Long-Term Services and Supports (LTSS) Quality Measures

Technical Specifications and Resource Manual

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Center for Medicaid and CHIP Services
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Appendix A contains the bibliographic references for the standardized tools included in this manual. Standardized tools that can be accessed online have been hyperlinked throughout the manual.

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I. Long-Term Services and Supports Quality Measures

Background

Medicaid long-term services and supports (LTSS) are commonly delivered through managed care programs (MLTSS) and fee-for-service programs (FFS LTSS). In May 2019, the Centers for Medicare & Medicaid Services (CMS) selected and published an initial set of eight quality measures, evaluating the delivery of MLTSS for voluntary use by states. In 2022, CMS released updates to the MLTSS measures, including changes to the measure names, clarifications to support measure compliance, and links to updated value sets. In this update to the measures, CMS has included the introduction of a set of corresponding measures for Medicaid FFS LTSS programs and made further clarifications to the Medicaid MLTSS measures. The current manual is available on the CMS website at https://www.medicaid.gov/media/3396.

The measures for Medicaid MLTSS and FFS LTSS, developed and tested for participants age 18 and older, assess the quality of Medicaid LTSS for:

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

These measures provide data and information that states, managed care plans, and other stakeholders can use for quality improvement purposes and comparison of the performance of LTSS programs within and across states. The LTSS quality measures in **Exhibit 1** offer nationally standardized measures that meet importance, usability, feasibility, and scientific acceptability (i.e., reliability and validity) standards for use by Medicaid MLTSS plans and state Medicaid programs in LTSS measure domains.

The LTSS quality measures are intended for use by managed care plans and states with FFS LTSS programs. States with hybrid LTSS programs, delivered via FFS and managed care delivery systems, should refer to **both** the FFS LTSS and MLTSS measures' specifications to evaluate performance for their state's LTSS programs.

Exhibit 1: LTSS Quality Measures

Measure Set Name	Measure Name	Data Collection Method	Measure Type
Assessment and Person-Centered Planning	Managed Long-Term Services and Supports Comprehensive Assessment and Update (MLTSS-1)	Hybrid	Process
	Fee-for-Service Long-Term Services and Supports Comprehensive Assessment and Update (FFS LTSS-1)	Hybrid	Process
	Managed Long-Term Services and Supports Comprehensive Person-Centered Plan[1] and Update (MLTSS-2)	Hybrid	Process
	Fee-for-Service Long-Term Services and Supports Comprehensive Person-Centered Plan and Update (FFS LTSS-2)	Hybrid	Process
	Managed Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider (MLTSS-3)	Hybrid	Process
	Fee-for-Service Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider (FFS LTSS-3)	Hybrid	Process
	Managed Long-Term Services and Supports Reassessment and Person-Centered Plan Update after Inpatient Discharge (MLTSS-4)	Hybrid	Process
	Fee-for-Service Long-Term Services and Supports Reassessment and Person-Centered Plan Update after Inpatient Discharge (FFS LTSS-4)	Hybrid	Process
Falls Prevention	Managed Long-Term Services and Supports Screening, Risk Assessment, and Plan of Care to Prevent Future Falls (MLTSS-5)	Hybrid	Process
Rebalancing LTSS	Managed Long-Term Services and Supports Admission to a Facility from the Community (MLTSS-6)	Administrative[2]	Outcome
	Admission to a Facility from the Community among Medicaid Fee-for-Service Home and Community-Based Services (HCBS) Participants (FFS LTSS-6)	Administrative	Outcome
	Managed Long-Term Services and Supports Minimizing Facility Length of Stay (MLTSS-7)	Administrative	Process
	Fee-for-Service Long-Term Services and Supports Minimizing Facility Length of Stay (FFS LTSS-7)	Administrative	Process

[1] In this manual, person-centered 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.

Measure Set Name	Measure Name	Data Collection Method	Measure Type
Rebalancing LTSS (continued)	Managed Long-Term Services and Supports Successful Transition after Long-Term Facility Stay (MLTSS-8)	Administrative	Outcome
	Fee-for-Service Long-Term Services and Supports Successful Transition after Long-Term Facility Stay (FFS LTSS-8)	Administrative	Outcome

Section II. Data Collection and Preparation for Reporting of this manual includes general guidelines for data collection, preparation, and reporting to support consistency in LTSS measure reporting.

Section III: Technical Specifications of this manual provides additional details for each LTSS measure.

Additional resources include the following:

- **Value sets directory** for MLTSS-4 and FFS LTSS-4 is available at https://www.medicaid.gov/media/141121.
- **Value sets directory** for MLTSS-6, FFS LTSS-6, MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 is available at https://www.medicaid.gov/media/141126.
- **Risk-adjustment tables** for MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 are available at https://www.medicaid.gov/media/3296.

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

Updates to the Long-Term Services and Supports (*LTSS) Quality Measures Technical Specifications and Resource Manual* in 2024

The 2024 *LTSS Quality Measures Technical Specifications and Resource Manual* includes updates from the 2022 version of the manual. Updates include the following:

- Included FFS versions of equivalent MLTSS measures;[3]
- Removed face-to-face participant engagement requirements for MLTSS-1, FFS LTSS-1, MLTSS-2, FFS LTSS-2, MLTSS-4, and FFS LTSS-4;
- Updated available telehealth modalities to include telephone and videoconference options for MLTSS-1, FFS LTSS-1, MLTSS-2, FFS LTSS-2, MLTSS-4, and FFS LTSS-4;
- Changed the *assessment of participant's current alcohol or other illicit substance use* from a supplemental element to a core element for MLTSS-1, FFS LTSS-1, MLTSS-4, and FFS LTSS-4;

[3] At the time of this document's publication, there is no equivalent FFS measure for MLTSS-5.

- Changed the *plan of care for meeting a participant's mental health needs* from a supplemental element to a core element for MLTSS-2, FFS LTSS-2, MLTSS-4, and FFS LTSS-4;
- Incorporated a *substance use disorder needs* element into the definition of mental health plan of care for MLTSS-2, FFS LTSS-2, MLTSS-4, and FFS LTSS-4;
- Updated the term *care plan* to *person-centered plan* for MLTSS-2, FFS LTSS-2, MLTSS-4, and FFS LTSS-4;
- Clarified exclusion language to distinguish between a participant's refusal to participate in measure activities and failure to respond to requests for participation for MLTSS-1, FFS LTSS-1, MLTSS-2, FFS LTSS-2, MLTSS-3, FFS LTSS-3, MLTSS-4, and FFS LTSS-4;
- Added footnotes highlighting the role of an LTSS participant's proxy or guardian to respond to a care manager as the participant would respond if the participant is unable to do so during assessment and person-centered-planning activities for MLTSS-1, FFS LTSS-1, MLTSS-2, FFS LTSS-2, MLTSS-4, FFS LTSS-4, and MLTSS-5;
- Revised exclusion language to indicate that participants without a person-centered plan or with a partial person-centered plan are eligible for inclusion in the MLTSS-1, FFS LTSS-1, MLTSS-2, FFS LTSS-2, MLTSS-3, FFS LTSS-3, MLTSS-4, and FFS LTSS-4 populations; and
- Amended the definition of *community residence* to include the participant's home for MLTSS-6, FFS LTSS-6, MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8.

II. Data Collection and Preparation for Reporting

To support consistency in reporting the LTSS measures, this section provides general guidelines for data collection, preparation, and reporting. In **Section III: Technical Specifications**, detailed information on how to calculate each measure is provided. For technical assistance with calculating and reporting these measures, contact the CMS technical assistance mailbox at MLTSSMeasures@cms.hhs.gov.

Aggregating information for state-level reporting. To obtain a state-level rate for a measure that combines the rates of multiple units of measurement (e.g., multiple Medicaid MLTSS plans), the state should calculate a weighted average from 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; this means that reporting units with larger eligible populations will contribute more toward the rate than reporting units with smaller eligible populations.

Allowable gap. Some measures specify an allowable gap that can occur during continuous enrollment. For example, if a measure requires continuous enrollment during the measurement year (e.g., 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 during the remainder of the measurement year because this participant has one 38-day gap (e.g., January 1 to February 7).

For these quality measures, a gap of up to 45 days is allowed during each measurement year for participants eligible for inclusion in the measures' denominators.

Anchor date. Some measures include an anchor date, which refers to the date by which a participant must be enrolled and be entitled to required benefits to be eligible for inclusion in the measure's denominator. 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 quality measures' measurement year for the current reporting period (e.g., the 2023 reporting period anchor date for the measurement year is December 31, 2022). States and managed care plans should use the specified anchor dates, along with the continuous enrollment requirements and allowable gaps for each measure, to identify the measure's eligible population.

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., LTSS, medical services). The technical specifications provide the continuous enrollment requirement for each measure, where applicable.

Data collection methods. The LTSS measures have three possible data collection methods: administrative, hybrid, and case management records. Each measure specifies the data collection method or methods that can be used. If a measure includes a choice of methods, any of the listed methods may be used.

- The *administrative* method uses transaction data (e.g., claims) to calculate the measure. These data can be used in cases in which the data are known to be accurate, valid, and reliable. When administrative data are used, all participants who meet the inclusion criteria are captured in the entire eligible population, and those without an exclusion are included in the denominator.
- The *hybrid* method uses both administrative data and case management record data to identify the eligible population and assess numerator compliance. Administrative data are reviewed to determine whether participants in the systematic sample received the service measured in the numerator; case management record data are reviewed for participants who do not meet the numerator criteria via administrative data. The denominator consists of a systematic sample of participants drawn from the measure's eligible population, removing those for whom an exclusion is present.[4]
- The *case management record* method is based on a review of case management records or electronic health records from a systematic sample drawn from the eligible population of participants receiving LTSS.

Data collection timeframes for measures. States and managed care plans should adhere to the measurement year(s) identified in the technical specifications for each measure. All of the LTSS quality measures are calculated using a calendar year (i.e., January 1 through December 31) of data; some measures might require examining data from the year prior to the measurement year. Data collection should come from the calendar year prior to the reporting year; for example, calendar year 2022 data should be used for calculating performance scores for the 2023 reporting period.

Date specificity. Documentation of a date must be specific enough to determine that an event occurred during the timeframe for the measure. There may be times when documentation of the year alone is adequate (e.g., most optional exclusions 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 too general to document a date.

Eligibility for benefits. For each measure, the benefits for which the participant must be eligible should be documented. Some measures require only that the participant be eligible for LTSS benefits to be included in the eligible population; others necessitate that participants be

[4] *Note:* The *hybrid* method is applicable to the MLTSS-1, FFS LTSS-1, MLTSS-2, FFS LTSS-2, MLTSS-3, FFS LTSS-3, MLTSS-4, FFS LTSS-4, and MLTSS-5 measures. The *administrative* method is applicable to the MLTSS-6, FFS LTSS-6, MLTSS-7, FFS LTSS-7, MLTSS-8, and FFS LTSS-8 measures.

eligible for both LTSS and medical care benefits through their LTSS plan for inclusion in the quality measure's eligible population.

Eligible population. For all of the LTSS quality measures, the eligible population includes Medicaid participants who satisfy measure-specific eligibility criteria (e.g., age, continuous enrollment, benefit, event, anchor date). The denominator is derived from the eligible population, removing participants for whom an exclusion (or exclusions) is present.

Reporting unit. Individual states should determine the appropriate reporting unit (i.e., the state, plan, organization, or other level).

Representativeness of data. For measures that rely on a sampling methodology, states, plans, or both states *and* plans should ensure that the sample used to calculate the quality measure is representative of the full eligible population for the measure.

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

Sampling. Sampling should be systematic to ensure all participants from the eligible population have an equal chance of inclusion in the sample. The sample size should be 411[5] for such measures, unless special circumstances apply. Regardless of the selected sample size, CMS recommends an oversample of participants from the eligible population to allow for substitution of cases, should those from the original sample prove ineligible for inclusion in the measure's denominator.

Telehealth. The LTSS measures consider synchronous telephone visits, telehealth visits, and asynchronous telehealth (i.e., e-visits, virtual check-ins) as separate modalities.

- *Synchronous telehealth* requires real-time interactive audio (i.e., telephone visit), audio/video telecommunications (i.e., telehealth visit), or both interactive audio *and* audio/video telecommunication.
- *Asynchronous telehealth*—sometimes referred to as an *e-visit* or *virtual check-in*—is not in real-time but still requires two-way interaction between the participant and the provider.

[5] The minimum case count was determined as part of reliability testing and was adopted by CMS for the LTSS Quality Measures Technical Specifications and Resource Manual and the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) measure set. For LTSS measures with a HEDIS equivalent (i.e., LTSS-1 through LTSS-4), states can choose to use the HEDIS equivalent for managed care and FFS populations.

Value sets. Some measure specifications reference value sets that must be used for calculating the measures. A value set directory contains the complete set of codes used to identify a service or condition included in a quality measure. The LTSS measures have two value sets:

- The value set directory for the *LTSS Reassessment and Person-Centered Plan Update after Inpatient Discharge* (MLTSS-4 and FFS LTSS-4) is available at https://www.medicaid.gov/media/141121.
- The value set directory for the *LTSS Admission to a Facility from the Community* (MLTSS-6 and FFS LTSS-6), *LTSS Minimizing Facility Length of Stay* (MLTSS-7 and FFS LTSS-7), and *LTSS Successful Transition after Long-Term Facility Stay* (MLTSS-8 and FFS LTSS-8) measures is available at https://www.medicaid.gov/media/141126.
- **Version of specifications**. This manual includes the most current version of the LTSS quality measures specifications, for Medicaid MLTSS and Medicaid FFS LTSS, effective as of March 2024.

III. Technical Specifications

This section presents the technical specifications for each measure, including a description, information about the eligible population, key definitions, data collection method or methods, instructions for calculation, and other relevant information, as appropriate. The 2024 manual contains the current version of the LTSS quality measures technical specifications.

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

Note: Technical specifications for FFS LTSS-1 can be found here.

Data source: Hybrid (Case Management Record and Administrative)

A. Description

The percentage of Medicaid MLTSS participants, aged 18 years and older, who have documentation of a comprehensive assessment, completed in a specified timeframe, which includes documentation of core and supplemental elements.

Guidance for Reporting
Two performance rates and two exclusions rates are reported for this measure. *Performance Rates* 1. *Assessment of Core Elements*. The percentage of Medicaid MLTSS participants who had an LTSS comprehensive assessment with 10 core elements documented within 90 days of enrollment (for new participants) or during the measurement year (for established participants). 2. *Assessment of Supplemental Elements*. The percentage of Medicaid MLTSS participants who had an LTSS comprehensive assessment with 10 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*[6] 1. *Participant Could Not Be Contacted*. The percentage of Medicaid MLTSS participants who could not be contacted for an LTSS comprehensive assessment within 90 days of enrollment (for new participants) or during the measurement year (for established participants). 2. *Participant Refused Assessment*. The percentage of Medicaid MLTSS participants who refused a comprehensive assessment.

[6] *Exclusion rates* are reported to identify portions of the eligible population not included in the performance rate. Medicaid MLTSS participants have the right to refuse an assessment at any point following contact; plans might have difficulty contacting some participants eligible for inclusion in a measure's population.

