admission date as the date of new FA. A direct transfer is when the discharge date from the first facility

setting precedes the admission date to a second facility setting by one calendar day or less. For example,

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

Step 4

Remove admissions from the hospital that originated from a facility. Keep the original FA date (that preceded the admission to the hospital) as the new FA date.

Step 5

Remove admissions that result in death in the facility or death within one day of discharge from the facility.

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 participant is discharged to the community, calculate LOS as the date of facility 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 participant is discharged to the hospital, look for the hospital discharge and location of discharge. If the participant is discharged from the hospital to the community, calculate LOS as the date of hospital discharge minus the FA date. If the participant is discharged from the hospital to the facility, repeat Steps 2 through 6 until there is a discharge to the community or until the end of the measurement year.
- If the participant is discharged to a different facility (i.e., a transfer), repeat Steps 2 through 6 until there is a discharge to the community or until the end of the measurement year.

Step 7

Remove all admissions where LOS is fewer 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 that lasted 101 days or longer make up the denominator for the observed rate and should include both new admissions that originated in the

community (FA) and prior admissions that were residing in the facility on July 1 of the year prior to the measurement year (PFA). These admissions are called long-term facility stays (LTFS).

Risk Adjustment Determination

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

Age and gender – Determine the participant's age and gender on July 1 of the year prior to the measurement year and assign it to the following categories: female, age 18 to 44; female, age 45 to 64; female, age 65 to 74; female, age 75 to 84; female, age 85 or older; male, age 18 to 44; male, age 45 to 64; male, age 65 to 74; male, age 75 to 84; male, age 85 or older.

Dual eligibility – Determine the participant's dual eligibility status for Medicare and Medicaid on the FA date. If the participant received full Medicaid and Medicare benefits, classify the participant as dually eligible. All other participants are not considered dually eligible.

Diagnoses – Assign a CCW code to the LTFS based on all diagnoses for the LTFS episode (e.g., admission diagnoses, transfer diagnoses, interim claim diagnoses) using Table Long-Term Services and Supports-CCW. For direct transfers, use the direct transfer's discharge diagnoses. Exclude diagnoses that cannot be mapped to Table LTTrans-RAW. Table Long-Term Services and Supports-CCW and Table LTTrans-RAW are available at https://www.medicaid.gov/Medicaid/downloads/ltss-risk-adjustment.xlsx.

Number of hospital stays – Determine whether the participant 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 Medicaid MTLSS plan – Determine the number of days the participant was enrolled in the Medicaid MLTSS plan during the classification period. Classify the total months of enrollment as fewer than 180 days or greater than or equal to 180 days.

Risk Adjustment Weighting

For each LTFS, use the following steps to identify risk adjustment weights based on dual eligibility for Medicare and Medicaid, age and gender, diagnoses from the LTFS, 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 LTFS.

Step 3

For each LTFS with dual eligibility for Medicare and Medicaid on July 1 of the year prior to the measurement year, link the dual eligibility weight.

Step 4

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

Step 5

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

Step 6

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

Step 7

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

Expected Transition Probability =
[exp (sum of weights for LTFS)] / [1+ exp (sum of weights for LTFS)]

Note: "Exp" refers to the exponential or antilog function. The formula above could also be written with superscripts: e (sum of weights for FA) /1 + e (sum of weights for FA), where e represents the antilog of the natural logarithm (i.e., the inverse of the logarithmic transformation), which is a constant called Euler's number. Euler's number is irrational but begins with 2.718. In SAS, the antilog can be obtained with the EXP function; in SPSS the ANTILOG function may be used. It is also a function on many scientific calculators.

Step 8

Calculate the count of successful transitions to the community (numerator). The count of expected discharges is the sum of the estimated transition probability calculated in Step 7 for each LTFS.

$$\textit{Count of Expected Transitions} = \sum(\text{Estimated Transition Probability})$$

As an example, below is a sample calculation of expected transition probability for a hypothetical participant with the following characteristics: male; 88 years old; two pre-period hospital stays; and ulcer victim. The participant was not dually eligible and had only three months' enrollment prior to the FA.

Base Risk Weight	Age	Gender	Age and Gender Weight	Number of Hospital Stays		LTFS Diagnosis			Sum of Weights	Expected Transition Probability
				Number of Hospital Stays	Weight	ICD-10 Diagnosis Code	CCW	Weight		
0.0496	88	Male	1.2319	2	-1.1997	I70231	Ulcer	-0.8866	0.8048	0.309

In this example, the expected probability of having a successful transition for this participant during the measure year is as follows.

$$Expected\ transition\ probability = \frac{exp(0.0496+1.2319-1.1997-0.8866)}{1+exp(0.0496+1.2319-1.1997-0.8866)} = 0.309$$

Numerator

The count of discharges from a facility to the community from July 1 of the year prior to the measurement year through 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 readmission to the facility within 60 days of discharge from the facility do not meet the numerator criteria.

Step 1

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

Step 3

Remove discharges to the community if the participant was hospitalized or was admitted to a facility in the 60 days after discharge from the LTFS.

Step 4

Remove discharges to the community if the participant died between days 2 and 60 in the 60 days after discharge from the LTFS.

Step 5

The resulting discharges to the community that were not readmitted to the hospital or to a facility or that 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 (LTFS count).

