MATHEMATICA
Policy Research

FROM: Mathematica Policy Research **DATE:** 9/05/2016

SUBJECT: Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees:
Questions for Public Comment on Managed Long-Term Services and Supports (MLTSS) Measures

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Project Overview:
The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following groups of Medicaid beneficiaries: (1) those eligible for both Medicare and Medicaid, or "dual enrollees"; (2) those receiving long-term services and supports (LTSS) through managed care organizations or through fee-for-service arrangements; and, (3) people with complex needs and high costs, substance use disorders, and physical and mental health integration needs. The contract number is HHSM-500-2013-13011I, Task Order #HHSM-500-T0004.

Documents and Measures for Comment:
As part of its measure development process, CMS requests interested parties to submit comments on the candidate or concept measures that may be suitable for this project.

This call for public comment concerns the measure specifications, and justification, for eight (8) measures for Medicaid beneficiaries enrolled in managed long-term services and supports (MLTSS) programs:

1. MLTSS-1 Comprehensive LTSS Assessment and Update
2. MLTSS-2 Comprehensive LTSS Care Plan and Update
3. MLTSS-3 LTSS Shared Care Plan
4. MLTSS-4 Re-assessment and Care Plan Update After Discharge
5. MLTSS-5 Falls Risk Screening, Assessment and Plan of Care
6. MLTSS-6 Admission to an Institution from the Community
7. MLTSS-7 Successful Discharge to the Community after Short-stays in an Institution
8. MLTSS-8 Successful Transition to the Community after Long-stays in an Institution

The Measure Information Forms (MIFs) and Measure Justification Forms (MJFs) for the 8 measures are available in separate files here: <MLTSS MIFs & MJFs.zip>

The project team seeks public comment on the following questions:

<u>General Questions</u>

1. Are the candidate measures <u>useful for measuring important domains of quality</u> for the Medicaid MLTSS enrollee population?

2. Are you aware of any new or additional measures (beyond those listed in the MJF) that have already been validated and widely used, are now under development, or will be submitted for consensus-based entity (NQF) endorsement?
3. Are the measure specifications in the MIFs clear, for example, the numerator, denominator, and any potential exclusions? What should be more clearly defined?
4. Are any revisions to the specifications needed either to make measure reporting more feasible, or to include or exclude certain individuals or events?
5. Are you aware of any new or additional studies that should be included in the MJF that support (or weaken) the justification for developing the measure? If so, please describe the findings and provide a full citation.

Questions specific to MLTSS measures

6. MLTSS 1 and MLTSS 2: Comprehensive LTSS Assessment & Care Plan. These measures currently require all of the required numerator elements to be documented to meet the numerator criteria (i.e. "all or nothing"). Should the measures use an alternative approach, for example, one in which documenting 5 out of 10 or 8 out of 10 of the domains would be sufficient to meet numerator criteria?
7. MLTSS-4: Re-Assessment and Care Plan Update After Discharge. Should this measure exclude from the denominator **planned** admissions to the hospital such as those for rehabilitation, organ transplant and chemotherapy?
8. MLTSS-5 Falls Risk Screening, Assessment and Plan of Care. This measure currently is specified to assess fall risk screening among all MLTSS enrollees age 18 and older. Is the use of screening in the population under age 65 justified and supported by the evidence?
9. MLTSS-5 Falls Risk Screening, Assessment and Plan of Care. This measure currently is specified to assess whether individuals at risk of future falls (i.e., individuals with a history of falls) received a recommendation for exercise (or physical therapy) and consideration of vitamin D therapy in accordance with recommendations from the US Preventive Services Task Force. Is it appropriate to hold MLTSS plans accountable for ensuring individuals at risk of falls receive consideration of Vitamin D therapy?

Public Comment Instructions:

- If you are providing comments on behalf of an organization, include the organization's name and contact information.
- If you are commenting as an individual, submit identifying or contact information.
- Please do not include personal health information in your comments.
- In the subject line of your message, put **Public Comments MLTSS**
- Send your comments **by close of business September 29, 2016** to MedicaidQualMeasures@mathematica-mpr.com

Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "dual enrollees"
- People receiving long-term services and supports (LTSS) through Medicaid managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program.

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on August 12, 2016.

Measure Name: Comprehensive LTSS Assessment and Update

Descriptive Information

Measure Name (Measure Title De.2.)

Comprehensive Long Term Services and Supports (LTSS) Assessment and Update

Measure Type De.1.

Process

Brief Description of Measure De.3.

The percentage of Medicaid Managed Long Term Services and Supports (MLTSS) plan enrollees who have documentation of a comprehensive assessment within the appropriate time frame (within 90 days of enrollment or annually).

If Paired or Grouped De.4.

This measure is grouped with two other measures that assess the continuum of assessment, care planning and care coordination. This continuum of care is described in greater detail in the accompanying Measure Justification Form.

- Comprehensive LTSS Care Plan
- Shared Care Plan measures.

Subject/Topic Areas De.5.

- See crosscutting areas

Crosscutting Areas De 6.

- Health and Functional Status: Health and Functional Status
- Health and Functional Status: Development/Wellness
- Health and Functional Status: Functional Status
- Prevention: Prevention
- Prevention: Social Determinants
- Care Coordination: Care Coordination
- Functional Status
- Safety: Safety

Measure Specifications

Measure-specific Web Page S.1.

Not applicable. This measure is still under development.

If This Is an eMeasure S.2a.

Not applicable. This is not an eMeasure.

Data Dictionary, Code Table, or Value Sets S.2b.
Not applicable. This measure is still under development.

For Endorsement Maintenance S.3.
Not applicable. This measure is still under development.