B. Definitions

Element	Definition
LTSS assessment	A discussion with a participant in their home using a structured or semi-structured tool that addresses the participant's health status and needs; and the assessment includes a minimum of 10 core elements and includes supplemental elements.
New participant	A participant 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 enrolled prior to August 1 of the year prior to the measurement year.
Home	The location where the participant lives, which might 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 might 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

Element	Definition
Age	Aged 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 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use the assessment completed during the last continuous enrollment period of 150 days or more, occurring during the measurement year. *Note*: One hundred fifty days of continuous enrollment allows for a single sample to be used across the set of MLTSS measures: *Long-Term Services and Supports Comprehensive Assessment and Update* (MLTSS-1), which looks for assessment to be conducted within 90 days of enrollment; *Long-Term Services and Supports.* *Comprehensive Person-Centered Plan and Update* (MLTSS-2), which looks for a person-centered plan to be developed within 30 days of assessment or 120 days of enrollment; *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (MLTSS-3), which looks for a person-centered plan to be shared within 30 days of development; and Part 1 of *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls* (MLTSS-5), which looks for screening for fall risk.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services.)[7]
Event/diagnosis	None.

[7] Provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in institutions for mental diseases (IMD) for individuals ages 65 and older.

Element	Definition
Modality	Assessment must be discussed during a face-to-face, telephone, or videoconference encounter between the care manager and the participant.
Required exclusions	Required exclusions are reported with the measure performance rate. Participants without a person-centered plan or with a partial person-centered plan are *not* excluded from the measure. *1. Participant Could Not Be Contacted* • New Medicaid MLTSS participants who could not be contacted for LTSS comprehensive assessment within 90 days of enrollment; or • Established participants who could not be contacted for LTSS comprehensive assessment during the measurement year. Medicaid MLTSS plans use their own process for identifying participants who could not be contacted for assessment and for documenting 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 criterion. *2. Participant Refused Assessment* • Medicaid MLTSS participants who refused a comprehensive assessment. Medicaid MLTSS plans should document, in the case management record, that the participant was contacted and 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 criterion.

D. Specifications

Denominator

This measure is based on a review of Medicaid MLTSS participant case management records, selected via 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* (MLTSS-1), *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (MLTSS-2), *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (MLTSS-3), and Part 1 of the *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls* (MLTSS-5) measures. Users should obtain a separate (or supplemental) sample for the *Reassessment and Person-Centered-Plan Update after Inpatient Discharge* (MLTSS-4) measure.[8]

Numerator

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

[8] *Note:* The initial population for part 2 for the MLTSS-5 measure is derived from those who fall into the numerator of part 1.

Rate 1: Assessment of Core Elements

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

- **New participants.** An LTSS comprehensive assessment, completed within 90 days of enrollment, containing all 10 core elements documented;[9] or
- **Established participants.** An LTSS comprehensive assessment, completed at least once during the measurement year, containing all 10 core elements documented.

The assessment must be a discussion with the participant[10] in the participant's home and must be performed face-to-face, via telephone, or via videoconference. Assessment in a 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* refused telephone or videoconference assessment);
- The participant is residing in an inpatient or institutional facility (e.g., hospital, skilled nursing facility, other post-acute-care facility) during the assessment period; or
- The state policy, regulation, or other state guidance (e.g., MLTSS plan contract language or state FFS LTSS policy guidance) excludes the participant from a requirement for in-home assessment.

Assessment Core Elements

The Medicaid MLTSS participant's assessment must include documentation of the following 10 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

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[9] If the comprehensive assessment (or part of the comprehensive assessment) is conducted as part of the process to determine eligibility for the LTSS benefit, and it occurs within 30 days prior to the enrollment start date, it may be counted in the numerator, as long as the assessment meets the numerator criteria for the rate.

[10] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care planning questions as a reflection of how the participant would respond to the same questions.

- 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 and has no proxy or guardian who can respond on the participant's behalf 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 and has no proxy or guardian who can respond on the participant's behalf meets the element.
6. Assessment of the participant's current alcohol use, illicit substance use, or both alcohol *and* illicit substance use using a standardized tool, such as one of the following
   - Single question: "How many times in the past year have you had five (5) or more drinks in a day?" (for men under 65 years) *or* "How many times in the past year have you had four (4) or more drinks in a day?" (for women and all adults older than 65 years).[11]
   - Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument

[11] This single question has been validated against the Brief Alcohol Use Disorders Identification Test (AUDIT 1–3) and is approved by the Centers for Disease Control and Prevention as an appropriate screening instrument for excessive alcohol use (*source:* https://www.cdc.gov/ncbddd/fasd/documents/ AlcoholSBIImplementationGuide.pdf).

- 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 and has no proxy or guardian who can respond on the participant's behalf meets the element.

7. Assessment of home safety risks (e.g., home fall risks, bathroom safety, chemical hazards, food preparation safety, crime).

   A standardized tool is not required. Direct observation of home safety risks is not required; queries about potential home safety risks meet the element. Documentation that no home safety risks exist meets the element.

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

   A standardized tool is not required. Documentation of the living arrangements of the participant meets the element.

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

   Caregivers include individuals who assist the participant with ADLs, instrumental activities of daily living (IADLs), healthcare tasks, and emotional support.

   Documentation that no family, friend, or other caregiver (paid or unpaid) is available meets the element.

10. Name and contact information for the participant's currently 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, or specialty care).

Rate 2: Assessment of Supplemental Elements

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

- **New participants.** An LTSS comprehensive assessment, completed within 90 days of enrollment, containing all 10 core elements *and* at least 12 supplemental elements documented;[12] or
- **Established participants.** An LTSS comprehensive assessment, completed during the measurement year, containing all 10 core elements *and* at least 12 supplemental elements documented.

[12] If the comprehensive assessment (or part of the comprehensive assessment) is conducted as part of the process to determine eligibility for the LTSS benefit, and it occurs within 30 days prior to the enrollment start date, it may be counted in the numerator, as long as the assessment meets the numerator criteria for the rate.

The assessment must be a discussion with the participant[13] in the participant's home and must be performed face-to-face, via telephone, or via videoconference. Assessment in a 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* refused telephone or videoconference assessment);
- The participant is residing in an inpatient or institutional facility (e.g., hospital, skilled nursing facility, other post-acute-care facility) during the assessment period; or
- The state policy, regulation, or other state guidance (e.g., MLTSS plan contract language or state FFS LTSS policy guidance) excludes the participant from a requirement for an in-home assessment.

The participant's assessment must document evidence of the 10 core elements, defined above, as well as evidence of at least 12 (of 18) supplemental elements and the assessment date.

Assessment Supplemental Elements

Supplemental elements include documentation of the following-

1. IADLs for at least four of the following activities: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, doing housework, making home repairs, doing laundry, taking medications, and handling finances.
2. Current use of an assistive device or technology to maintain or improve mobility (e.g., wheelchair, walker, scooter, cane, crutches, prosthesis, 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, such as the following:
   - Self-rated health single question: "In general, would you say that your health is excellent, very good, good, fair, or poor?"[14]
   - Short-Form Health Survey-12® (SF-12)
   - Patient-Reported Outcome Measurement Information System (PROMIS) Global 10

[13] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care-planning questions as a reflection of how the participant would respond to the same questions.

[14] The self-rated health single question allows the clinician to perform a quick global assessment of participant-perceived well-being. It was originally administered alongside the Parsley Symptom Index and has been validated for use as a single question (*Source:* https://www.ncbi.nlm.nih.gov/pmc/articles/ PMC9673004/).

Documentation that the participant is too cognitively impaired to self-report on a standardized tool and has no proxy or guardian who can respond on the participant's behalf 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 and has no proxy or guardian who can respond on the participant's behalf 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 increases 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 increases 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 risk of falls, or no problem with balance or gait meets the element.

11. Smoking status, including whether the participant is currently a smoker or tobacco user.

Documentation that the participant currently neither smokes nor uses tobacco meets the element.

12. 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 subsidies, gas subsidies, housing subsidies).

    Documentation that the participant does not use resources to address social risk factors meets the element.

13. 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]).

14. Assessment of participant's self-reported social isolation or loneliness using a standardized tool, such as the following:

    - 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 and has no proxy or guardian who can respond on the participant's behalf meets the element.

15. Cultural and linguistic preferences (e.g., participant's culture, preferred language, need for interpreter services).

16. Existence of an advance care plan, including some or all of the following:

    - Preferences for life-sustaining treatment and end-of-life care (or documented surrogate decisionmaker);
    - Designated surrogate decisionmaker—documentation of an individual other than the participant to make medical treatment choices for the participant;
    - Advance directive—a directive about treatment preferences or designation of a surrogate who can make medical decisions if the participant 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; and
- 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.

The participant's indicating that he or she does not wish to discuss an advance care plan 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. All oral statements must be documented in writing.

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

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

18. Recent use of medical services (e.g., emergency department services, hospitalization, home health, skilled nursing facility, paid home healthcare).

    Documentation of no recent use of medical services meets the element.

MLTSS-2: Managed Long-Term Services and Supports Comprehensive Person-Centered Plan and Update

Note: Technical specifications for FFS LTSS-2 can be found here.

Data source: Hybrid (Case Management Record and Administrative)

A. Description

The percentage of Medicaid MLTSS participants, aged 18 years and older, who have documentation of an LTSS comprehensive person-centered plan, completed in a specified timeframe, which includes documentation of core and supplemental elements.

Guidance for Reporting
Two performance rates and two exclusion rates are reported for this measure. *Performance Rates* 1. *Person-Centered Plan with Core Elements*. The percentage of Medicaid MLTSS participants who had an LTSS comprehensive person-centered plan with 10 core elements documented within 120 days of enrollment (for new participants) or during the measurement year (for established participants). 2. *Person-Centered Plan with Supplemental Elements*. The percentage of Medicaid MLTSS participants who had an LTSS comprehensive person-centered plan with 10 core elements *and* at least 4 supplemental elements documented within 120 days of enrollment (for new participants) or during the measurement year (for established participants).

Exclusion Rates[15]

1. *Participant Could Not Be Contacted*. The percentage of Medicaid MLTSS participants who could not be contacted to create an LTSS comprehensive person-centered plan within 120 days of enrollment (for new participants) or during the measurement year (for established participants).
2. *Participant Refused Person-Centered Planning*. The percentage of Medicaid MLTSS participants who refused a comprehensive person-centered plan.

B. Definitions

Element	Definition
LTSS person-centered plan	A document or electronic tool that identifies participant needs, preferences, and risks; the document or tool 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 person-centered plan.
Care manager	The person responsible for conducting an assessment and developing a person-centered 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 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 enrolled prior to August 1 of the year prior to the measurement year.

C. Eligible Population

Element	Definition
Age	Aged 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 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use the assessment completed during the last continuous enrollment period of 150 days or more, occurring during the measurement year.

[15] Exclusion rates are reported to identify portions of the eligible population not included in the performance rate. Medicaid MLTSS participants have the right to refuse person-centered planning at any point following contact; plans might have difficulty contacting some participants eligible for inclusion in a measure's population.

Element	Definition
Continuous enrollment (continued)	*Note:* One hundred fifty days of continuous enrollment allows for a single sample to be used across the set of MLTSS measures: *Long-Term Services and Supports Comprehensive Assessment and Update* (MLTSS-1), which looks for assessment to be conducted within 90 days of enrollment; *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (MLTSS-2), which looks for a person-centered plan to be developed within 30 days of assessment or 120 days of enrollment; *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (MLTSS-3), which looks for a person-centered plan to be shared within 30 days of development; and Part 1 of *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls* (MLTSS-5), which looks for screening for fall risk.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services.)[16]
Event/diagnosis	None.
Modality	The person-centered plan must be discussed during a face-to-face, telephone, or videoconference encounter between the care manager and the participant.
Required exclusions	Required exclusions are reported with the measure rates. Participants without a person-centered plan or with a partial person-centered plan are *not* excluded from the measure. *1. Participant Could Not Be Contacted* • New Medicaid MLTSS participants who could not be contacted to create an LTSS comprehensive person-centered plan within 120 days of enrollment; or • Established Medicaid MLTSS participants who could not be contacted to create an LTSS comprehensive person-centered plan during the measurement year. Medicaid MLTSS plans use their own process for identifying participants who could not be contacted for person-centered planning and for documenting that at least three attempts were made to contact the participant. To calculate the rate of participants who could not be reached for person-centered planning, divide the number of participants meeting this exclusion criterion by the number of participants meeting the continuous enrollment criterion. *2. Participant Refused Person-Centered Planning* • Participants who refused a comprehensive person-centered plan. Medicaid MLTSS plans should document, in the case management record, that the participant was contacted and the participant refused to participate in person-centered planning. To calculate the rate of participants who refused person-centered planning, divide the number of participants who meet this exclusion criterion by the number of participants meeting the continuous enrollment criterion.

[16] Provided in nursing facilities, ICFs/IID, hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in an IMD for individuals ages 65 and older.

D. Specifications

Denominator

This measure is based on a review of Medicaid MLTSS participant case management records, selected via 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* (MLTSS-1), *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (MLTSS-2), *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (MLTSS-3), and Part 1 of the *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls* (MLTSS-5) measures. Users should obtain a separate (or supplemental) sample for the *Reassessment and Person-Centered-Plan Update after Inpatient Discharge* (MLTSS-4) measure.

Numerator

Rate 1: Person-Centered Plan with Core Elements

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

- **New participants.** An LTSS comprehensive person-centered plan completed within 120 days of enrollment, containing all 10 core elements documented; or
- **Established participants.** An LTSS comprehensive person-centered plan completed at least once during the measurement year, containing all 10 elements documented.

Person-centered plans must be discussed during an encounter between the care manager and the participant.[17] The person-centered plan is not required to be created in the participant's home. The person-centered plan may be discussed during the same encounter as the comprehensive assessment; assessment of the participant and development of the person-centered plan may be done during the same encounter or during different encounters.

Person-Centered-Plan Core Elements

The initial person-centered plan or person-centered plan update must include documentation of the following 10 core elements and the person-centered plan date:

1. At least one individualized participant goal (medical or non-medical outcome important to the participant [e.g., 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]).

[17] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care-planning questions as a reflection of how the participant would respond to the same questions.

Documentation that the participant is too cognitively impaired to provide a goal and has no proxy or guardian who can respond on the participant's behalf meets the element.

Note: Goals determined solely by the provider, without participant input or automatically generated based on the participant's 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 plan of care to meet the participant's mental health or substance use disorder needs (e.g., depression, anxiety, alcohol, illicit substance use).

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

6. A list of all LTSS 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 LTSS meets the element.

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

8. 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 during a 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.

9. Name and contact information for a family or friend caregiver or caregivers who were involved in the participant's person-centered-plan development.

Documentation of no family, friend, or other caregiver (paid or unpaid) involvement meets the element. Documentation that family, friends, or other caregivers were invited but declined to participate in person-centered planning meets the element.

10. Agreement of the participant (or the participant's proxy or guardian[18]) to the completed person-centered plan, or appeal of all or part of the person-centered plan.

    Documentation that a person-centered plan was discussed or reviewed does *not* meet the measure; agreement or appeal by the participant or the proxy or guardian must be documented.

Rate 2: Person-Centered Plan with Supplemental Elements Documented

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

- **New participants.** An LTSS comprehensive person-centered plan, completed within 120 days of enrollment, containing all 10 core elements *and* at least 4 supplemental elements documented; or
- **Established participants.** An LTSS comprehensive person-centered plan, created during the measurement year, containing all 10 core elements *and* at least 4 supplemental elements documented.

The person-centered plan must be completed within 120 days of enrollment and must be updated annually thereafter.

Person-centered plans must be discussed during an encounter between the care manager and the participant.[19] The person-centered plan is not required to be created in the participant's home. The person-centered plan may be discussed during the same encounter as the comprehensive assessment.