Report the observed discharge rate as the observed performance rate of successful transition to the community after LTFS.

Calculate the expected discharge rate by dividing the expected count of successful transitions by the denominator (LTFS count). Report the expected transition rate as the expected performance rate of successful transition to the community after LTFS.

Plans can understand their results by calculating the ratio of their 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 a 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 LTFS for each plan k is equal to the following.

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

IV. Resources

The 2022 Medicaid Managed Long-Term Services and Supports Measures Technical Specifications and Resource Manual includes updates from the 2019 version of the manual. Resources mentioned in this manual include the following.

- The Medicaid MLTSS Measures Technical Specifications and Resource Manual with updated MLTSS measures is available at https://www.medicaid.gov/medicaid/managed-care/ltss/index.html.
- The Long-Term Services and Supports VSD also is available at https://www.medicaid.gov/medicaid/managed-care/ltss/index.html. .
- The HEDIS measure name is provided for the four aligned MLTSS measures that the HEDIS portfolio comprises.

The Medicaid Managed Long-Term Services and Supports Measures Technical Specifications and Resource Manual is expected to be updated to include fee-for-service versions of the applicable MLTSS measures after full respecification and testing is complete in 2023.

For technical assistance with calculating and reporting the MLTSS measures, contact the technical assistance mailbox at MLTSSMeasures@cms.hhs.gov.

Appendix A: Standardized Tools Bibliographic References

Berg Functional Balance Scale

Berg, K.O., Wood-Dauphinee, S.L., Williams, J.I., & Maki, B. (1992). Measuring balance in the elderly: validation of an instrument. *Canadian journal of public health = Revue canadienne de sante publique*, 83 Suppl 2, S7–S11.

Center for Epidemiologic Studies Depression Scale (CES-D)

Radloff, L.S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurements*, 1(3), 385–401.

Cornell Scale Screening

Alexopoulos, G.A., Abrams, R.C., Young, R.C., & Shamoian, C.A.: Cornell scale for depression in dementia. *Biol Psych*, 1988, 23:271–284.

Depression Scale (DEPS)

Salokangas, R.K.R., Poutanen, O., & Stengård, E. Screening for depression in primary care. Development and validation of the Depression Scale, a screening instrument for depression. *Acta Psychiatr Scand*. 1995 July; 92(1):10–CrossRefGoogle ScholarPubMed.

Duke Social Support Index

George et al. (1989). Social support and the outcome of major depression. *Br J Psychiatry*, 154(4), 478–485. PMID: 2590779.

Blazer, D., Hybels, C., & Hughes, D.C. (1990). Duke Social Support Index. *Educational Testing Service*.

Geriatric Depression Scale (GDS)

Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M.B., & Leirer, V.O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research*, 17, 37–49.

Get-Up-and-Go test

Podsiadlo, D., & Richardson, S. (1991). The timed "Up and Go": A test of basic functional mobility for frail elderly persons. *Journal of the American Geriatrics Society*, 39(2), 142–148.

Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

Jorm, A.F., & Jacomb, P.A. The Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE): socio-demographic correlates, reliability, validity and some norms. *Psychol Med*. 1989 Nov; 19(4):1015–22. doi: 10.1017/s0033291700005742. PMID: 2594878

Memory Impairment Screen (MIS)

Buschke, H., Kuslansky, G., Katz, M., Stewart, W.F., Sliwinski, M.J., Eckholdt, H.M., & Lipton, R.B. (1999). Screening for dementia with the memory impairment screen. *Neurology*, 52(2), 231–238. https://doi.org/10.1212/wnl.52.2.231

Morse Fall Scale

Morse, J., Morse, R.M., & Tylko, S.J. (1989). Development of a scale to identify the fall-prone patient. *Canadian Journal on Ageing*, 8, 366–377.

Patient Health Questionnaire 2-item or 9-item (PHQ2, PHQ9)

Kroenke, K., Spitzer, R.L., & Williams, J.B. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. *Medical Care*. 2003:41(11), 1284–92.

Kroenke, K., Spitzer, R.L., & Williams, J.B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9): 606–613.

Snellen Eye Charts

Snellen, H. (1862). *Probebuchstaben zur Bestimmung der Sehschärfe*. Utrecht, Van de Weijer.

Stanford Chronic Disease Self-Efficacy Scale (CDSM)

Lorig, K.R., Sobel, D.S., Ritter, P.L., Laurent, D., & Hobbs, M. (2001). Effect of a self-management program for patients with chronic disease. *Effective Clinical Practice*, 4, 256–262.

Three Item Loneliness Scale

Hughes, M.E., Waite, L.J., Hawkley, L.C., & Cacioppo, J.T. (2004). A Short Scale for Measuring Loneliness in Large Surveys: Results from Two Population-Based Studies. *Research on aging*, 26(6), 655–672. https://doi.org/10.1177/0164027504268574.

Tinetti Gait and Balance Test

Tinetti M.E. (1986). Performance-oriented assessment of mobility problems in elderly patients. *Journal of the American Geriatrics Society*, *34*(2), 119–126. https://doi.org/10.1111/j.1532-5415.1986.tb05480.x

University of California, Los Angeles (UCLA) Loneliness Scale

Russell, D.W. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. *Journal of Personality Assessment*, 66(1), 20–40.