Numerator Statement S.4.
Medicaid MLTSS plan enrollees who had either of the following:

- A comprehensive assessment within 90 days of enrollment for new enrollees, or
- A comprehensive assessment at least once during the measurement year for all other enrollees.

Note: Numerator statement may change as this measure is still under development.

Time Period for Data S.5.
15 months (October 1 of the year prior to the measurement year to December 31 of the measurement year).

Numerator Details S.6.
Definitions (*Note: Numerator definitions and details may change as this measure is still under development.)*

Assessment: A face-to-face discussion with the enrollee in the home (unless there is documentation of a enrollee refusing in-home assessment) using a structured or semi-structured tool that assesses the enrollee's health status and needs in all of the following domains: (1) physical functioning and disability, (2) medical conditions, (3) mental and behavioral health, (4) needs, (5) risks, (6) social support, (7) preferences, and (8) use of services. Each domain is defined below.

Physical functioning/disability: The enrollee's ability to carry out various activities. Assessment must include documentation of limitations in activities of daily living, instrumental activities in daily living, and current use of accommodations related to the physical disability, such as use of assistive technology.

Medical conditions: The enrollee's overall health status, acute and chronic health conditions, and list of current medications.

Mental and behavioral health: The enrollee's mental and behavioral health functioning. Assessment must include cognitive function (concentration, memory, and/or problem solving abilities), behavior difficulties, mental health status (mood, affect, and/or anxiety), and patient activation or self-efficacy.

Needs: Enrollee needs that must include vision, hearing, speech, and physical/occupational therapy needs.

Risks: Enrollee risk factors that must include assessment of falls risk, home safety risks, alcohol and other drug use, and smoking.

Social support: The enrollee's living arrangement and the availability of social support. Assessment must include living arrangement, availability of friend or family caregiver support, availability of public and plan benefits (Medicare, Medicaid, Supplemental Security Income, transportation services, and housing subsidies), availability of social support in community, and assessment of social isolation or other social issues.

Preferences: Enrollee preferences that must include cultural and linguistic needs, documentation of advance care planning or enrollee refusal of advance care planning, preference for routine activities, and preference for participating in care planning.

Use of services: Recent use of services that may include emergency department, hospitalization, home health, skilled nursing facility, paid home care, homemaker, or other services. Documentation of current providers including primary care provider.

Numerator Details

Enrollees who have either of the following:

- A comprehensive assessment (face-to-face, in the home) within 90 days of enrollment for enrollees newly enrolled in the plan between October 1 of the year prior to the measurement year and September 30 of the measurement year, or
- A comprehensive assessment (face-to-face, in the home) during the measurement year for enrollees enrolled in the plan prior to October 1 of the year prior to the measurement year.

The comprehensive assessment must include documentation of all of the following components:

- Assessment of core domains: physical functioning and disability, medical conditions, mental and behavioral health, needs, risks, social support, preferences, and use of services. Assessment of each domain must meet minimum requirements as defined above.
- Date of assessment completion.
- Identification of whether any family or friend caregivers are providing paid or unpaid assistance to the enrollee (assistance with activities of daily living, instrumental activities of daily living, health care related tasks, or emotional support).
- Contact information for one or more family or friend caregiver, if identified in assessment.

Documentation of no change in status is not sufficient to meet the numerator criteria; assessment must reflect current status and needs.

Note: Numerator details may change as this measure is still under development.

Denominator Statement S.7.

Medicaid MLTSS plan enrollees age 18 years and older.

Note: Denominator statement may change as this measure is still under development.

Target Population Category S.8.

- Populations at Risk: Populations at Risk
- Populations at Risk: Dual-Eligible Enrollees

Denominator Details S.9.

A systematic sample drawn from the eligible population, which includes Medicaid enrollees:

- Who are 18 years and older as of the first day of the measurement year,
- Who are enrolled in a Medicaid MLTSS plan for at least 90 days between October 1 of the year prior to the measurement year and September 30 of the measurement year, and
- Who have either of the following benefits: 1) long-term services and supports: home and community based or 2) long-term services and supports: facility based.

Note: Denominator details may change as this measure is still under development.

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10.

Enrollees who refuse assessment are excluded. Enrollees who refuse in-home assessment are excluded from the numerator requirement of in-home assessment but are not excluded from the other measure elements.

Note: Denominator exclusions may change as this measure is still under development.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11.

- Enrollees who refuse assessment are excluded from this measure. There must be documentation that the enrollee refused assessment to meet this exclusion. Documentation that the enrollee could not be reached is not sufficient.
- In-home assessment is not required if there is documentation of enrollee refusal of in-home assessment or of safety concerns for MLTSS staff. However, these enrollees are not excluded from the other requirements of the measure.

Note: Denominator exclusion details may change as this measure is still under development.

Stratification Details/Variables S.12.

Consideration of stratification by the following variables:

- Ages 18-64
- Ages 65+
- Community dwelling non-home and community based services (HCBS) users
- Community dwelling HCBS users
- Non-community dwelling population (e.g., nursing facility and intermediate care facility residents)

Note: Stratification details may change as this measure is still under development.

Risk Adjustment Type S.13.

Not applicable.

Statistical Risk Model and Variables S.14.

Not applicable.

Detailed Risk Model Specifications S.15.

Not applicable.

Type of Score S.16.

Rate/proportion

Interpretation of Score S.17.

A higher score denotes better performance.

Calculation Algorithm/Measure Logic S.18.

Step 1. Determine the eligible population.

Step 2. From the eligible population, draw a systematic sample.

Step 3a. From the systematic sample, identify all enrollees who were newly enrolled in the plan between October 1 of the year prior to the measurement year and September 30 of the measurement year.

Step 3b. Identify if these enrollees have documentation of a comprehensive assessment conducted within 90 days of enrollment.