The participant's person-centered plan must document evidence of the 10 core elements, defined above, evidence of at least 4 (of 7) supplemental elements, and the person-centered plan date.

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[18] A participant's proxy or guardian is anyone who has been authorized to make decisions on behalf of the participant; this includes, but is not limited to, a power of attorney, spouse, parent, or other family member. Documentation includes verbal agreement by the participant or guardian or proxy in person, by telephone, or via videoconference; the documentation may also be sent in writing (i.e., with signature) to the care manager.

[19] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care-planning questions as a reflection of how the participant would respond to the same questions.

Person-Centered Plan Supplemental Elements

Supplemental elements include documentation of the following:

1. 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 element.

2. Duration of all LTSS the participant receives (i.e., how long services will be provided or when need for services will be assessed) or is expected to receive in the next month, within 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 LTSS meets the element.

3. Contact information for the participant's LTSS providers.

   Documentation that the participant receives no LTSS meets the element.

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

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

6. The participant's first point of contact.

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

7. Contact information for the participant's PCP[20] (or a plan for connecting the participant to a PCP if the participant does not have one, currently).

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

Note: Technical specifications for FFS LTSS-3 can be found here.

Data source: Hybrid (Case Management Record and Administrative)

A. Description

The percentage of Medicaid MLTSS participants, aged 18 years and older, with a person-centered plan transmitted to their PCP (or other documented medical care provider) identified by the participant within 30 days of its development.

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

Guidance for Reporting
Performance Rate 1. *Participant with Person-Centered Plan Transmitted to PCP*. The percentage of Medicaid MLTSS participants whose person-centered 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 person-centered plan. *Exclusion Rate*[21] 1. *Participant Refused to Share Person-Centered Plan*. The percentage of Medicaid MLTSS participants who refused to have the person-centered plan shared with a PCP (or other documented medical care provider).

B. Definitions

Element	Definition
LTSS person-centered plan	A document or electronic tool that identifies participant needs, preferences, and risks; the document or tool contains a list of the services and supports planned to meet those needs while reducing risks. The person-centered plan must include 10 core elements and might also include supplemental elements. The document or electronic tool must include evidence that a participant agreed to the person-centered plan.[22]
Other documented medical care provider	A medical care provider identified by the participant as the primary point of contact for medical care. This provider need not be a PCP.
Primary care provider (PCP)	A physician, non-physician (e.g., nurse practitioner, physician assistant), other clinician, or group of providers who offer primary care medical services. Licensed practical nurses and registered nurses cannot be not considered PCPs.
Transmitted	Dissemination of the person-centered plan to the participant or providers via United States mail, fax, secure email, or mutual access to an electronic portal or electronic health record. *Note*: Transmitting the entire person-centered plan is unnecessary to meet the numerator criteria. Plans may select the most relevant portions of the person-centered plan or may provide a summary.

[21] Exclusion rates are reported to identify portions of the eligible population not included in the performance rate. Medicaid MLTSS participants have the right to refuse sharing of a person-centered plan with their PCP at any point following contact; plans might have difficulty contacting some participants eligible for inclusion in a measure's population.

[22] For the purposes of this measure, care plans that are under appeal are not expected to be shared by states and managed care plans, until the appeal process has been concluded.

C. Eligible Population

Element	Definition
Age	Aged 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 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use the assessment completed during the last continuous enrollment period of 150 days or more, occurring during the measurement year. *Note*: One hundred fifty days of continuous enrollment allows for a single sample to be used across the set of MLTSS measures: *Long-Term Services and Supports Comprehensive Assessment and Update* (MLTSS-1), which looks for assessment to be conducted within 90 days of enrollment; *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (MLTSS-2), which looks for a person-centered plan to be developed within 30 days of assessment or 120 days of enrollment; *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (MLTSS-3), which looks for a person-centered plan to be shared within 30 days of development; and Part 1 of *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls* (MLTSS-5), which looks for screening for fall risk.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services.)[23]
Event/diagnosis	Documentation of a person-centered plan with core elements, as specified in the *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (MLTSS-2) measure. If multiple person-centered plans are documented or updated in the measurement year, the numerator action can be identified after any of these events.
Required exclusions	Required exclusions are reported with the measure rate. Participants without a person-centered plan (or with a partial person-centered plan) are *not* excluded from the measure. *1. Participant Refused to Share Person-Centered Plan* • Participants who refuse to allow the person-centered plan to be shared. There must be documentation in the record that the participant refused to allow the person-centered plan to be shared. Notation of verbal refusal is sufficient. To calculate the rate of participants who refused person-centered plan sharing, divide the number of participants who meet this exclusion criterion by the number of participants meeting the continuous enrollment criterion.

[23] Provided in nursing facilities, ICFs/IID, hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in an IMD for individuals ages 65 and older.

D. Specifications

Denominator

This measure is based on a review of Medicaid MLTSS participant case management records, selected via 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* (MLTSS-1), *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (MLTSS-2), *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (MLTSS-3), and Part 1 of the *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls* (MLTSS-5) measures. Users should obtain a separate (or supplemental) sample for the *Reassessment and Person-Centered-Plan Update after Inpatient Discharge* (MLTSS-4) measure.

Numerator

The number of Medicaid MLTSS participants whose person-centered 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 person-centered plan (i.e., within 31 days, total, following finalization and agreement of the person-centered plan).

The documentation must show transmission at least once between August 1 of the year prior to the measurement year and December 31 of the measurement year. If multiple person-centered plans are documented or updated in the measurement year, evidence of one transmission within 30 days of the participant's agreement to the person-centered plan is sufficient to meet the numerator criteria. *Transmission of person-centered plans to a participant's PCP is the responsibility of the managed care plan or the state,* not *the participant.*

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

MLTSS-4: Managed Long-Term Services and Supports Reassessment and Person-Centered-Plan Update after Inpatient Discharge[24]

Note: Technical specifications for FFS LTSS-4 can be found here.

Data source: Hybrid (Case Management Record and Administrative)

[24] The following coding ontologies are used in this measure: ICD-10-CM, ICD-10-PCS, CPT, HCPCS, SNOMED CT, and UB. Refer to the **Acknowledgments** section, located at the beginning of this document, for copyright information.

A. Description

The percentage of discharges from inpatient facilities for Medicaid MLTSS participants, aged 18 years and older, for whom a reassessment and person-centered-plan update occurred within 30 days following discharge.

Guidance for Reporting
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 for Medicaid MLTSS participants that result in an LTSS reassessment within 30 days following discharge. 2. *Reassessment and Person-Centered-Plan Update after Inpatient Discharge*. The percentage of discharges from inpatient facilities for Medicaid MLTSS participants that result in an LTSS reassessment and person-centered-plan update within 30 days following discharge. *Exclusion Rates*[25] 1. *Discharges for Planned Admissions.* The percentage of hospital admissions that were planned. 2. *Participant Could Not Be Contacted*. The percentage of Medicaid MLTSS participants who could not be contacted for reassessment or person-centered-plan updates following inpatient discharges. At least three attempts to contact the participant were made and documented, including the date and mode of each contact (e.g., telephone call, letter, email), all of which were unsuccessful. 3. *Participant Refused Assessment or Person-Centered Planning*. The percentage of Medicaid MLTSS participants who refused reassessment or update to an LTSS person-centered plan following inpatient discharge.

B. Definitions

Element	Definition
LTSS reassessment	A discussion between the participant and the care manager that identifies the participant's health status and addresses the participant's needs, preferences, and risks. The assessment must include 10 core elements and might also include supplemental elements.

[25] *Exclusion rates* are reported to identify portions of the eligible population not included in the performance rate. Medicaid MLTSS participants have the right to refuse reassessment or person-centered planning at any point following contact; plans might have difficulty contacting some participants eligible for inclusion in a measure's population.

Element	Definition
LTSS person-centered plan	A document or electronic tool that identifies participant needs, preferences, and risks; the document or tool 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 person-centered plan. The person-centered plan must include 10 core elements and might also include supplemental elements.
Standardized tool	A set of structured questions that elicit participant information, which might 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 conducting a reassessment and updating a person-centered 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

Element	Definition
Age	Aged 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 following the date of discharge.
Allowable gap	None.
Anchor date	Date of discharge.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services) *and* benefit for medical care and services.[26] Benefits should be determined at the participant level. Any participant receiving a benefit for both LTSS 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, locate: 1. Acute and nonacute inpatient stays (using codes from the MLTSS-4 value set directory and inpatient stay revenue codes); and 2. Date of discharge for the stay (or stays). The denominator for MLTSS-4 is based on inpatient discharges, not on participants. If participants have more than one discharge, include all discharges that occur on or between January 1 and December 1 of the measurement year.
Modality	The reassessment or update to a person-centered plan must be discussed during a face-to-face, telephone, or videoconference encounter between the care manager and the participant.

[26] Provided in nursing facilities, ICFs/IID, hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in an IMD for individuals ages 65 and older.

Element	Definition
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 (i.e., over a 31-day period), count only the last discharge. To identify readmissions and direct transfers during the 31-day period, identify: 1. All acute and nonacute inpatient stays (using codes from the MLTSS-4 value set directory and inpatient stay revenue codes); 2. Stay admission date (admission date must occur during the 31-day period); and 3. Stay discharge date (date of discharge is the event date). Exclude both initial and readmission/direct transfer discharges if the final discharge occurs after December 1 during 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. However, 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 occurring prior to December 1. If the organization cannot confirm that 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* • Participants without a person-centered plan (or with a partial person-centered plan) are *not* excluded from the measure. Exclude planned hospital admissions from the measure denominator. A hospital stay is considered planned if it meets any of the following criteria: o Hospital stays with a principal diagnosis of pregnancy or a condition originating in the perinatal period (using codes from the MLTSS-4 value set directory for perinatal conditions); o Principal diagnosis of maintenance chemotherapy (using codes from the MLTSS-4 value set directory for chemotherapy encounters); o Principal diagnosis of rehabilitation (using codes from the MLTSS-4 value set directory for rehabilitation); Organ transplant (using codes from the MLTSS-4 value set directory for kidney transplant procedures, bone marrow transplant procedures, organ transplants [other than kidney procedures], and introduction of autologous pancreatic cells procedures); and o Potentially planned procedures (using codes from the MLTSS-4 value set directory for potentially planned procedures) without a principal acute diagnosis (using codes from the MLTSS-4 value set directory for acute conditions). • The exclusion for planned admissions is not reported with the measure performance rates.

Element	Definition
Required exclusions (continued)	*2. Participant Could Not Be Contacted* • Participants who could not be contacted for reassessment and update to the person-centered plan following inpatient discharge. At least three attempts were made to contact the participant, including the date and mode of each contact (e.g., telephone 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 criterion. *3. Participant Refused Assessment or Person-Centered Planning* • Participants who refused to participate in reassessment or update to an LTSS person-centered 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 criterion.

D. Specifications

Denominator

A systematic sample of inpatient discharges from the eligible population.

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

Numerator

Rate 1: Reassessment after Inpatient Discharge

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

Reassessment must be a discussion between the participant[27] and the care manager. Reassessment in the inpatient facility on the day of discharge meets the element.

Reassessment must document evidence of the 10 core elements described below and the reassessment date. Documenting *no change* does not meet the element.

Reassessment Core Elements

1. At least five of the following ADLs: 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).

[27] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care-planning questions as a reflection of how the participant would respond to the same questions.

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 and has no proxy or guardian who can respond on the participant's behalf 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 and has no proxy or guardian who can respond on the participant's behalf meets the element.
6. Assessment of the participant's current alcohol use, illicit substance use, or both alcohol *and* illicit substance use using a standardized tool, such as one of the following
    - Single question: "How many times in the past year have you had five (5) or more drinks in a day?" (for men under 65 years) *or* "How many times in the past year have

you had four (4) or more drinks in a day?" (for women and all adults older than 65 years).[28]

- 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 and has no proxy or guardian who can respond on the participant's behalf meets the element.

7. Assessment of home safety risks (e.g., home fall risks, bathroom safety, chemical hazards, food preparation safety, crime).

   A standardized tool is not required. Direct observation of home safety risks is not required; queries about potential home safety risks meet the element. Documentation that no home safety risks exist meets the element.

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

   A standardized tool is not required. Documentation of the living arrangements of the participant meets the element.

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

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

   Documentation that no family, friend, or other (paid or unpaid) is available meets the element.

10. Name and contact information for the participant's currently 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 Person-Centered Plan Update after Inpatient Discharge

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

[28] This single question has been validated against the Brief Alcohol Use Disorders Identification Test (AUDIT 1–3) and is approved by the Centers for Disease Control and Prevention as an appropriate screening instrument for excessive alcohol use (*source:* https://www.cdc.gov/ncbddd/fasd/documents/ AlcoholSBIImplementationGuide.pdf).

Reassessment must document evidence of the 10 core elements described above and the reassessment date.

The person-centered plan update must be conducted during an encounter between the care manager and the participant.[29] A person-centered plan updated in the inpatient facility on the day of discharge meets the requirement.

Person-centered plan update must document evidence of the 10 core elements described below and the person-centered plan date. Documenting *no change* does not meet the element.

Person-Centered Plan Core Elements

1. At least one individualized participant goal (medical or non-medical outcome important to the participant [e.g., 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 proxy or guardian who can respond on the participant's behalf is sufficient to meet the element.

   Note: Goals determined solely by the provider, without participant input or automatically generated based on the participant's 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.

[29] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care-planning questions as a reflection of how the participant would respond to the same questions.

5. A plan of care to meet the participant's mental health or substance use disorder needs (e.g., depression, anxiety, alcohol or illicit substance use).

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

6. A list of all LTSS 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 LTSS meets the element.

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

8. 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 during a 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.

9. Name and contact information for family or friend caregiver or caregivers who were involved in the participant's person-centered plan development.

   Documentation of no family, friend, or other caregiver (paid or unpaid) involvement meets the element. Documentation that family, friend, or other caregivers were invited but declined to participate in person-centered planning meets the element.

10. Agreement of the participant (or the participant's proxy or guardian[30]) to the completed person-centered plan, or appeal of all or part of the person-centered plan.

    Documentation that a person-centered plan was discussed or reviewed does *not* meet the measure; agreement or appeal by the participant or participant's representative must be documented.

[30] A participant's proxy or guardian is anyone who has been authorized to make decisions on behalf of the participant; this includes, but is not limited to, a power of attorney, spouse, parent, or other family member. Documentation includes verbal agreement by the participant or guardian or proxy in person, by telephone, or via videoconference; the documentation may also be sent in writing (i.e., with signature) to the care manager.

MLTSS-5: Managed Long-Term Services and Supports Screening, Risk Assessment, and Plan of Care to Prevent Future Falls[31]

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

Falls Part 1: Screening

Data source: Hybrid (Case Management Record and Administrative)

A. Description

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

Guidance for Reporting
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

Element	Definition
Fall	A *fall* is defined as a sudden, unintentional change in position, causing an individual to land at a lower level, on an object, on the floor, or on 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

Element	Definition
Age	Aged 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 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use the screening completed during the last continuous enrollment period of 150 days or more, occurring during the measurement year.

[31] There is no equivalent FFS measure for MLTSS-5.