Step 3c. From the systematic sample, identify all enrollees who were enrolled prior to October 1 of the year prior to the measurement year.

Step 3d. Identify if any of these enrollees have documentation of a comprehensive assessment conducted during the measurement year.

Step 4. Add the number of enrollees from Steps 3c and d.

Step 5. Divide the total number of enrollees from Step 4 by the number of enrollees from Step 2 to calculate the rate.

Note: Calculation algorithm/measure logic may change as this measure is still under development. Specifically, we are exploring whether all elements of the comprehensive assessment need to be documented to meet the numerator criteria (i.e. "all-or-nothing") or if the measure will look for a certain proportion of assessment elements to be documented.

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.

Not applicable.

Sampling S.20.

The approach for sampling will be determined during the measure testing phase.

Survey/Patient-Reported Data S.21.

Not applicable.

Missing Data S.22.

The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23.

- Electronic Clinical Data: Electronic Health Record
- Paper Medical Records
- Other (Care Management Records)

Data Source or Collection Instrument S.24.

Not applicable.

Data Source or Collection Instrument (Reference) S.25.

Not applicable.

Level of Analysis S.26.

Health plan

Care Setting S.27.

Home Health; Hospital/Acute Care Facility; Post-Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; Post-Acute/Long Term Care Facility: Inpatient Rehabilitation Facility; Post-Acute/Long Term Care Facility: Long Term Acute Care Hospital/Other (Home)

Composite Performance Measure S.28.

Not applicable.

Measure Justification Form

Project Title:

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Date:

Information included is current on August 12, 2016.

Measure Name

Comprehensive Long Term Services and Supports Assessment and Update

Type of Measure

Process

Importance

1a—Opportunity for Improvement

1a.1. This is a measure of process. It is the rate of Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees who have documentation of a comprehensive assessment conducted within the appropriate timeframe (i.e., within 90 days of enrollment or annually).

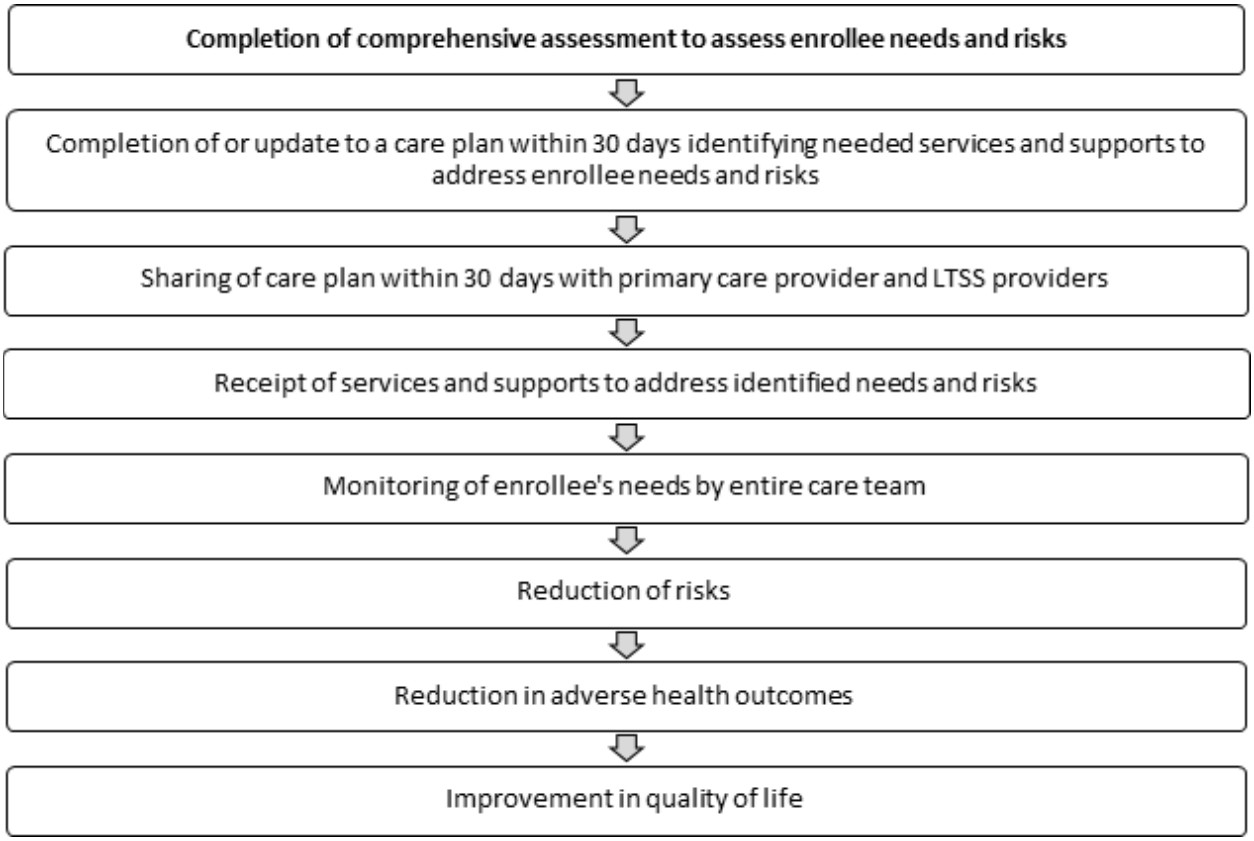
1a.2.—Linkage

Not applicable.

1a.2.1 Rationale

Not applicable.

1a.3.—Linkage



1a.3.1. Source of Systematic Review

- Clinical Practice Guideline recommendation – ***complete sections 1a.4, and 1a.7***
- US Preventive Services Task Force Recommendation – ***complete sections 1a.5 and 1a.7***
- Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections 1a.6 and 1a.7***

✓ Other – complete section 1a.8

1a.4.—Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation

Not applicable.