Element	Definition
Continuous enrollment (continued)	*Note*: One hundred fifty days of continuous enrollment allows for a single sample to be used across the set of MLTSS measures: *Long-Term Services and Supports Comprehensive Assessment and Update* (MLTSS-1), which looks for assessment to be conducted within 90 days of enrollment; *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (MLTSS-2), which looks for a person-centered plan to be developed within 30 days of assessment or 120 days of enrollment; *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (MLTSS-3), which looks for a person-centered plan to be shared within 30 days of development; and Part 1 of *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls* (MLTSS-5), which looks for screening for fall risk.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services.)[32]
Event/diagnosis	None.
Modality	Assessment must be discussed during a face-to-face, telephone, or videoconference encounter between the care manager and the participant.
Required exclusions	*1.* Required exclusions are *not* reported with the measure rate. *Participants Who Are Not Ambulatory* • Medicaid MLTSS participants who are bedridden, immobile, or confined to a chair, as well as wheelchair users.

D. Specifications

Denominator

This measure is based on a review of Medicaid MLTSS participant case management records, selected via a systematic sample that was 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* (MLTSS-1), *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (MLTSS-2), *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (MLTSS-3), and Part 1 of *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls* (MLTSS-5) measures. Users should obtain a separate (or supplemental) sample for the *Reassessment and Person-Centered-Plan Update after Inpatient Discharge* (MLTSS-4) measure.

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.

[32] Provided in nursing facilities, ICFs/IID, and mental health facilities, including inpatient psychiatric hospital services for individuals under age 21 and services in IMD for individuals ages 65 and older.

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 Up & Go (TUG) 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

Data source: Case Management Record

A. Description

The percentage of Medicaid MLTSS participants, aged 18 and older, with a documented history of falls (i.e., at least two falls ever 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.

Guidance for Reporting
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 Risk Assessment and Plan of Care for Falls.* The percentage of Medicaid MLTSS plan participants who refused a risk assessment for falls, creation of a plan of care for falls, or both a risk assessment for falls *and* a plan of care for falls.

B. Definitions

Element	Definition
Fall	A *fall* is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, on the floor, or on the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.
Falls risk assessment	A *falls risk assessment* must include, at a minimum, a balance and gait assessment *and* one or more of the following assessments: postural blood pressure assessment, vision assessment, home fall hazards assessment, or documentation on whether medications are a contributing factor to falls.
Plan of care for falls	A plan of care to prevent falls must include, at a minimum, exercise therapy or referral to exercise.

C. Eligible Population

Element	Definition
Age	Aged 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 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use the last continuous enrollment period of 150 days or more, occurring during the measurement year.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services.)[33]
Event/diagnosis	A documented history of falls (at least two falls ever or one fall with injury in the past year). Documentation of the participant's self-reported history of falls is sufficient.
Modality	Person-centered plan must be discussed during a face-to-face, telephone, or videoconference encounter between the care manager and the participant.
Required exclusions	1. *Participant Refused Risk Assessment, Plan of Care for Falls, or Both Risk Assessment and Plan of Care for Falls* • Participants who refused a risk assessment, a plan of care, or both a risk assessment for falls *and* a plan of care for falls. Document that the participant was contacted and refused to participate in an assessment, plan of care development, or both a risk assessment for falls *and* a plan of care for falls. Exclusion of Medicaid MLTSS participants who refused risk assessment, plan of care development, or both risk assessment *and* plan of care development for falls is reported with the measure rate. 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 criterion. 2. *Participants Who Are Not Ambulatory* • Medicaid MLTSS participants who are bedridden, immobile, or confined to a chair, as well as wheelchair users. Exclusion of Medicaid MLTSS participants who are not ambulatory is *not* reported with the measure performance rates.

A. Specifications

Denominator

This measure is based on a review of Medicaid MLTSS participant case management records, selected via a systematic sample that was drawn from the eligible population.

[33] Provided in nursing facilities, ICFs/IID, hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in an IMD for individuals ages 65 and older.

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 assessment, vision assessment, home fall hazards assessment, or medication review. 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 conducted during an in-person assessment:
  - Documentation of observed transfer and walking;
  - Documented use of a standardized scale for assessment of balance and gait (e.g., Get-Up-and-Go test, Berg Functional Balance Scale, Tinetti Gait and Balance Test); or
  - 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 conducted during an in-person assessment:
  - Documentation that a participant is functioning well with vision based on discussion with the participant; or
  - 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 might 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; or
- Occupational therapy provided or referral for occupational therapy.

MLTSS-6: Managed Long-Term Services and Supports Admission to a Facility from the Community[34]

Note: Technical specifications for FFS LTSS-6 can be found here.

Data source: Administrative

A. Description

The number of admissions to a facility among Medicaid MLTSS participants, aged 18 years 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 months each participant is enrolled in the program and residing in the community for at least one day of the month.

Guidance for Reporting
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; and 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.

[34] The following coding ontology is used in this measure: UB. Refer to the **Acknowledgments** section, located at the beginning of this document, for copyright information.

B. Definitions

Element	Definition
Facility	Medicaid- or Medicare-certified nursing facilities, Medicaid-certified ICFs/IID, hospitals or hospitals and nursing facilities that are considered IMDs.
Community residence	Any residence that is not a facility (see definition above). *Note*: Residence might include the participant's home, assisted living, adult foster care, or other care in another setting 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 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 a participant dies or any subsequent months. See **Subsection D: Specifications** 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 admissions are based on paid claims only.

C. Eligible Population

Element	Definition
Age	Aged 18 and older as of the first day of the measurement year.
Continuous enrollment	The 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 July 31 of the measurement year.
Allowable gap	None.
Anchor date	None.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services) *and* benefit for medical care and services.[35] Benefits should be determined at the participant level. Any participant receiving a benefit for both LTSS and medical care through the Medicaid MLTSS plan is eligible for this measure.
Event/diagnosis	None
Required exclusions	1. *Participant Resided in a Facility for an Entire Month* • Participants whose residence was identified as within a facility (i.e., did not reside at home or a location identified as their home) do *not* contribute days in the community for this month. 2. *Participant Expired* • Participants who die during the measurement period contribute days in the community to the measure until the month in which they expire. The month of expiration (and any subsequent months for which coverage is extended) do *not* contribute days in the community.

[35] Provided in nursing facilities, ICFs/IID, and mental health facilities, including inpatient psychiatric hospital services for individuals under age 21 and services in IMD for individuals ages 65 and older.

D. Specifications

Denominator

Number of participant months where the participant was residing in the community for at least one day of the month.[36]

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 day of the month, the final 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 during the measurement period.

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 criterion.

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.

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

Numerator

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

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

Use the steps below to identify numerator events.

Step 1

Identify all facility admissions between August 1 of the year prior to the measurement year and July 31 of the measurement year (using codes from the MLTSS-6 through MLTSS-8 value set directory for facility Uniform Bill codes).

Step 2

Remove facility admissions that are direct transfers from another facility. Keep the original admission date as the date of new facility admission. 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 fewer. For example,

- A facility discharge occurs on June 1, followed by admission to another facility setting on June 1; this would be considered a **direct** transfer.
- A facility discharge occurs on June 1, followed by admission to another facility setting on June 2; this would be considered a **direct** transfer.
- A facility discharge occurs on June 1, followed by admission to another facility setting on June 3; this is **not** a direct transfer but rather reflects **two distinct new facility stays**.

Step 3

Remove admissions to the hospital that originated from a facility. Keep the original facility admission date (that preceded the admission to the hospital) as the new facility admission 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 facility admissions, look for the location of the first discharge in the measurement year:

- If the participant is discharged to the community, calculate *length of stay* as the date of facility discharge minus the index admission date.
- If there is no discharge, calculate length of stay 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 length of stay as the date of hospital discharge minus the facility admission 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 length of stay, include all hospital days between the facility admission 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 length of stay, include all facility days between the facility admission 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 length of stay for each facility admission as short-term (i.e., 1 to 20 days), medium-term (i.e., 21 to 100 days), or long-term (i.e., greater than or equal to 101 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.

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: Managed Long-Term Services and Supports Minimizing Facility Length of Stay[37]

Note: Technical specifications for FFS LTSS-7 can be found here.

Data source: Administrative

A. Description

The proportion of admissions to a facility among Medicaid MLTSS participants, aged 18 years and older, that result in successful discharge to the community (community residence for 60 or more days) within 100 days of admission.

Guidance for Reporting
This measure is reported as an observed rate and a risk-adjusted rate. The measure focuses on discharges within 100 days because admissions lasting longer than 100 days are generally considered a crossover point into long-term care. After that time, evidence shows that 1) a participant's residence in the facility becomes considered semi-permanent; 2) participants dually eligible for Medicare and Medicaid lose Medicare coverage for their facility stay; and 3) participants might lose their community-based housing, limiting the probability they can easily return to the community.

B. Definitions

Element	Definition
Facility	Medicaid- or Medicare-certified nursing facilities, Medicaid-certified ICFs/IID, hospitals or hospitals and nursing facilities that are considered IMDs.
Discharge to the community	A discharge to the community from the facility for all facility admissions 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 admission to the facility from the hospital setting only if the Medicaid MLTSS participant lived in the community prior to the hospital admission. Facility admission is based on paid claims only.

[37] The following coding ontology is used in this measure: UB. Refer to the **Acknowledgments** section, located at the beginning of this document, for copyright information.

Element	Definition
Community residence	Any residence that is not a facility (see definition above). *Note*: Community residence may include the participant's home, assisted living, adult foster care, or other care in another setting that is not defined as a facility.
Classification period	One hundred eighty days prior to and including the facility admission date.

C. Risk Adjustment Tables[38]

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

MinInstit—RAW: Weights for risk-adjustment weighting.

D. Eligible Population

Element	Definition
Age	Aged 18 and older as of the first day of the measurement year.
Continuous enrollment	Enrollment in the Medicaid MLTSS plan on the facility admission date through 160 days following the facility admission date.
Allowable gap	None.
Anchor date	Facility admission date.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services) *and* benefit for medical care and services.[39] Benefits should be determined at the participant level. Any participant receiving a benefit for both LTSS 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: Specifications** to identify new facility admissions.
Required exclusions	1. *Participant Transferred between Facilities* • Admissions associated with a transfer between facilities (i.e., a participant was admitted at one facility and transferred to another) are not included in the measure. 2. *Participant Expired* • Participants who expire while admitted (or within one day of admission) are removed from the measure.

[38] LTSS risk adjustment tables are available at https://www.medicaid.gov/media/3296.

[39] Provided in nursing facilities, ICFs/IID, hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in an IMD for individuals ages 65 and older.

E. Specifications

Denominator

Number of facility admissions occurring during the measurement period, removing those for which the admission represented a transfer between facilities and those for which an expiration occurred while admitted (on the same day as the admission or within one day of discharge).

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 (using codes from the MLTSS-6 through MLTSS-8 value set directory for facility Uniform Bill codes).

Step 2

Remove facility admissions that are direct transfers from another facility. Keep the original facility admission date as the date of the new facility admission. 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 fewer. For example,

- A facility discharge occurs on June 1, followed by an admission to another facility setting on June 1; this would be considered a **direct** transfer.
- A facility discharge occurs on June 1, followed by an admission to another facility setting on June 2; this would be considered a **direct** transfer.
- A facility discharge occurs on June 1, followed by an admission to another facility setting on June 3; this is **not** a direct transfer, but rather reflects **two distinct new facility stays**.

Step 3

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

Risk-Adjustment Determination

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

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

Dual eligibility. Determine the participant's status for dual eligibility for Medicare and Medicaid on the facility admission 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 the *Long-Term Services and Supports—CCW* table (within the *Risk-Adjustment Tables* workbook[40]), assign a CCW code to the facility admission based on diagnoses listed on the admission claim or claims. For direct transfers, use all diagnoses that occurred during the episode (i.e., original admission diagnoses and direct 'transfers' diagnoses). Exclude diagnoses that cannot be mapped to the *MinInstit—RAW* table.

Number of hospital stays. Determine whether the participant had any acute care hospitalizations in the six months prior to the measurement year. Classify the total acute hospitalizations as zero, one, or two or more.

Days of enrollment in Medicaid MLTSS plan. Determine the number of days the participant was enrolled in the Medicaid MLTSS plan prior to the facility admission 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 facility admission, use the following steps to identify risk-adjustment weights based on dual eligibility for Medicare and Medicaid, age, gender, diagnoses from the facility admission, number of hospital stays, and months of enrollment in the measurement period. Risk-adjustment weights are listed in *MinInstit—RAW* table.

Step 1

Identify the base weight.

Step 2

Link the age and gender weights for each facility admission.

Step 3

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

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[40] LTSS risk adjustment tables are available at https://www.medicaid.gov/media/3296.

Step 4

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

Step 5

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

Step 6

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

Step 7

Sum all weights associated with the facility admission (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 facility admission.

Expected Discharge Probability = [exp (sum of weights for facility admission)]/[1+exp (sum of weights for facility admission)][41]

Step 8

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

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

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 experienced a stroke. The participant was not dually eligible and had only three months' enrollment prior to the facility admission.

[41] *Exp* refers to the exponential or antilog function. The formula above could also be written with superscripts: e (sum of weights for facility admission)/1 + e (sum of weights for facility admission), 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.

Base Risk Weight	Age	Gender	Age and Gender Weight	Number of Hospital Stays		Facility-Admission 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 element.

Step 1

Identify all facility admissions (see **Denominator** criteria).

Step 2

Look for the location of the first discharge for each facility admission 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 length of stay as the date of facility discharge minus the index admission date.
- If there is no discharge, calculate length of stay as the date of the last day of the measurement year minus the facility 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 length of stay as the date of hospital discharge minus the facility admission date.
- If the participant is discharged to the hospital and dies in the hospital, exclude the admission from the facility admission 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 facility admission 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 occurs), 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 facility admissions with lengths of stay of fewer than or equal to 100 days. This number should include only discharges to the community (i.e., 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, expired, 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 (facility-admission count). Report the observed discharge rate as the observed performance rate for the *Minimizing Length of Facility Stay* (MLTSS-7) measure.

Calculate the expected discharge rate by dividing the expected count of successful discharges by the denominator (facility admission count). Report the expected discharge rate as the expected performance rate of the *Minimizing Length of Facility Stay* (MLTSS-7) measure.

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

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

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

The risk-adjusted rate (r_k) for the *Minimizing Facility Length of Stay* (MLTSS-7) measure 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: Managed Long-Term Services and Supports Successful Transition after Long-Term Facility Stay[42]

[42] The following coding ontology is used in this measure: UB. Refer to the **Acknowledgments** section, located at the beginning of this document, for copyright information.

Note: Technical specifications for FFS LTSS-8 can be found here.

Data source: Administrative

A. Description

The proportion of long-term facility stays among Medicaid MLTSS participants, aged 18 years and older, that result in successful transitions to the community (community residence for 60 or more days).

Guidance for Reporting
This measure is reported as an observed rate and a risk-adjusted rate.

B. Definitions

Element	Definition
Facility	Medicaid- or Medicare-certified nursing facilities, Medicaid-certified ICFs/IID, hospitals or hospitals and nursing facilities that are considered IMDs.
Discharge to the community	A discharge to the community from the facility for all facility admissions and prior facility admissions 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 (as defined above). *Note*: Community residence might include the participant's home, assisted living, adult foster care, or other care in another setting not defined as a facility.

C. Risk-Adjustment Tables[43]

Long-Term Services and Supports—CCW: ICD-10 codes for CCW classification.

LTTrans—RAW: Weights for risk-adjustment weighting.

D. Eligible Population

Element	Definition
Age	Aged 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 following discharge to the community, the continuous enrollment period does not include the period after expiration.
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 the year prior to the measurement year.

[43] LTSS risk adjustment tables are available at https://www.medicaid.gov/media/3296.

Element	Definition
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services) *and* benefit for medical care and services.[44] Benefits should be determined at the participant level. Any participant receiving a benefit for both LTSS and medical care through the Medicaid MLTSS plan is eligible for this measure.
Event/diagnosis	Facility admission with a length of stay of 101 days or more between July 1 of the year prior to the measurement year and June 30 of the measurement years *or* prior facility admission 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 prior facility admission is considered a stay of at least 101 days for a participant identified as residing in a facility on 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 E: Specifications** to identify new facility admissions and prior facility admissions.
Required exclusions	1. *Participant Transferred between Facilities* • Admissions associated with a transfer between facilities (i.e., a participant was admitted at one facility and transferred to another) are not included in the measure. 2. *Participant Expired* • Participants who expired while admitted (or within one day of admission) are removed from the measure.

E. Specifications

Denominator

Number of discharges occurring during the measurement period, removing those for which the discharge represented a transfer between facilities and those for which an expiration occurred while admitted (on the same day as the admission or within one day of discharge).

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 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 prior facility admissions.

[44] Provided in nursing facilities, ICFs/IID, and mental health facilities, including inpatient psychiatric hospital services for individuals under age 21 and services in IMD for individuals ages 65 and older.

Step 2

Identify all new admissions to facilities (nursing facilities, ICFs/IID, hospitals or hospitals and nursing facilities that are considered IMDs) from July 1 of the year prior to the measurement year through June 30 of the measurement year (using codes from the MLTSS-6 through MLTSS-8 value set directory for facility Uniform Bill codes). These admissions are considered facility admissions.

Step 3

Remove admissions that are direct transfers from another facility. Keep the original admission date as the date of new facility admission. 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 fewer. For example,

- Facility discharge occurs on June 1, followed by an admission to another facility setting on June 1; this would be considered a **direct** transfer.
- Facility discharge occurs on June 1, followed by an admission to another facility setting on June 2; this would be considered a **direct** transfer.
- Facility discharge occurs on June 1, followed by an admission to another facility setting on June 3; this is **not** a direct transfer, but rather reflects **two distinct new facility stays**.

Step 4

Remove admissions to the hospital that originated from a facility. Keep the original facility admission date (that preceded the admission to the hospital) as the new facility admission 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 the 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 length of stay as the date of facility discharge minus the index admission date.
- If there is no discharge, calculate the length of stay as the date of the last day of the measurement year minus the 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 length of stay as the date of hospital discharge minus the facility admission date. If the

participant is discharged from the hospital to the facility, repeat **Step 2** through **Step 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 occurred), repeat **Step 2** through **Step 6** until there is a discharge to the community or until the end of the measurement year.

Step 7

Remove all admissions where length of stay 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 (facility admission) and prior admissions that were residing in the facility on July 1 of the year prior to the measurement year (prior facility admission). These admissions are called long-term facility stays.

Risk-Adjustment Determination

For each long-term facility stay, use the following steps to identify risk-adjustment categories based on dual eligibility for Medicare and Medicaid, age, gender, diagnoses from the long-term facility stay, number of hospital stays, and months of enrollment in the measurement 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, aged 18 to 44; female, aged 45 to 64; female, aged 65 to 74; female, aged 75 to 84; female, aged 85 or older; male, aged 18 to 44; male, aged 45 to 64; male, aged 65 to 74; male, aged 75 to 84; and male, aged 85 or older.

Dual eligibility. Determine the participant's dual eligibility status for Medicare and Medicaid on the facility admission 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 long-term facility stay based on all diagnoses for the long-term facility stay episode (i.e., admission diagnoses, transfer diagnoses, interim claim diagnoses) using the *Long-Term Services and Supports—CCW* table.[45] For direct transfers, use the direct transfers discharge diagnoses. Exclude diagnoses that cannot be mapped to the *LTTrans—RAW* table.

[45] LTSS risk adjustment tables are available at https://www.medicaid.gov/media/3296.

Number of hospital stays. Determine whether the participant had any acute care hospitalizations in the classification period. Classify the total acute hospitalizations as zero, one, or two or more.

Days of enrollment in Medicaid MLTSS plan. Determine the number of days the participant was enrolled in the Medicaid MLTSS plan during the measurement period. Classify the total days of enrollment as fewer than 180 days or greater than or equal to 180 days.

Risk-Adjustment Weighting

For each long-term facility stay, use the following steps to identify risk-adjustment weights based on dual eligibility for Medicare and Medicaid, age, gender, diagnoses from the long-term facility stay, number of hospital stays, and months of enrollment in the measurement period. Risk-adjustment weights are listed in the *LTTrans—RAW* table.

Step 1

Identify the base weight.

Step 2

Link the age and gender weights for each long-term facility stay.

Step 3

For each long-term facility stay 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 long-term facility stay with a CCW category, link the long-term facility stay CCW category weight. Use all diagnoses that occurred across the long-term facility stay episode.

Step 5

For each long-term facility stay with one or more hospitalizations in the measurement period, link the number of hospitalizations weight.

Step 6

For each long-term facility stay with six months' or more enrollment prior to the measurement period, link the six months' enrollment weight.

Step 7

Sum all weights associated with the long-term facility stay (i.e., base, age and gender, dual eligibility for Medicare and Medicaid, long-term-facility stay diagnoses, number of

hospitalizations, and six months' enrollment weight) to calculate the expected estimated probability of successful transition to the community for each long-term facility stay.

Expected Transition Probability =
[exp (sum of weights for long-term facility stays)]/
[1+ exp (sum of weights for long-term facility stays)][46]

Step 8

Calculate the expected count of successful transitions to the community. The count of expected successful transitions is the sum of the estimated transition probability calculated in **Step 7** for each long-term facility stay.

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

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 diagnosed with ulcers. The participant was not dually eligible and had only three months' enrollment prior to the facility admission.

Base Risk Weight	**Age**	**Gender**	**Age and Gender Weight**	**Number of Hospital Stays**		**Long-Term-Facility-Stay 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 a 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 element.

[46] *Exp refers* to the exponential or antilog function. The formula above could also be written with superscripts: e (sum of weights for facility admission)/1 + e (sum of weights for facility admission), 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 1

Identify all long-term facility stays (see **Denominator** criteria).

Step 2

Look for the 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 to 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 long-term facility stay.

Step 4

Remove discharges to the community if the participant died between day 2 and day 60 in the 60 days after discharge from the long-term facility stay.

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 (long-term facility stay count).

Report the observed discharge rate as the observed performance rate of a successful transition to the community after the long-term facility stay.

Calculate the expected discharge rate by dividing the expected count of successful transitions by the denominator (i.e., the long-term facility stay count). Report the expected transition rate as the expected performance rate of a successful transition to the community after the long-term facility stay.

States and plans can understand their results by calculating the ratio of their observed-to-expected (O/E) rates. A ratio of greater than 1 implies a higher-than-expected rate of successful

transitions, whereas a ratio of less than 1 implies a lower-than-expected rate of successful transitions.

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

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

The risk-adjusted rate (r_k) of successful transition to the community after long-term facility stay for each plan, k, is equal to the following:

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

FFS LTSS-1: Fee-for-Service Long-Term Services and Supports Comprehensive Assessment and Update

Note: Technical specifications for MLTSS-1 can be found here.

Data source: Hybrid (Case Management Record and Administrative)

A. Description

The percentage of participants receiving Medicaid FFS LTSS, aged 18 years and older, who have documentation of a comprehensive assessment, completed in a specified timeframe, which includes documentation of core and supplemental elements.

Guidance for Reporting
Two performance rates and two exclusions rates are reported for this measure. *Performance Rates* 1. *Assessment of Core Elements*. The percentage of Medicaid FFS LTSS participants who had an LTSS comprehensive assessment with 10 core elements documented within 90 days of enrollment (for new participants) or during the measurement year (for established participants). 2. *Assessment of Supplemental Elements*. The percentage of Medicaid FFS LTSS participants who had an LTSS comprehensive assessment with 10 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[47]

1. *Participant Could Not Be Contacted*. The percentage of Medicaid FFS LTSS participants who could not be contacted for an LTSS comprehensive assessment within 90 days of enrollment (for new participants) or during the measurement year (for established participants).
2. *Participant Refused Assessment*. The percentage of Medicaid FFS LTSS participants who refused a comprehensive assessment.

B. Definitions

Element	Definition
LTSS assessment	A discussion with a participant in their home using a structured or semi-structured tool that addresses the participant's health status and needs, and the assessment includes a minimum of 10 core elements and might include supplemental elements.
New participant	A participant newly enrolled in Medicaid FFS LTSS between August 1 of the year prior to the measurement year and July 31 of the measurement year.
Established participant	A participant enrolled prior to August 1 of the year prior to the measurement year.
Home	The location where the participant lives, which might 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 might include person-reported outcome measures, screening or assessment tools, or standardized questionnaires developed by the state or by another organization to assess risks and needs.

C Eligible Population

Element	Definition
Age	Aged 18 and older as of the first day of the measurement year.
Continuous enrollment	A participant must be enrolled in Medicaid FFS LTSS for at least 150 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use the assessment completed during the last continuous enrollment period of 150 days or more, occurring during the measurement year. *Note*: One hundred fifty days of continuous enrollment allows for a single sample to be used across the set of FFS LTSS measures: *Long-Term Services and Supports Comprehensive Assessment and Update* (FFS LTSS-1), which looks for assessment to be conducted within 90 days of enrollment; *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (FFS LTSS-2), which looks for a person-centered plan to be developed within 30 days of assessment or 120 days of enrollment; and *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (FFS LTSS-3), which looks for a person-centered plan to be shared within 30 days of development.

[47] *Exclusion rates* are reported to identify portions of the eligible population not included in the performance rate. Medicaid FFS LTSS participants have the right to refuse an assessment at any point following contact; states might have difficulty contacting some participants eligible for inclusion in a measure's population.

Element	Definition
Allowable gap	None
Anchor date	December 31 of the measurement year.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services.)[48]
Event/diagnosis	None.
Modality	Assessment must be discussed during a face-to-face, telephone, or videoconference encounter between the care manager and the participant.
Required exclusions	Required exclusions are reported with the measure performance rate. Participants without a person-centered plan or with a partial person-centered plan are *not* excluded from the measure. *1. Participant Could Not Be Contacted* • New Medicaid FFS LTSS participants who could not be contacted for an LTSS comprehensive assessment within 90 days of enrollment; or • Established participants who could not be contacted for an LTSS comprehensive assessment during the measurement year. States use their own process for identifying participants who could not be contacted for assessment and documenting 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 criterion. *2. Participant Refused Assessment* • Medicaid FFS LTSS participants who refused a comprehensive assessment. States should document, in the case management record, that the participant was contacted and 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 criterion.

D. Specifications

Denominator

This measure is based on review of Medicaid FFS LTSS participant case management records, selected via 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* (FFS LTSS-1), *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (FFS LTSS-2), and *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (FFS LTSS-3) measures. Users should obtain a separate (or supplemental) sample for the

[48] Provided in nursing facilities, ICFs/IID, hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in an IMD for individuals ages 65 and older.

Reassessment and Person-Centered-Plan Update after Inpatient Discharge (FFS LTSS-4) measure.[49]

Numerator

The FFS LTSS-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 participants receiving Medicaid FFS LTSS who had *either* of the following:

- **New participants.** An LTSS comprehensive assessment, completed within 90 days of enrollment, containing all 10 core elements documented;[50] or
- **Established participants.** An LTSS comprehensive assessment, completed at least once during the measurement year, containing all 10 core elements documented.

The assessment must be a discussion with the participant[51] in the participant's home and must be performed face-to-face, via telephone, or via videoconference. Assessment in a 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* refused telephone or videoconference assessment);
- The participant is residing in an inpatient or institutional facility (e.g., hospital, skilled nursing facility, other post-acute-care facility) during the assessment period; or
- The state policy, regulation, or other state guidance (e.g., state FFS LTSS policy guidance) excludes the participant from a requirement for in-home assessment.

Assessment Core Elements

The Medicaid FFS LTSS participant's assessment must include documentation of the following 10 core elements and the assessment date:

1. At least five of the following ADLs: 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).

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[49] *Note:* The initial population for rate 2 for the FFS LTSS-5 measure is derived from those who fall into the numerator of rate 1.

[50] If the comprehensive assessment (or part of the comprehensive assessment) is conducted as part of the process to determine eligibility for the LTSS benefit, and it occurs within 30 days prior to the enrollment start date, it may be counted in the numerator as long as the assessment meets the numerator criteria for the rate.

[51] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care planning questions as a reflection of how the participant would respond to the same questions.

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)
    - Informant Questionnaire on Cognitive Decline in the Elderly
    - 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 and has no proxy or guardian who can respond on the participant's behalf 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 and has no proxy or guardian who can respond on the participant's behalf meets the element.
6. Assessment of the participant's current alcohol, illicit substance use, or both alcohol *and* illicit substance use using a standardized tool, such as one of the following:
    - Single question: "How many times in the past year have you had five (5) or more drinks in a day?" (for men under 65 years) *or* "How many times in the past year have

you had four (4) or more drinks in a day?" (for women and all adults older than 65 years).[52]

- 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 and has no proxy or guardian who can respond on the participant's behalf meets the element.

7. Assessment of home safety risks (e.g., home fall risks, bathroom safety, chemical hazards, food preparation safety, crime).

   A standardized tool is not required. Direct observation of home safety risks is not required; queries about potential home safety risks meet the element. Documentation that no home safety risks exist meets the element.

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

   A standardized tool is not required. Documentation of the living arrangements of the participant meets the element.

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

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

   Documentation that no family, friend, or other caregiver (paid or unpaid) is available meets the element.

10. Name and contact information for the participant's currently 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).

[52] This single question has been validated against the Brief Alcohol Use Disorders Identification Test (AUDIT 1–3) and is approved by the Centers for Disease Control and Prevention as an appropriate screening instrument for excessive alcohol use (*Source:* https://www.cdc.gov/ncbddd/fasd/documents/ AlcoholSBIImplementationGuide.pdf).

Rate 2: Assessment of Supplemental Elements

The number of participants receiving Medicaid FFS LTSS who had *either* of the following:

- **New participants.** An LTSS comprehensive assessment, completed within 90 days of enrollment, containing all 10 core elements *and* at least 12 supplemental elements documented;[53] or
- **Established participants.** An LTSS comprehensive assessment, completed during the measurement year, containing all 10 core elements *and* at least 12 supplemental elements documented.

The assessment must be a discussion with the participant[54] in the participant's home and must be performed face-to-face, via telephone, or via videoconference. Assessment in a 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 refused telephone or videoconference assessment);
- The participant is residing in an inpatient or institutional facility (e.g., hospital, skilled nursing facility, other post-acute-care facility) during the assessment period; or
- The state policy, regulation, or other state guidance (e.g., state FFS LTSS policy guidance) excludes the participant from a requirement for in-home assessment.

The participant's assessment must document evidence of the 10 core elements defined above, as well as document evidence of at least 12 (of 18) supplemental elements and the assessment date.

Assessment Supplemental Elements

Supplemental elements include documentation of the following:

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

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[53] If the comprehensive assessment (or part of the comprehensive assessment) is conducted as part of the process to determine eligibility for the LTSS benefit, and it occurs within 30 days prior to the enrollment start date, it may be counted in the numerator, as long as the assessment meets the numerator criteria for the rate.

[54] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care-planning questions as a reflection of how the participant would respond to the same questions.

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, such as the following.
   - Self-rated health single question: "In general, would you say that your health is excellent, very good, good, fair, or poor?"[55]
   - 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 and has no proxy or guardian who can respond on the participant's behalf 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 and has no proxy or guardian who can respond on the participant's behalf 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.