1a.4.2. Specific Guideline

Not applicable.

1a.4.3. Grade

Not applicable.

1a.4.4. Grades and Associated Definitions

Not applicable.

1a.4.5. Methodology Citation

Not applicable.

1a.4.6. Quantity, Quality, and Consistency

Not applicable.

1a.5.—United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation

Not applicable.

1a.5.2. Specific Recommendation

Not applicable.

1a.5.3. Grade

Not applicable.

1a.5.4. Grades and Associated Definitions

Not applicable.

1a.5.5. Methodology Citation

Not applicable.

1a.6.—Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation

Not applicable.

1a.6.2. Methodology Citation

Not applicable.

1a.7.—Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review

Not applicable.

1a.7.2. Grade

Not applicable.

1a.7.3. Grades and Associated Definitions

Not applicable.

1a.7.4. Time Period

Not applicable.

1a.7.5. Number and Type of Study Designs

Not applicable.

1a.7.6. Overall Quality of Evidence

Not applicable.

1a.7.7. Estimates of Benefit

Not applicable.

1a.7.8. Benefits Over Harms

Not applicable.

1a.7.9. Provide for Each New Study

Not applicable.

1a.8.—Other Source of Evidence

The Medicaid MLTSS enrollee population includes individuals with complex health and social support needs, such as individuals with physical, cognitive, and mental disabilities and older adults with multiple functional limitations and chronic conditions.[1,2] Given their complex needs, MLTSS enrollees require high levels of care coordination.[3] Delivering effective care coordination for complex populations, such as MLTSS enrollees, begins with conducting and

[1] Medicaid and CHIP Payment and Access Commission (MACPAC). (2016). Users of long-term services and supports. Available at https://www.macpac.gov/subtopic/long-term-services-and-supports-population/.
[2] Kaiser Family Foundation (KFF). (2015). Medicaid and Long-Term Services and Supports: A Primer. Available at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.
[3] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

regularly updating comprehensive assessments to identify a wide array of enrollee needs and potential health and safety risks.[4]

Variation in How Comprehensive Assessment is Defined and Conducted

State Medicaid agencies have implemented numerous MLTSS care coordination models,[5] and most require an assessment at initial enrollment and on a regular basis thereafter. However, the tools used to conduct assessments and the performance measures used to evaluate the quality of assessments conducted vary widely.[6,7,8] A recent analysis by Medicaid and CHIP Payment and Access Commission (MACPAC) identified at least 124 assessment tools currently in use by states to assess functional status.[9] An environmental scan conducted in 2012 under a previous CMS contract (Prime Contract No. HHSM-500-2010-00026I/HHSM-500-T0011) also highlighted this variation particularly for MLTSS plans (included as Appendix 1: Environmental Scan of Assessment and Care Planning Measures). In some states MLTSS plans use a state mandated assessment, in other states MLTSS plans conduct their own assessment in addition to a state "level-of-care" assessment. Some states require assessments to be in person and others do not specify the mode or location of assessment. The variation in assessment domains, mode and timing across states and managed care arrangements limits the ability to make apples-to-apples comparisons across states and health plans.

This measure would address the lack of standardization by assessing the percentage of Medicaid MLTSS enrollees who have an assessment conducted with a specified mode (face-to-face, in the home), in a specified timeframe, and addressing specific domains (physical functioning and disability, medical conditions, mental and behavioral health, physical and occupational therapy needs, risks, social support, preferences, and use of services). In

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[4] Agency for Research and Healthcare Quality (AHRQ). (2012). Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Available at https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf.

[5] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

[6] MACPAC. (2016). Chapter 4. Functional Assessments for Long-Term Services and Supports. Report to Congress on Medicaid and CHIP. Available at https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf.

[7] KFF. (2015). Medicaid and Long-Term Services and Supports: A Primer. Available at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

[8] Atkins, G. L., & B. Gage. (2014). The Need to Standardize Assessment Items for Persons in Need of LTSS. Available at http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images/LTQA-The-Need-to-Standardize-Assessment-Items-4-14-1.pdf.

[9] MACPAC. (2016). Chapter 4. Functional Assessments for Long-Term Services and Supports. Report to Congress on Medicaid and CHIP. Available at https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf.

addition, documentation of the assessment must include the date of assessment completion, identification of whether any family or friend caregivers are providing assistance, and contact information for one or more family or friend caregivers, if identified in the assessment.

Evidence to Support Impact of Comprehensive Assessment on Outcomes

We were unable to find a systematic review evaluating the impact of comprehensive assessment on outcomes for individuals with LTSS needs. However, we were able to identify several studies of successful interventions in the populations receiving LTSS, specifically older adults and adults with intellectual and developmental disabilities, which demonstrate the relationship between conducting comprehensive assessments and positive health outcomes and the critical role of such assessments in producing these outcomes.

Example 1: Comprehensive Geriatric Assessment (CGA)

CGA is defined as a "multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional limitations of a frail older person in order to develop a coordinated plan to maximize overall health with aging."[10] A meta-analysis of 28 controlled trials found that CGA programs linking geriatric evaluation with strong long-term management were effective for improving survival and function in older adults.[11] More recent studies have found that, when used in the hospital setting, CGA can also lead to increased in-home residence up to 12 months post-discharge[12,13] and, in the ambulatory care setting, to reduced length of hospital stays and increased sense of security in care interactions.[14]

Example 2: Geriatric Resources for Assessment and Care of Elders (GRACE)

GRACE is an integrated care model that targets low-income seniors, many dually eligible and most with multiple chronic conditions. The model uses in-home assessments by a team consisting of a nurse practitioner and social worker to develop individualized care