[55] The self-rated health single question allows the clinician to perform a quick global assessment of participant-perceived well-being. It was originally administered alongside the Parsley Symptom Index and has been validated for use as a single question (*Source:* https://www.ncbi.nlm.nih.gov/pmc/articles/ PMC9673004/).

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 risk of falls, or no problem with balance or gait meets the element.

11. Smoking status, including whether the participant is currently a smoker or tobacco user.

    Documentation that the participant currently neither smokes nor uses tobacco meets the element.

12. 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 subsidies, gas subsidies, housing subsidies).

    Documentation that the participant does not use resources to address social risk factors meets the element.

13. 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]).

14. Assessment of participant's self-reported social isolation or loneliness using a standardized tool, such as the following:

    - 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 and has no proxy or guardian who can respond on the participant's behalf meets the element.

15. Cultural and linguistic preferences (e.g., participant's culture, preferred language, need for interpreter services).

16. Existence of an advance care plan, including some or all of the following:
    - Preferences for life-sustaining treatment and end-of-life care or documented surrogate decision maker;
    - Surrogate decisionmaker—a document designating someone other than the participant to make medical treatment choices;
    - Advance directive—a directive about treatment preferences or designation of a surrogate who can make medical decisions if the participant 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., 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; and
    - 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.

    The participant's indication that he or she does not wish to discuss an advance care plan 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. All oral statements must be documented in writing.
17. Current engagement or preference for engaging in work or volunteer activities.

    Documentation of the participant's current work or volunteer status meets the element.
18. Recent use of medical services (e.g., emergency department services, hospitalization, home health, skilled nursing facility, paid home healthcare).

    Documentation of no recent use of medical services meets the element.

FFS LTSS-2: Fee-for-Service Long-Term Services and Supports Comprehensive Person-Centered Plan and Update

Note: Technical specifications for MLTSS-2 can be found here.

Data source: Hybrid (Case Management Record and Administrative)

A. Description

The percentage of Medicaid FFS LTSS participants, aged 18 years and older, who have documentation of an LTSS comprehensive person-centered plan, completed in a specified timeframe, which includes documentation of core and supplemental elements.

Guidance for Reporting
Two performance rates and two exclusion rates are reported for this measure. *Performance Rates* 1. *Person-Centered Plan with Core Elements*. The percentage of Medicaid FFS LTSS participants who had an LTSS comprehensive person-centered plan with 10 core elements documented within 120 days of enrollment (for new participants) or during the measurement year (for established participants). 2. *Person-Centered Plan with Supplemental Elements*. The percentage of Medicaid FFS LTSS participants who had an LTSS comprehensive person-centered plan with 10 core elements *and* at least 4 supplemental elements documented within 120 days of enrollment (for new participants) or during the measurement year (for established participants). *Exclusion Rates*[56] 1. *Participant Could Not Be Contacted*. The percentage of Medicaid FFS LTSS participants who could not be contacted to create an LTSS comprehensive person-centered plan within 120 days of enrollment (for new participants) or during the measurement year (for established participants). 2. *Participant Refused Person-Centered Planning*. The percentage of Medicaid FFS LTSS participants who refused a comprehensive person-centered plan.

B. Definitions

Element	Definition
LTSS person-centered plan	A document or electronic tool that identifies participant needs, preferences, and risks; the document or tool 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 person-centered plan.

[56] *Exclusion rates* are reported to identify portions of the eligible population not included in the performance rate. Medicaid FFS LTSS participants have the right to refuse person-centered planning at any point following contact; states might have difficulty contacting some participants eligible for inclusion in a measure's population.

Element	Definition
Care manager	The person responsible for conducting an assessment and developing a person-centered plan with a participant. The Medicaid FFS LTSS program may designate an agency employee or a contracted employee. The care manager is not required to have a specific type of professional license.
New participant	A participant newly enrolled in Medicaid FFS LTSS between August 1 of the year prior to the measurement year and July 31 of the measurement year.
Established participant	A participant enrolled prior to August 1 of the year prior to the measurement year.

C. Eligible Population

Element	Definition
Age	Aged 18 and older as of the first day of the measurement year.
Continuous enrollment	A participant must be enrolled in Medicaid FFS LTSS for at least 150 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use the assessment completed during the last continuous enrollment period of 150 days or more, occurring during the measurement year. *Note*: One hundred fifty days of continuous enrollment allows for a single sample to be used across the set of FFS LTSS measures: *Long-Term Services and Supports Comprehensive Assessment and Update* (FFS LTSS-1), which looks for assessment to be conducted within 90 days of enrollment; *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (FFS LTSS-2), which looks for a person-centered plan to be developed within 30 days of assessment or 120 days of enrollment; and *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (FFS LTSS-3), which looks for a person-centered plan to be shared within 30 days of development.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services.)[57]
Event/diagnosis	None.
Modality	The person-centered plan must be discussed during a face-to-face, telephone, or videoconference encounter between the care manager and the participant.

[57] Provided in nursing facilities, ICFs/IID, hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in an IMD for individuals ages 65 and older.

Element	Definition
Required exclusions	Required exclusions are reported with the measure rates. Participants without a person-centered plan or with a partial person-centered plan are *not* excluded from the measure. *1. Participant Could Not Be Contacted* • New Medicaid FFS LTSS participants who could not be contacted to create an LTSS comprehensive person-centered plan within 120 days of enrollment; or • Established Medicaid FFS LTSS participants who could not be contacted to create an LTSS comprehensive person-centered plan during the measurement year. States use their own process for identifying participants who could not be contacted for person-centered planning and for documenting that at least three attempts were made to contact the participant. To calculate the rate of participants who could not be reached for person-centered planning, divide the number of participants meeting this exclusion criterion by the number of participants meeting the continuous enrollment criterion. *2. Participant Refused Person-Centered Planning* • Participants who refused a comprehensive person-centered plan. States should document, in the case management record, that the participant was contacted and that the participant refused to participate in a person-centered plan. To calculate the rate of participants who refused person-centered planning, divide the number of participants who meet this exclusion criterion by the number of participants meeting the continuous enrollment criterion.

D. Specifications

Denominator

This measure is based on a review of Medicaid FFS LTSS participant case management records, selected via 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* (FFS LTSS-1), *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (FFS LTSS-2), and *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (FFS LTSS-3) measures. Users should obtain a separate (or supplemental) sample for the *Reassessment and Person-Centered Plan Update after Inpatient Discharge* (FFS LTSS-4) measure.

Numerator

Rate 1: Person-Centered Plan with Core Elements

The number of Medicaid FFS LTSS participants who had *either* of the following:

- **New participants.** An LTSS comprehensive person-centered plan completed within 120 days of enrollment, containing all 10 core elements documented; or

- **Established participants.** An LTSS comprehensive person-centered plan completed at least once during the measurement year, containing all 10 elements documented.

Person-centered plans must be discussed during an encounter between the care manager and the participant.[58] The person-centered plan is not required to be created in the participant's home. The person-centered plan may be discussed during the same encounter as the comprehensive assessment.

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

Person-Centered Plan Core Elements

The initial person-centered plan or person-centered plan update must include documentation of the following 10 core elements and the person-centered plan date:

1. At least one individualized participant goal (medical or non-medical outcome important to the participant [e.g., 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 proxy or guardian who can respond on the participant's behalf meets the element.

   Note: Goals determined solely by the provider, without participant input or automatically generated based on the participant's 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).

[58] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care-planning questions as a reflection of how the participant would respond to the same questions.

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 plan of care to meet the participant's mental health or substance use disorder needs (e.g., depression, anxiety, alcohol or illicit substance use).

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

6. A list of all LTSS 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 LTSS meets the numerator criteria.

7. A plan for the care manager to follow up and communicate with the participant (i.e., follow-up and communication schedule).

8. 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 during a natural disaster).

   Note: At a minimum, the plan must include the name of Medicaid FFS LTSS program staff or a contracted provider to contact in an emergency.

9. Name and contact information for family or friend caregivers who were involved in the participant's person-centered plan development.

   Documentation of no family, friend, or other caregiver (paid or unpaid) involvement meets the element. Documentation that family, friends, or other caregivers were invited but declined to participate in person-centered planning meets the element.

10. Agreement of the participant (or the participant's proxy or guardian[59]) to the completed person-centered plan or appeal of all or part of the person-centered plan.

    Documentation that a person-centered plan was discussed or reviewed does *not* meet the measure; agreement or appeal by the participant or the proxy or guardian must be documented.

[59] A participant's proxy or guardian is anyone who has been authorized to make decisions on behalf of the participant; this includes, but is not limited to, a power of attorney, spouse, parent, or other family member. Documentation includes verbal agreement by the participant or guardian or proxy in person, by telephone, or via videoconference; the documentation may also be sent in writing (i.e., with signature) to the care manager.

Rate 2: Person-Centered Plan with Supplemental Elements Documented

The number of Medicaid FFS LTSS participants who had *either* of the following:

- **New participants.** An LTSS comprehensive person-centered plan, completed within 120 days of enrollment, containing all 10 core elements *and* at least 4 supplemental elements documented; or
- **Established participants.** An LTSS comprehensive person-centered plan, created during the measurement year, containing all 10 core elements *and* at least 4 supplemental elements documented.

The person-centered plan must be completed within 120 days of enrollment and must be updated annually thereafter.

Person-centered plans must be discussed during an encounter between the care manager and the participant.[60] The person-centered plan is not required to be created in the participant's home. The person-centered plan may be discussed during the same encounter as the comprehensive assessment.

The participant's person-centered plan must document evidence of the 10 core elements, defined above, evidence of at least 4 (of 7) supplemental elements, and the person-centered plan date.

Person-Centered Plan Supplemental Elements

Supplemental elements include the following:

1. 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 element.

2. Duration of all LTSS the participant receives (i.e., how long services will be provided or when need for services will be assessed) or is expected to receive in the next month, within 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 LTSS meets the element.

3. Contact information for the participant's LTSS providers.

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[60] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care-planning questions as a reflection of how the participant would respond to the same questions.

Documentation that the participant receives no LTSS meets the element.

4. A plan to assess the participant's progress toward meeting established goals, including a timeframe for reassessment and follow-up.
5. Documentation of barriers to the participant's meeting defined goals (e.g., life, community, or health factors that might make meeting goals difficult for the participant).
6. The participant's first point of contact.

   The care manager's contact information, if provided to the participant, meets the element.
7. Contact information for the participant's PCP[61] or a plan for connecting the participant to a PCP if the participant does not have one, currently.

FFS LTSS-3: Fee-for-Service Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider

Note: Technical specifications for MLTSS-3 can be found here.

Data source: Hybrid (Case Management Record and Administrative)

A. Description

The percentage of Medicaid FFS LTSS participants, aged 18 and older, with a person-centered plan transmitted to their PCP (or other documented medical care provider) identified by the participant within 30 days of its development.

Guidance for Reporting
Performance Rate 1. *Participant with Person-Centered Plan Transmitted to PCP*. The percentage of Medicaid FFS LTSS participants whose person-centered 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 person-centered plan. *Exclusion Rate*[62] 1. *Participant Refused to Share Person-Centered Plan*. The percentage of Medicaid FFS LTSS participants who refused to have the person-centered plan shared with a PCP (or other documented medical care provider).

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

[62] *Exclusion rates* are reported to identify portions of the eligible population not included in the performance rate. Medicaid FFS LTSS participants have the right to refuse sharing of a person-centered plan with their PCP at any point following contact; states might have difficulty contacting some participants eligible for inclusion in a measure's population.

B. Definitions

Element	Definition
LTSS person-centered plan	A document or electronic tool that identifies participant needs, preferences, and risks; the document or tool contains a list of the services and supports planned to meet those needs while reducing risks. The person-centered plan must include 10 core elements and might also include supplemental elements. The document or electronic tool must include evidence that a participant agreed to the person-centered plan.[63]
Other documented medical care provider	A medical care provider identified by the participant as the primary point of contact for medical care. This provider need not be a PCP.
Primary care provider	A physician, non-physician (e.g., nurse practitioner, physician assistant), other clinician, or group of providers who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.
Transmitted	Dissemination of the person-centered plan to the participant or providers via United States mail, fax, secure email, or mutual access to an electronic portal or electronic health record. *Note*: Transmitting the entire person-centered plan is unnecessary to meet the numerator criteria. States may select the most relevant parts of the person-centered plan or may provide a summary.

C. Eligible Population

Element	Definition
Age	Aged 18 and older as of the first day of the measurement year.
Continuous enrollment	A participant must be enrolled in Medicaid FFS LTSS for at least 150 days, continuously, between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use the assessment completed during the last continuous enrollment period of 150 days or more, occurring during the measurement year. *Note*: One hundred fifty days of continuous enrollment allows for a single sample to be used across the set of FFS LTSS measures: *Long-Term Services and Supports Comprehensive Assessment and Update* (FFS LTSS-1), which looks for assessment to be conducted within 90 days of enrollment; *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (FFS LTSS-2), which looks for a person-centered plan to be developed within 30 days of assessment or 120 days of enrollment; and *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (FFS LTSS-3), which looks for a person-centered plan to be shared within 30 days of development.
Allowable gap	None.
Anchor date	December 31 of the measurement year.

[63] For the purposes of this measure, care plans that are under appeal are not expected to be shared by states and managed care plans, until the appeal process has been concluded.

Element	Definition
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services.)[64]
Event/diagnosis	Documentation of a person-centered plan with core elements, as specified in the *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (FFS LTSS-2) measure. If multiple person-centered plans are documented or updated in the measurement year, the numerator action can be identified after any of these events.
Required exclusions	Required exclusions are reported with the measure rate. Participants without a person-centered plan or with a partial person-centered plan are *not* excluded from the measure. *1. Participant Refused to Share Person-Centered Plan* • Participants who refuse to allow the person-centered plan to be shared. There must be documentation in the record that the participant refused to allow the person-centered plan to be shared. Notation of verbal refusal is sufficient. To calculate the rate of participants who refused person-centered plan sharing, divide the number of participants who meet this exclusion criterion by the number of participants meeting the continuous enrollment criterion.

D. Specifications

Denominator

This measure is based on a review of Medicaid FFS LTSS participant case management records, selected via 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* (FFS LTSS-1), *Long-Term Services and Supports Comprehensive Person-Centered Plan and Update* (FFS LTSS-2), and *Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider* (FFS LTSS-3) measures. Users should obtain a separate (or supplemental) sample for the *Reassessment and Person-Centered Plan Update after Inpatient Discharge* (FFS LTSS-4) measure.

Numerator

The number of Medicaid FFS LTSS participants whose person-centered 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 person-centered plan (i.e., 31 days, total, following finalization and agreement of the person-centered plan)

The documentation must show transmission at least once between August 1 of the year prior to the measurement year and December 31 of the measurement year. If multiple person-centered plans are documented or updated in the measurement year, evidence of one transmission within 30 days of the participant's agreement to the person-centered plan is sufficient to meet the

[64] Provided in nursing facilities, ICFs/IID, and mental health facilities, including inpatient psychiatric hospital services for individuals under age 21 and services in IMD for individuals ages 65 and older.

numerator criteria. *Transmission of person-centered plans to participants' PCPs is the responsibility of the managed care plan or the state,* not *the participant.*

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

FFS LTSS-4: Fee-for-Service Long-Term Services and Supports Reassessment and Person-Centered-Plan Update after Inpatient Discharge[65]

Note: Technical specifications for MLTSS-4 can be found here.