[10] Ward, K. T., & D. Reuben. (2016). Comprehensive geriatric assessment. Available at http://www.uptodate.com/contents/comprehensive-geriatric-assessment.
[11] Stuck, A. E., A. L. Siu, G. D. Wieland, J. Adams, & L. Z. Rubenstein. (1993). Comprehensive geriatric assessment: a meta-analysis of controlled trials. *Lancet*, 342(8878), 1032-1036.
[12] Ellis, G., Whitehead, M. A., O'Neill, D., Langhorne, P., & Robinson, D. (2011). Comprehensive geriatric assessment for older adults admitted to hospital. *Cochrane Database of Systematic Reviews,* 7, CD006211.
[13] Avelino-Silva, T. J., Farfel, J. M., Curiati, J. A., Amaral, J. R., Campora, F., & Jacob-Filho, W. (2014). Comprehensive geriatric assessment predicts mortality and adverse outcomes in hospitalized older adults. *BMC Geriatrics, 14*, 129.
[14] Ekdahl, A. W., Wirehn, A. B., Alwin, J., Jaarsma, T., Unosson, M., Husberg, M.,Carlsson, P. (2015). Costs and Effects of an Ambulatory Geriatric Unit (the AGe-FIT Study): A Randomized Controlled Trial. *Journal of the American Medical Directors Association*.

plans.[15,16,17,18] A randomized controlled trial found that high-risk patients enrolled in GRACE had fewer emergency department visits, hospitalizations, and readmissions and reduced hospital costs compared to a control group. In addition, the GRACE model saved $1,500 per enrolled high-risk patient by its second year. Finally, the GRACE model received higher care satisfaction ratings by physicians and quality of life reports by patients compared to a control group.

Example 3: Comprehensive Health Assessment Program (CHAP)

Similar to older adults, persons with intellectual disabilities often have unrecognized health conditions, impaired communication, and cognition and recall difficulties and benefit from regular health assessments.[19,20,21]

CHAP is a comprehensive assessment tool developed and tested in New Zealand and used to evaluate medical histories, conduct targeted examinations, assess for syndrome-specific comorbidities, and develop action plans for persons with intellectual disabilities. A randomized controlled trial found that CHAP increased provider awareness of health needs of persons with intellectual disabilities and disease detection.[22] A more recent study including interviews and focus groups with various stakeholders (i.e., physicians, nurse practitioners, support workers, and families) determined that the CHAP was beneficial for

[15] Bielaszka-DuVernay, C. (2011). The 'GRACE' Model: In-Home Assessments Lead to Better Care for Dual Eligibles. *Health Affairs*, 30(3), 431-434.
[16] Counsell, S. R., C. M. Callahan, A. B. Buttar, D. O. Clark, & K. I. Frank. (2006). Geriatric Resources for Assessment and Care of Elders (GRACE): a new model of primary care for low-income seniors. *Journal of the American Geriatrics Society*, 54(7), 1136-1141.
[17] Counsell, S. R., C. M. Callahan, D. O. Clark, W. Tu, A. B. Buttar, T. E. Stump, & G. D. Ricketts. (2007). Geriatric care management for low-income seniors: a randomized controlled trial. *Journal of the American Medical Association*, 298(22), 2623-2633.
[18] Counsell, S. R., C. M. Callahan, W. Tu, T. E. Stump, & G. W. Arling. (2009). Cost analysis of the Geriatric Resources for Assessment and Care of Elders care management intervention. *Journal of the American Geriatrics Society*, 57(8), 1420-1426.
[19] Cooper, S. A., J. Morrison, C. Melville, et al. (2006). Improving the health of people with intellectual disabilities: outcomes of a health screening programme after 1 year. *Journal of Intellectual Disability Research*, 50, 667-677.
[20] Lennox, N. G., M. Green, J. Diggens, & A. Ugoni. (2001). Audit and comprehensive health assessment programme in the primary healthcare of adults with intellectual disability: a pilot study. *Journal of Intellectual Disability Research*, 45, 226-232.
[21] Webb, O., & L. Rogers. (1999). Health screening for people with intellectual disability: the New Zealand experience. *Journal of Intellectual Disability Research,* 43, 497-503.
[22] Lennox, N., C. Bain, T. Rey-Conde, D. Purdie, R. Bush, & N. Pandeya. (2007). Effects of a comprehensive health assessment programme for Australian adults with intellectual disability: a cluster randomized trial. *International Journal of Epidemiology*, 36(1), 139-146.

persons with intellectual disabilities, including greater continuity of care, and was strongly supported for use in Canada.[23]

Example 4: Post-Acute Care Tools

Assessments are also used routinely in the post-acute care setting (home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals) to identify patient needs, potential health risks, and monitor outcomes.

- Long-Term Care Minimum Data Set (MDS): A standardized screening and assessment tool of health status that serves as the basis of a comprehensive assessment for all residents in a Medicare and/or Medicaid-certified long-term care facility.
- Outcome and Assessment Information Set (OASIS): A group of data elements that dictates core items of a comprehensive assessment for adult home health care patients and serves as the basis for measuring patient outcomes.
- Continuity Assessment Record and Evaluation (CARE): A tool developed by the U.S. Department of Health and Human Services to assess patients' needs for post-acute services in the four settings listed above. The CARE item set builds on the MDS and OASIS instruments.

All of these other assessment tools have been shown to be reliable, valid, and useful for identifying patients' health care and social support needs and developing individualized care plans.[24,25,26]

Identifying the Domains for the Comprehensive Assessment

To identify the appropriate domains for inclusion in this measure, we conducted a scan of assessment domains required for the following programs/assessment, which focus on high need populations: Special Needs Plans, Medicare-Medicaid Integrated Health Plans, Medicaid Balancing Incentive Program, Medicare Home Health OASIS, Continuity Assessment Record and Evaluation, Nursing Facility Minimum Data Set, and the Program of All Inclusive Care for the Elderly. To augment our environmental scan, we conducted one-on-one

[23] Shooshtari, S., B. Temple, C. Waldman, S. Abraham, H. Ouellette-Kuntz, & N. Lennox. (2016). Stakeholders' Perspectives towards the Use of the Comprehensive Health Assessment Program (CHAP) for Adults with Intellectual Disabilities in Manitoba. *Journal of Applied Research in Intellectual Disabilities*.
[24] Centers for Medicare & Medicaid Services (CMS). (2012). Long Term Care Minimum Data Set (MDS). Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/IdentifiableDataFiles/LongTermCareMinimumDataSetMDS.html.
[25] CMS. (2012). Outcome and Assessment Information Set (OASIS). Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html.
[26] CMS. (2015). CARE Item Set and B-CARE. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html.

interviews with key stakeholders and Technical Expert Panel (TEP) members to solicit additional assessment domains.

We identified eight domains (physical functioning, medical conditions, mental and behavioral health, needs and risks, social support, preferences, and service use) made up of 39 elements. To prioritize domains and elements we conducted a survey of the TEP members and selected items that were supported by 75 percent or more of TEP members for inclusion in the measure (See Measure Information Form for a complete list of domains and elements included in the measure). Complete details of the voting process and the results from the 2013 TEP survey can be found in Appendix 2.

1a.8.1. Process Used

In the absence of a systematic review, the project team conducted a targeted literature review to gather evidence in support of this measure. We searched for academic journal articles, gray literature, and federal and state agency reports published in the last 23 years using PubMed, Google, and Google Scholar. We also convened a TEP in 2013 to provide insight into the priority areas for measurement and the usefulness and feasibility of the identified measures for MLTSS plans. The TEP was comprised of individuals representing multiple perspectives from the MLTSS community including consumers, practitioners, health plans, the federal government, and state governments.

We also built upon an environmental scan of Assessment and Care Planning measures conducted under a previous CMS contract (Contract No. HHSM-500-2010-00026I/HHSM-500-T0011) and included here in Appendix 1.

1a.8.2. Citation

See footnotes from Section 1a.8.1 above.

1b.—Evidence to Support Measure Focus

1b.1. Rationale

Comprehensive assessments serve as the foundation for providing high quality and well-coordinated care. However, the tools used to conduct assessments and the performance measures used to evaluate the quality of assessments conducted vary widely. This measure would address the lack of standardization by assessing the percentage of Medicaid MLTSS enrollees who have a comprehensive assessment conducted that includes specific domains addressing the physical, mental, and social aspects of health and wellness. A standardized measure of comprehensive assessment will allow for apples-to-apples comparisons of MLTSS plans across states.

1b.2. Performance Scores

Not applicable.

1b.3. Summary of Data Indicating Opportunity

Comprehensive assessments serve as the foundation for providing high quality and well-coordinated care. While almost all MLTSS plans require annual assessment of members, there is little data on the rate of comprehensive assessments among the MLTSS enrollee population.

A central challenge to measuring the rate of assessment is the variation in the way assessments are conducted across states and health plans. The tools used to conduct assessments and the performance measures used to evaluate the quality of assessments conducted vary widely. A recent review by MACPAC in 2016 found that over 124 tools are currently in use.[27] On average, states use three different tools each, as they generally use separate tools for different populations.

In its 2013 report to Congress, the Commission on Long-Term Care called for "…the development and implementation of a standardized assessment tool that can produce a single care plan across care settings for an individual with cognitive or functional limitations."[28] More recently in the May 6, 2016 Federal Register,[29] CMS issued a final rule that included provisions for Medicaid managed care programs to be implemented no later than July 1, 2017. More specifically, the rule requires "mechanisms to detect both underutilization and overutilization of services and the quality and appropriateness of care furnished to enrollees with special health care needs" and "quality assessment and performance improvement programs for plans offering LTSS must include assessments of care between care settings and comparisons of services and supports received with those set forth in the enrollee's treatment/service plan."[30]

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[27] MACPAC. (2016). Chapter 4. Functional Assessments for Long-Term Services and Supports. Report to Congress on Medicaid and CHIP. Available at https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf.

[28] Atkins, G. L., & B. Gage. (2014). The Need to Standardize Assessment Items for Persons in Need of LTSS. Available at http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images/LTQA-The-Need-to-Standardize-Assessment-Items-4-14-1.pdf.

[29] CMS. (2016). 42 CFR Parts 431, 433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

[30] Integrated Care Resource Center (ICRC). (2016). Spotlight: CMS Medicaid Managed Care Final Rule – Provisions Related to Integrated Programs for Medicare-Medicaid Enrollees. Available at http://www.integratedcareresourcecenter.com/PDFs/2016%2005%2012%20Medicaid%20Managed%20Care%20Regulations.pdf

This measure would address the lack of standardization by assessing the percentage of Medicaid MLTSS enrollees who have an assessment conducted with a specified mode (face-to-face, in the home), in a specified timeframe, and addressing specific domains (physical functioning and disability, medical conditions, mental and behavioral health, physical and occupational therapy needs, risks, social support, preferences, and use of services). Through testing we will explore the rate of assessment and variation between MLTSS plans and states.

1b.4. and 1b.5. Disparities

There is little research on potential disparities in the use of comprehensive assessments among the MLTSS enrollee population. However, studies have identified disparities in the need for and use of LTSS more broadly, which highlight the need for more comprehensive and well-documented assessments.