Data source: Hybrid (Case Management Record and Administrative)

A. Description

The percentage of discharges from inpatient facilities for Medicaid FFS LTSS participants, aged 18 and older, for whom a reassessment and person-centered-plan update occurred within 30 days following discharge.

Guidance for Reporting
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 for Medicaid FFS LTSS participants that result in an LTSS reassessment within 30 days following discharge. 2. *Reassessment and Person-Centered-Plan Update after Inpatient Discharge*. The percentage of discharges from inpatient facilities for Medicaid FFS LTSS participants that result in an LTSS reassessment and person-centered-plan update within 30 days following discharge.

[65] The following coding ontologies are used in this measure: ICD-10-CM, ICD-10-PCS, CPT, HCPCS, SNOMED CT, and UB. Refer to the **Acknowledgments** section, located at the beginning of this document, for copyright information.

Exclusion Rates[66]

1. *Discharges for Planned Admissions.* The percentage of hospital admissions that were planned.
2. *Participant Could Not Be Contacted.* The percentage of Medicaid FFS LTSS participants who could not be contacted for reassessment and person-centered-plan updates following inpatient discharges.

   At least three attempts to contact the participant were made and documented, including the date and mode of each contact (e.g., telephone call, letter, email), all of which were unsuccessful.
3. *Participant Refused Assessment or Person-Centered Planning.* The percentage of Medicaid FFS LTSS participants who refused reassessment or update to an LTSS person-centered plan following inpatient discharge.

B. Definitions

Element	Definition
LTSS reassessment	A discussion between the participant and the care manager that identifies the participant's health status and addresses the participant's needs, preferences, and risks. The assessment must include 10 core elements and might also include supplemental elements.
LTSS person-centered plan	A document or electronic tool that identifies participant needs, preferences, and risks; and the document or tool 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 person-centered plan. The person-centered plan must include 10 core elements and might also include supplemental elements.
Standardized tool	A set of structured questions that elicit participant information, which might include person-reported outcome measures, screening or assessment tools, or standardized questionnaires developed by the state, the Medicaid FFS LTSS program, or another organization to assess risks and needs
Care manager	The person responsible for conducting a reassessment and updating a person-centered plan for a participant. The Medicaid FFS LTSS program may designate an agency employee or a contracted employee. The care manager is not required to have a specific type of professional license.

[66] *Exclusion rates* are reported to identify portions of the eligible population not included in the performance rate. Medicaid FFS LTSS participants have the right to refuse reassessment or person-centered planning at any point following contact; states might have difficulty contacting some participants eligible for inclusion in a measure's population.

C. Eligible Population

Element	Definition
Age	Aged 18 and older as of the first day of the measurement year.
Continuous enrollment	Enrollment in Medicaid FFS LTSS on the date of discharge through 30 days following the date of discharge.
Allowable gap	None.
Anchor date	Date of discharge.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services) *and* benefit for medical care and services.[67] Benefits should be determined at the participant level. Any participant receiving a benefit for both LTSS and medical care through Medicaid FFS LTSS 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, locate: 1. Acute and nonacute inpatient stays (using codes from the FFS LTSS-4 value sets directory and inpatient stay revenue codes); and 2. Date of discharge for the stay (or stays). The denominator for FFS LTSS-4 is based on inpatient discharges, not on participants. If participants have more than one discharge, include all discharges that occur on or between January 1 and December 1 of the measurement year.
Modality	The reassessment or update to a person-centered plan must be discussed during a face-to-face, telephone, or videoconference encounter between the care manager and the participant.
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 (i.e., over a 31-day period), count only the last discharge. To identify readmissions and direct transfers during the 31-day period, identify 1. All acute and nonacute inpatient stays (using codes from the FFS LTSS-4 value set directory and inpatient stay revenue codes); 2. Stay admission date (admission date must occur during the 31-day period); and 3. Stay discharge date (date of discharge is the event date). Exclude both initial and readmission/direct transfer discharges if the final discharge occurs after December 1 during 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. However, the state 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 prior to December 1. If the state cannot confirm that 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.

[67] Provided in nursing facilities, ICFs/IID, hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in an IMD for individuals ages 65 and older.

Element	Definition
Required exclusions	*1. Discharges for Planned Admissions* • Participants without a person-centered plan (or with a partial person-centered plan) are *not* excluded from the measure. • Exclude planned hospital admissions from the measure denominator. A hospital stay is considered planned if it meets any of the following criteria: o Hospital stays with a principal diagnosis of pregnancy or a condition originating in the perinatal period (using codes from the FFS LTSS-4 value set directory for perinatal conditions); o Principal diagnosis of maintenance chemotherapy (using codes from the FFS LTSS-4 value set directory for chemotherapy encounters); o Principal diagnosis of rehabilitation (using codes from the FFS LTSS-4 value set directory for rehabilitation); Organ transplant (using codes from the FFS LTSS-4 value set directory for kidney transplant procedures, bone marrow transplant procedures, organ transplants than kidney procedures], and introduction of autologous pancreatic cells procedures); and o Potentially planned procedure (using codes from the FFS LTSS-4 value set directory for potentially planned procedures) without a principal acute diagnosis (using codes from the FFS LTSS-4 value set directory for acute conditions). • 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 reassessment and update to the person-centered plan following inpatient discharge At least three attempts were made to contact the participant, including the date and mode of each contact (e.g., telephone 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 criterion. *3. Participant Refused Assessment or Person-Centered Planning* • Participants who refused to participate in reassessment or update to an LTSS person-centered 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 criterion.

D. Specifications

Denominator

A systematic sample of inpatient discharges from the eligible population.

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

Numerator

Rate 1: Reassessment after Inpatient Discharge

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

Reassessment must be a discussion between the participant[68] and the care manager. Reassessment in the inpatient facility on the day of discharge meets the requirement.

Reassessment must document evidence of the 10 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 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 and has no proxy or guardian who can respond on the participant's behalf 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)

[68] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable to do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care-planning questions as a reflection of how the participant would respond to the same questions.

- 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 and has no proxy or guardian who can respond on the participant's behalf meets the element.

6. Assessment of the participant's current alcohol or other illicit substance use or both using a standardized tool, such as one of the following:
   - Single question: "How many times in the past year have you had five (5) or more drinks in a day?" (for men under 65 years) *or* "How many times in the past year have you had four (4) or more drinks in a day?" (for women and all adults older than 65 years).
   - 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 and has no proxy or guardian who can respond on the participant's behalf meets the element.
7. Assessment of home safety risks (e.g., home fall risks, bathroom safety, chemical hazards, food preparation safety, crime).

   A standardized tool is not required. Direct observation of home safety risks is not required; queries about potential home safety risks meet the element. Documentation that no home safety risks exist meets the element.
8. Confirmation of living arrangements (e.g., nursing facility, assisted living, adult foster care, general community, other setting).

   A standardized tool is not required. Documentation of the living arrangements of the participant meets the element.
9. Confirmation of current and future family or friend caregiver (or both family and friend caregiver) availability with name and contact information for caregivers (paid or unpaid).

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

Documentation that no family, friend, or other caregiver (paid or unpaid) is available meets the element.

10. Name and contact information for the participant's currently 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 Person-Centered Plan Update after Inpatient Discharge

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

Reassessment must document evidence of the 10 core elements described above and the reassessment date.

The person-centered plan update must be conducted during an encounter between the care manager and the participant.[69] A person-centered plan updated in the inpatient facility on the day of discharge meets the requirement.

Person-centered plan update must document evidence of the 10 core elements described below and the person-centered plan date. Documenting *no change* does not meet the element.

Person-Centered Plan Core Elements

1. At least one individualized participant goal (medical or nonmedical outcome important to the participant [e.g., 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 proxy or guardian who can respond on the participant's behalf 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.

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[69] Although care managers should encourage sampled LTSS participants to respond directly to the assessment or person-centered-plan questions, some participants are unable do so. A care manager could decide that a proxy or guardian may complete the assessment and person-centered planning for a participant who cannot physically, mentally, or cognitively respond directly to a question or questions; the proxy or guardian may also answer a subset of the questions from the assessment or person-centered plan to support the participant. The proxy or guardian would complete the assessment or care-planning questions as a reflection of how the participant would respond to the same questions.

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 plan of care to meet the participant's mental health or substance use disorder needs (e.g., depression, anxiety, alcohol or illicit substance use).

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

6. A list of all LTSS 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 LTSS meets the element.

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

8. 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 during a natural disaster).

   Note: At a minimum, the plan must include the name of Medicaid FFS LTSS program staff or a contracted provider to contact in an emergency.

9. Name and contact information for family or friend caregiver or caregivers who were involved in the participant's person-centered plan development.

   Documentation of no family, friend, or other caregiver (paid or unpaid) involvement meets the element. Documentation that family, friend, or other caregivers were invited but declined to participate in person-centered planning meets the element.

10. Agreement of the participant (or the participant's proxy or guardian[70]) to the completed person-centered plan, or appeal of all or part of the person-centered plan.

[70] A participant's proxy or guardian is anyone who has been authorized to make decisions on behalf of the participant; this includes, but is not limited to, a power of attorney, spouse, parent, or other family member. Documentation includes verbal agreement by the participant or guardian or proxy in person, by telephone, or via videoconference; the documentation may also be sent in writing (i.e., with signature) to the care manager.

Documentation that a person-centered plan was discussed or reviewed does *not* meet the measure; agreement or appeal by the participant or participant's representative must be documented.

FFS LTSS-6: Admission to a Facility from the Community among Medicaid Fee-for-Service HCBS Participants[71]

Note: Technical specifications for MLTSS-6 can be found here.

Data source: Administrative

A. Description

The number of admissions to a facility among Medicaid FFS LTSS participants, aged 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 months each participant is enrolled in the program and residing in the community for at least one day of the month.

Guidance for Reporting
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 FFS LTSS participant months; 2. *Medium-Term Stay*. The rate of admissions resulting in a medium-term stay (21 to 100 days) per 1,000 Medicaid FFS LTSS participant months; and 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 FFS LTSS participant months.

B. Definitions

Element	Definition
Facility	Medicaid- or Medicare-certified nursing facilities, Medicaid-certified ICFs/IID, hospitals or hospitals and nursing facilities that are considered IMDs.
Community residence	Any residence that is not a facility (see definition above). *Note*: Residence might include the participant's home, assisted living, adult foster care, or other care in another setting that is not defined as a facility.

[71] The following coding ontology is used in this measure: UB. Refer to the **Acknowledgments** section, located at the beginning of this document, for copyright information.

Element	Definition
Participant months	Participant months are a Medicaid FFS LTSS participant's contribution to the total yearly enrollment. Participant months are calculated by summing the total months each participant is receiving Medicaid FFS LTSS and residing in the community for at least 1 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 a participant dies or any subsequent months. See **Subsection D: Specifications** 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 is based on paid claims only.

C. Eligible Population

Element	Definition
Age	Aged 18 and older as of the first day of the measurement year
Continuous enrollment	The participant must be enrolled in Medicaid FFS LTSS for at least 30 days between August 1 of the year prior to the measurement year and July 31 of the measurement year.
Allowable gap	None.
Anchor date	None.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services) *and* benefit for medical care and services.[72] Benefits should be determined at the participant level. Any participant receiving a benefit for both LTSS and medical care through Medicaid FFS LTSS is eligible for this measure.
Event/diagnosis	None.
Required exclusions	*1. Participant Resided in a Facility for an Entire Month* • Participants whose residence was identified as within a facility (i.e., did not reside at home or a location identified as their home) do not contribute days in the community for this month. *2. Participant Expired* • Participants who die during the measurement period contribute days in the community to the measure until the month in which they expire. The month of expiration (and any subsequent months for which coverage is extended) do *not* contribute to days in the community.

[72] Provided in nursing facilities, ICFs/IID, and mental health facilities, including inpatient psychiatric hospital services for individuals under age 21 and services in IMD for individuals ages 65 and older.

D. Specifications

Denominator

Number of participant months where the participant was residing in the community for at least one day of the month.[73]

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 day of the month, the final 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 Medicaid FFS LTSS 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 during the measurement period.

Step 3

Identify the months when the Medicaid FFS LTSS 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 criterion.

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 10 participant months to the 65 to 74 age group category.

[73] For example, if a participant were admitted to a facility on February 12 and were 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.

Numerator

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

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

Use the steps below to identify numerator events.

Step 1

Identify all facility admissions between August 1 of the year prior to the measurement year and July 31 of the measurement year (using codes from the FFS LTSS-6 through FFS LTSS-8 value set directory for facility Uniform Bill codes).

Step 2

Remove facility admissions that are direct transfers from another facility. Keep the original admission date as the date of new facility admission. 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 fewer. For example,

- A facility discharge occurs on June 1, followed by admission to another facility setting on June 1; this would be considered a **direct** transfer.
- A facility discharge occurs on June 1, followed by admission to another facility setting on June 2 this would be considered a **direct** transfer.
- A facility discharge occurs on June 1, followed by admission to another facility setting on June 3; this is not a direct transfer but rather reflects **two distinct new facility stays**.

Step 3

Remove admissions to the hospital that originated from a facility. Keep the original facility admission date (that preceded the admission to the hospital) as the new facility admission 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 facility admissions, look for the location of the first discharge in the measurement year:

- If the participant is discharged to the community, calculate *length of stay* as the date of facility discharge minus the index admission date.
- If there is no discharge, calculate length of stay 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 length of stay as the date of hospital discharge minus the facility admission 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 length of stay, include all hospital days between the facility admission 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 length of stay, include all facility days between the facility admission 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 length of stay for each facility admission as short-term (i.e., 1 to 20 days), medium-term (i.e., 21 to 100 days), or long-term (i.e., greater than or equal to 101 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.

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.

FFS LTSS-7: Fee-for-Service Long-Term Services and Supports Minimizing Facility Length of Stay[74]

Note: Technical specifications for MLTSS-7 can be found here.

Data source: Administrative

A. Description

The proportion of admissions to a facility among Medicaid FFS LTSS participants, aged 18 years and older, that result in successful discharge to the community (community residence for 60 or more days) within 100 days of admission.

Guidance for Reporting
This measure is reported as an observed rate and a risk-adjusted rate. The measure focuses on discharges within 100 days because admissions lasting longer than 100 days are generally considered a crossover point into long-term care. After that time, evidence shows that 1) a participant's residence in the facility becomes considered semi-permanent; 2) participants dually eligible for Medicare and Medicaid lose Medicare coverage for their facility stay; and 3) participants might lose their community-based housing, limiting the probability they can easily return to the community.

B. Definitions

Element	Definition
Facility	Medicaid- or Medicare-certified nursing facilities, Medicaid-certified ICFs/IID, hospitals or hospitals and nursing facilities that are considered IMDs.
Discharge to the community	A discharge to the community from the facility for all facility admissions 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 FFS LTSS 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 FFS LTSS participant lived in the community prior to the hospital admission. Facility admission is based on paid claims only.

[74] The following coding ontology is used in this measure: UB. Refer to the **Acknowledgments** section, located at the beginning of this document, for copyright information.

Element	Definition
Community residence	Any residence that is not a facility (see definition above) *Note*: Community residence might include the participant's home, assisted living, adult foster care, or other care in another setting that is not defined as a facility.
Classification period	One hundred eighty days prior to and including the facility admission date.

C. Risk Adjustment Tables[75]

Long-Term Services and Supports—CCW: ICD-10 codes for CCW classification.

MinInstit—RAW: Weights for risk-adjustment weighting.