The Congressional Budget Office identified racial and ethnic disparities in the need for LTSS. More specifically, it found that older black and Hispanic individuals have higher rates of functional impairment than whites.[31]

Another report identified disparities in care coordination and access to care for newly transitioned Medicaid managed care enrollees with complex needs. It found that primary care providers in California felt unprepared and untrained for the level of effort required to coordinate care for newly transitioned seniors and persons with disabilities. It also found that fewer than 60 percent of newly transitioned seniors and persons with disabilities were successfully contacted and administered a health risk assessment, a much less intensive assessment than required by this measure.[32]

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

- Affects large numbers
- High resource use
- Patient/social consequences of poor quality

[31] Congressional Budget Office. (2013). Rising Demand for Long-Term Services and Supports for Elderly People. Washington, DC: Congressional Budget Office.
[32] KFF. (2013). Issue Brief. Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Insights from California. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/06/8453-transitioning-beneficiaries-with-complex-care-needs2.pdf.

1c.3. Epidemiologic or Resource Use Data

Although criteria vary by state, individuals are generally eligible for Medicaid LTSS if they need assistance with at least one, and often more activities of daily living or instrumental activities of daily living. The MLTSS enrollee population who receives LTSS is diverse. It includes individuals with complex health and social support needs who often receive care from multiple providers and settings. Older adults and adults with physical disabilities are the most common groups receiving LTSS.[33] As of 2012, adults with intellectual or development disabilities and children with disabilities were also covered in half of MLTSS state programs.[34] It also includes individuals who are also more likely to be Medicare-Medicaid enrollees. As of 2013, approximately one-third of dual eligible enrollees nationwide were receiving LTSS.[35]

Medicaid covers LTSS in institutional settings, such as skilled nursing facilities, intermediate care facilities, and mental health facilities. It also covers LTSS in home and community settings, where enrollees receive home and community based services (HCBS) that allow them to reside in the community but still receive assistance. HCBS are designed to prevent or delay institutionalization and generally include home health, personal care, medical equipment, assistive devices, rehabilitative therapy, adult day care, targeted case management, home modifications, transportation, and respite care for caregivers.[36,37] Roughly half of MLTSS programs include only enrollees at the institutional level of care (HCBS programs and institutions), which account for 25 percent of enrollment nationwide.[38] In fiscal year (FY) 2012, 43.4 percent of Medicaid expenditures ($169.2 billion) were spent on

[33] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.
[34] Saucier, P. K. (2012). *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Centers for Medicare & Medicaid Services.
[35] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.
[36] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.
[37] The Lewin Group & General Dynamics Information Technology. (2013). Evaluating Medicaid Long-Term Services and Supports Utilization.
[38] Saucier, P. K. (2012). *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Centers for Medicare & Medicaid Services.

LTSS users, even though LTSS users comprised only 6.2 percent (4.3 million) of Medicaid enrollees.[39]

As payment models shift away from fee-for-service, state Medicaid agencies are moving their LTSS enrollees into managed care plans, either stand-alone MLTSS plans, or comprehensive managed care plans that provide both LTSS and medical care. As of 2014, 17 states provide LTSS through managed care programs and the number of Medicaid enrollees using, or at risk of needing, LTSS who were enrolled in managed care programs covering LTSS grew from about 916,000 in 2013 to more than 1.6 million in 2014.[40]

MLTSS enrollees often experience highly fragmented care and are at risk for numerous adverse health care utilization patterns and outcomes. [41,42,43,44,45,46,47] At its best, managed care offers the promise of delivering community-based coordinated care by integrating medical care, behavioral health care, and LTSS across providers and settings. At its worst, it could disrupt longstanding relationships (e.g., if patients' providers are not part of the managed care plan's network) and create additional barriers to obtaining needed care (e.g., through gatekeeping or coverage restrictions). Because the range of potential outcomes from these shifts in care delivery is so broad, it is necessary to systematically monitor the quality of care delivered to people in MLTSS plans.

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[39] Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. MACStats: Medicaid and CHIP data book. December 2015. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2015.pdf.

[40] Centers for Medicare & Medicaid Services. 2015. Medicaid Managed Care Enrollment and Program Characteristics, 2014. Mathematica Policy Research, prepared for CMS. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf.

[41] Naylor, M. D., E. T. Kurtzman, & M. V. Pauly. (2009). Transitions of Elders Between Long-Term Care and Hospitals. *Policy, Politics, and Nursing Practice*, 10(3), 187-194.

[42] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

[43] Freedman, V. & B. C. Spillman. (2014). Disability and Care Needs Among Older Americans. *The Milbank Quarterly*, 92(3), 509-541.

[44] Allen, S. M., E. R. Piette, & V. Mor. (2014). The Adverse Consequences of Unmet Need Among Older Persons Living in the Community: Dual-Eligible Versus Medicare-Only Beneficiaries. *The Journals of Gerontology: Psychological Sciences*, 69(1), S51-S58.

[45] Komisar, H. L., J. Feder, & J. D. Kasper. (2005). Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles. *Inquiry*, 42(2), 171-182.

[46] Sands, L. P., Y. Wang, G. P. McCabe, K. Jennings, C. Eng, & K. E. Covinsky. (2006). Rates of Acute Care Admissions for Frail Older People Living with Met Versus Unmet Activity of Daily Living Needs. *Journal of the American Geriatrics Society*, 53(2), 339-344.

[47] Gaugler, J. E., S. Duval, K. A. Anderson, & R. L. Kane. (2007). Predicting Nursing Home Admission in the U.S.: A Meta-Analysis. *BMC Geriatrics*, 7(1), 1.

To assess the care provided during this time of transition, most states have incorporated LTSS specific measures into their managed care plans quality management programs. However, the lack of a nationally endorsed set of measures has resulted in highly unique approaches that vary by state.

1c.4. Citations

See footnotes from section 1c.3 above.

1c.5. Patient-Reported Outcome Performance Measure (PRO-PM)

Not applicable.