D. Eligible Population

Element	Definition
Age	Aged 18 and older as of the first day of the measurement year
Continuous enrollment	Participants receiving Medicaid FFS LTSS on the facility admission date through 160 days following the facility admission date.
Allowable gap	None.
Anchor date	Facility admission date.
Benefit	LTSS (home and community-based services [HCBS]), institutional services, or both HCBS *and* institutional services) *and* benefits for medical care and services.[76] Benefits should be determined at the participant level. Any participant receiving a benefit for both LTSS and medical care through Medicaid FFS LTSS 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 FFS LTSS programs should follow the steps below in **Subsection E: Specifications** to identify new facility admissions.
Required exclusions	1. *Participant Transferred between Facilities* • Admissions associated with a transfer between facilities (i.e., a participant was admitted at one facility and transferred to another) are not included in the measure. 2. *Participant Expired* • Participants who expire while admitted (or within one day of admission) are removed from the measure.

[75] LTSS risk adjustment tables are available at https://www.medicaid.gov/media/3296.

[76] Provided in nursing facilities, ICFs/IID, hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in an IMD for individuals ages 65 and older.

E. Specifications

Denominator

Number of facility admissions occurring during the measurement period, removing those for which the admission represented a transfer between facilities and those for which an expiration occurred while admitted (on the same day as the admission or within one day of discharge).

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 (using codes from the FFS LTSS-6 through FFS LTSS-8 value set directory for facility Uniform Bill codes).

Step 2

Remove facility admissions that are direct transfers from another facility. Keep the original facility admission date as the date of the new facility admission. 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 fewer. For example,

- A facility discharge occurs on June 1, followed by an admission to another facility setting on June 1; this would be considered a **direct** transfer.
- A facility discharge occurs on June 1, followed by an admission to another facility setting on June 2; this would be considered a **direct** transfer.
- A facility discharge occurs on June 1, followed by an admission to another facility setting on June 3; this is **not** a direct transfer, but rather reflects **two distinct new facility stays**.

Step 3

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

Risk-Adjustment Determination

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

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

Dual eligibility. Determine the participant's status for dual eligibility for Medicare and Medicaid on the facility admission 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 the *Long-Term Services and Supports—CCW* table (within the *Risk Adjustment Tables* workbook[77]), assign a CCW code to the facility admission based on diagnoses listed on the admission claim or claims. For direct transfers, use all diagnoses that occurred during the episode (i.e., original admission diagnoses and direct 'transfers' diagnoses). Exclude diagnoses that cannot be mapped to the *MinInstit—RAW* table.

Number of hospital stays. Determine whether the participant had any acute care hospitalizations in the six months prior to the measurement year. Classify the total acute hospitalizations as zero, one, or two or more.

Days of enrollment in Medicaid FFS LTSS. Determine the number of days the participant was enrolled in Medicaid FFS LTSS prior to the facility admission 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 facility admission, use the following steps to identify risk-adjustment weights based on dual eligibility for Medicare and Medicaid, age, gender, diagnoses from the facility admission, number of hospital stays, and months of enrollment in the classification period. Risk adjustment weights are listed in the *MinInstit—RAW* table.

Step 1

Identify the base weight.

Step 2

Link the age and gender weights for each facility admission.

Step 3

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

[77] LTSS risk adjustment tables are available at https://www.medicaid.gov/media/3296.

Step 4

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

Step 5

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

Step 6

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

Step 7

Sum all weights associated with the facility admission (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 facility admission.

$$\text{Expected Discharge Probability} = [\exp(\text{sum of weights for facility admission})]/[1+\exp(\text{sum of weights for facility admission})]$$ [78]

Step 8

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

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

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 experienced a stroke. The participant was not dually eligible and had only three months' enrollment prior to the facility admission.

Base Risk Weight	**Age**	**Gender**	**Age and Gender Weight**	**Number of Hospital Stays**		**Facility-Admission 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

[78] *Exp* refers to the exponential or antilog function. The formula above could also be written with superscripts: e (sum of weights for facility admission)/1 + e (sum of weights for facility admission), 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.

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 element.

Step 1

Identify all facility admissions (see **Denominator** criteria).

Step 2

Look for the location of the first discharge for each facility admission 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 length of stay as the date of facility discharge minus the index admission date.
- If there is no discharge, calculate length of stay as the date of the last day of the measurement year minus the facility 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 length of stay as the date of hospital discharge minus the facility admission date.
- If the participant is discharged to the hospital and dies in the hospital, exclude the admission from the facility admission 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 facility admission 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 occurs), 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 facility admissions with lengths of stay of fewer than or equal to 100 days. This number should include only discharges to the community (i.e., 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 (facility admission count). Report the observed discharge rate as the observed performance rate for the *Minimizing Length of Facility Stay* (FFS LTSS-7) measure.

Calculate the expected discharge rate by dividing the expected count of successful discharges by the denominator (facility admission count). Report the expected discharge rate as the expected performance rate of the *Minimizing Length of Facility Stay* (FFS LTSS-7) measure.

States 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 it by the sum of all observed denominator events.

The risk-adjusted rate (r_k) for the *Minimizing Facility Length of Stay* (FFS LTSS-7) measure for each entity, k, is equal to the O/E ratio multiplied by the multi-population rate, Y.

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

FFS LTSS-8: Fee-for-Service Long-Term Services and Supports Successful Transition after Long-Term Facility Stay[79]

Note: Technical specifications for MLTSS-8 can be found here.

Data source: Administrative

[79] The following coding ontology is used in this measure: UB. Refer to the **Acknowledgments** section, located at the beginning of this document, for copyright information.

A. Description

The proportion of long-term facility stays among Medicaid FFS LTSS participants, aged 18 years and older, that result in successful transitions to the community (community residence for 60 or more days).

Guidance for Reporting
This measure is reported as an observed rate and a risk-adjusted rate.

B. Definitions

Element	Definition
Facility	Medicaid- or Medicare-certified nursing facilities, Medicaid-certified ICFs/IID, hospitals or hospitals and nursing facilities that are considered IMDs.
Discharge to the community	A discharge to the community from the facility for all facility admissions and prior facility admissions 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 FFS LTSS 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 (as defined above). *Note*: Community residence might include the participant's home, assisted living, adult foster care, or other care in another setting not defined as a facility.

C. Risk Adjustment Tables[80]

Long-Term Services and Supports—CCW: ICD-10 codes for CCW classification.

LTTrans—RAW: Weights for risk-adjustment weighting.

D. Eligible Population

Element	Definition
Age	Aged 18 and older as of July 1 of the year prior to the measurement year.
Continuous enrollment	Continuously enrolled in Medicaid FFS LTSS 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 the year prior to the measurement year.

[80] LTSS risk adjustment tables are available at https://www.medicaid.gov/media/3296.

Element	Definition
Benefit	LTSS (home and community-based services [HCBS], institutional services, or both HCBS *and* institutional services) *and* benefits for medical care and services.[81] Benefits should be determined at the participant level. Any participant receiving a benefit for both LTSS and medical care through Medicaid FFS LTSS is eligible for this measure.
Event/Diagnosis	Facility admission with a length of stay of 101 days or more between July 1 of the year prior to the measurement year and June 30 of the measurement year *or* prior facility admission 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 prior facility admission 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. States should follow the steps in **Subsection E: Specifications** to identify new facility admissions and prior facility admissions.
Required exclusions	1. *Participant Transferred between Facilities* • Admissions associated with a transfer between facilities (i.e., a participant was admitted at one facility and transferred to another) are not included in the measure. 2. *Participant Expired* • Participants who expired while admitted (or within one day of admission) are removed from the measure.

E. Specifications

Denominator

Number of discharges occurring during the measurement period, removing those for which the discharge represented a transfer between facilities and those for which an expiration occurred while admitted (on the same day as the admission or within one day of discharge).

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 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 prior facility admissions.

[81] Provided in nursing facilities, ICFs/IID, hospitals and hospitals and nursing facilities furnishing inpatient psychiatric hospital services for individuals under age 21 and services in an IMD for individuals ages 65 and older.

Step 2

Identify all new admissions to facilities (nursing facilities, ICFs/IID, hospitals or hospitals and nursing facilities that are considered IMDs) from July 1 of the year prior to the measurement year through June 30 of the measurement year (using codes from the FFS LTSS-6 through FFS LTSS-8 value set directory for facility Uniform Bill codes). These admissions are considered facility admissions.

Step 3

Remove admissions that are direct transfers from another facility. Keep the original admission date as the date of new facility admission. 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 fewer. For example,

- Facility discharge occurs on June 1, followed by an admission to another facility setting on June 1; this would be considered a **direct** transfer.
- Facility discharge occurs on June 1, followed by an admission to another facility setting on June 2; this would be considered a **direct** transfer.
- Facility discharge occurs on June 1, followed by an admission to another facility setting on June 3; this is not a direct transfer, but rather reflects **two distinct new facility stays**.

Step 4

Remove admissions to the hospital that originated from a facility. Keep the original facility admission date (that preceded the admission to the hospital) as the new facility admission 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 the 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 length of stay as the date of facility discharge minus the index admission date.
- If there is no discharge, calculate length of stay 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 length of stay as the date of hospital discharge minus the facility admission date. If the

participant is discharged from the hospital to the facility, repeat **Step 2** through **Step 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 occurred), repeat **Step 2** through **Step 6** until there is a discharge to the community or until the end of the measurement year.

Step 7

Remove all admissions where length of stay 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 (facility admission) and prior admissions that were residing in the facility on July 1 of the year prior to the measurement year (prior facility admission). These admissions are called long-term facility stays.

Risk-Adjustment Determination

For each long-term facility stay, use the following steps to identify risk adjustment categories based on dual eligibility for Medicare and Medicaid, age and gender, diagnoses from the long-term facility stay, 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, aged 18 to 44; female, aged 45 to 64; female, aged 65 to 74; female, aged 75 to 84; female, aged 85 or older; male, aged 18 to 44; male, aged 45 to 64; male, aged 65 to 74; male, aged 75 to 84; and male, aged 85 or older.

Dual eligibility. Determine the participant's dual eligibility status for Medicare and Medicaid on the facility admission 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 long-term facility stay based on all diagnoses for the long-term facility stay episode (e.g., admission diagnoses, transfer diagnoses, interim claim diagnoses) using the *Long-Term Services and Supports—CCW* table.[82] For direct transfers, use the direct transfer's discharge diagnoses. Exclude diagnoses that cannot be mapped to the *LTTrans—RAW* table.

[82] LTSS risk adjustment tables are available at https://www.medicaid.gov/media/3296.

Number of hospital stays. Determine whether the participant had any acute care hospitalizations in the classification period. Classify the total acute hospitalizations as zero, one, or two or more.

Days of enrollment in Medicaid FFS LTSS. Determine the number of days the participant was enrolled in Medicaid FFS LTSS during the measurement period. Classify the total days of enrollment as fewer than 180 days or greater than or equal to 180 days.

Risk-Adjustment Weighting

For each long-term facility stay, use the following steps to identify risk-adjustment weights based on dual eligibility for Medicare and Medicaid, age, gender, diagnoses from the long-term facility stay, number of hospital stays, and months of enrollment in the measurement period. Risk-adjustment weights are listed in the *LTTrans—RAW* table.

Step 1

Identify the base weight.

Step 2

Link the age and gender weights for each long-term facility stay.

Step 3

For each long-term facility stay 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 long-term facility stay with a CCW category, link the long-term facility stay CCW category weight. Use all diagnoses that occurred across the long-term facility stay episode.

Step 5

For each long-term facility stay with one or more hospitalizations in the classification period, link the number of hospitalizations weight.

Step 6

For each long-term facility stay 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 long-term facility stay (i.e., base, age and gender, dual eligibility for Medicare and Medicaid, long-term facility stay diagnoses, number of

hospitalizations, and six months' enrollment weight) to calculate the expected estimated probability of successful transition to the community for each long-term facility stay.

Expected Transition Probability =
[exp (sum of weights for long-term facility stays)]/
[1+ exp (sum of weights for long-term facility stays)][83]

Step 8

Calculate the expected count of successful transitions to the community. The count of expected transitions is the sum of the estimated transition probability calculated in **Step 7** for each long-term facility stay.

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

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 diagnosed with ulcers. The participant was not dually eligible and had only three months' enrollment prior to the facility admission.

Base Risk Weight	Age	Gender	Age and Gender Weight	Number of Hospital Stays		Long-Term Facility Stay 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 a 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 element.

[83] *Exp* refers to the exponential or antilog function. The formula above could also be written with superscripts: e (sum of weights for facility admission)/1 + e (sum of weights for facility admission), 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 1

Identify all long-term facility stays (see **Denominator** criteria).

Step 2

Look for the 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 to 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 long-term facility stay.

Step 4

Remove discharges to the community if the participant died between days 2 and 60 in the 60 days after discharge from the long-term facility stay.

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 (long-term facility stay count).

Report the observed discharge rate as the observed performance rate of a successful transition to the community after the long-term facility stay.

Calculate the expected discharge rate by dividing the expected count of successful transitions by the denominator (long-term facility stay count). Report the expected transition rate as the expected performance rate of a successful transition to the community after the long-term 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 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-population rate.

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

The risk-adjusted rate (r_k) of successful transition to the community after long-term facility stay for each entity, *k*, is equal to the following:

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

Appendix A: Standardized Tools Bibliographic References

Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument

Saunders, J.B., Aasland, O.G., Babor, T.F., de la Fuente, J.R., and Grant, M. (1993). Development of the alcohol use disorders identification test (AUDIT): World Health Organization collaborative project on early detection of persons with harmful alcohol consumption II. *Addiction*; 88:791–804. doi: 10.1111/j.1360-0443.1993.tb02093.x

Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Screening Instrument

Higgins-Biddle, J.C., & Babor, T.F. (2018). A review of the Alcohol Use Disorders Identification Test (AUDIT), AUDIT-C, and USAUDIT for screening in the United States: Past issues and future directions. *The American Journal of Drug and Alcohol Abuse*; 44(6), 578–586. doi: 10.1080/00952990.2018.1456545

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. https://pubmed.ncbi.nlm.nih.gov/1468055

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. https://psycnet.apa.org/record/1979-10129-001

Cornell Scale Screening

Alexopoulos, G.A., Abrams, R.C., Young, R.C., & Shamoian, C.A. (1988). Cornell scale for depression in dementia. *Biol Psych*; 23:271–284. https://cgatoolkit.ca/Uploads/ContentDocuments/cornell_scale_depression.pdf

Depression Scale (DEPS)

Salokangas, R.K.R., Poutanen, O., & Stengård, E. (1995). Screening for depression in primary care: Development and validation of the Depression Scale, a screening instrument for depression. *Acta Psychiatr Scand*; 92(1):10. https://pubmed.ncbi.nlm.nih.gov/7572242

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.*

Eight-Item Informant Interview to Differentiate Aging and Dementia (AD8™)

Galvin, J., Roe, C., & Morris, J. (2012). P3-088: The ad8 dementia screening test detects mild cognitive impairment. *Alzheimer's & Dementia*, 8(4S_Part_13). https://doi.org/10.1016/j.jalz.2012.05.1307

Five Wishes

Five Wishes booklet. (n.d.). *Five Wishes.* https://www.fivewishes.org/for-myself

General Practitioner Assessment of Cognition (GPCOG)

Seeher, K. M., & Brodaty, H. (2017). The general practitioner assessment of cognition (GPCOG). *Cognitive Screening Instruments*, 231–239. https://doi.org/10.1007/978-3-319-44775-9_10

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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.

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