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.2. Identify the Specific Dataset

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.3. What are the Dates of the Data Used in Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.4. What Levels of Analysis Were Tested?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.7. Sample Differences, if Applicable

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.2. Method of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.3. Statistical Results from Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.4. Interpretation

Not applicable. Reliability will be determined during the measure testing phase.

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.2. Method of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.3. Statistical Results from Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.4. Interpretation

Not applicable. Validity will be determined during the measure testing phase.

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.2. Statistical Results From Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.3. Interpretation

Not applicable. Exclusions will be determined during the measure testing phase.

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable.

2b4.2. Rationale why Risk Adjustment is not Needed

Not applicable.

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable.

2b4.4. Statistical Results

Not applicable.

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable.

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R2)

Not applicable.

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable.

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable.

2b4.9. Results of Risk stratification Analysis

Not applicable.

2b4.10. Interpretation

Not applicable.

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable.

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method for determining

Not applicable. Differences will be determined during the measure testing phase.

2b5.2. Statistical Results

Not applicable. Differences will be determined during the measure testing phase.

2b5.3. Interpretation

Not applicable. Differences will be determined during the measure testing phase.

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable. Comparability will be determined during the measure testing phase.

2b6.2. Statistical Results

Not applicable. Comparability will be determined during the measure testing phase.

2b6.3. Interpretation

Not applicable. Comparability will be determined during the measure testing phase.

Feasibility

3a.1. How are the data elements needed to compute measure scores generated

Data elements will be generated through routine care and collected from MLTSS care management records. Feasibility will be determined during the measure testing phase.

3b.1. Are the data elements needed for the measure as specified available electronically

We do not anticipate all data elements will be available electronically to all MLTSS plans. The availability of data elements in structured electronic fields will be evaluated in testing.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable. This is not an eMeasure.

3c.1. Describe what you have learned or modified as a result of testing

Not applicable. Measure is under development.

3c.2. Describe any fees, licensing, or other requirements

No fees, licensing, or other requirements at this phase.

Usability and Use

4.1—Current and Planned Use

Use	Planned	Current	For current use, provide Program Name and URL
a. Public Reporting	X		
b. Public Health/Disease Surveillance			
c. Payment Program			
d. Regulatory and Accreditation Programs			
e. Professional Certification or Recognition Program			
f. Quality Improvement with Benchmarking (external benchmarking to multiple organizations)	X		
g. Quality Improvement (Internal to the specific	X		
h. Not in use			
i. Use Unknown			

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients

Not applicable. This is a new measure.

4a.2. If not publicly reported or used for accountability, reasons

This measure is currently under development.

4a.3. If not, provide a credible plan for implementation

This measure is intended for use by states to monitor and improve the quality of care provided for the Medicaid MLTSS enrollee population. A measure implementation plan will be proposed for CMS review following testing.

4b.1. Progress on improvement

Not applicable. This is a new measure.

4b.2. If no improvement was demonstrated, what are the reasons

Not applicable. This is a new measure.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. The measure titles and NQF numbers are listed here

There are no NQF-endorsed measures related to comprehensive LTSS assessment.

5.1b. If the measures are not NQF-endorsed, indicate the measure title

A complete review of existing Assessment measures can be found in Appendix 1.

While there are many existing measures that include some form of assessment, none define the *specific elements* of a comprehensive assessment for the target population and can be used across states. Across the Medicare-Medicaid Coordination Office Financial Alignment Initiative demonstration projects, we found several state-specific measures that reflect some of these aspects. Examples include:

- Documentation of Care Goals: Percent of enrollees with documented discussions of care goals. (**CMS Financial Alignment Initiative Core Measure** and CA, IL, MA, MI, NY, OH, RI, SC, VA)
- Assessment (including Risk Assessment): Percent of members with initial assessments completed within 30 or 90 days of enrollment. (**CMS Financial Alignment Initiative Core Measure** and CA, IL, MA, NY, OH, VA, WA)
- Care for persons with intellectual and developmental disabilities (I/DD) – Assessment: Percent of enrollees with I/DD who have a completed assessment and related goals in the care plan. (MI)

Many of these measures, including the CMS Financial Alignment Initiative Core Measures, do not specify which domains or data elements should be included in a comprehensive assessment or the mode of assessment, which limits the ability to compare rates meaningfully across entities.

There are essentially no measures of comprehensive assessment in use by national entities at this time, but there is one measure in development for Medicare Advantage plans focused on adults with multiple chronic conditions that is related.

- Comprehensive Assessment for Enrollees with Multiple Chronic Conditions: Percent of enrollees with three or more chronic conditions who received a comprehensive assessment including documentation of functional status assessment, pain assessment, medication review, advance care plan discussion, and patient goals.

5a—Harmonization

5a.1. Are the measure specifications completely harmonized

No. The measure elements are not completely harmonized; however, we will aim to align the measure with existing measures to the greatest extent possible through testing.

5a.2. If not completely harmonized, identify the differences rationale, and impact

This measure is under development. A summary of the differences between this measure and existing measures of assessment will be provided after the measure is finalized.

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures

Not applicable.

Additional Information

Co.1.—Measure Steward Point of Contact

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

Roxanne Dupert-Frank
7500 Security Boulevard, Mail Stop: S3-02-01
Baltimore, MD
Roxanne.Dupert-Frank@cms.hhs.gov
(410) 786-9667

Co.2.—Developer Point of Contact (indicate if same as Measure Steward Point of Contact

Mathematica Policy Research
Debra Lipson
DLipson@Mathematica-Mpr.com
(202) 484-9220

Ad.1. Workgroup/Expert Panel Involved in Measure Development

Development of Assessment and Care Planning Measures for Use in Medicaid Managed Long Term Services and Supports (MLTSS) Programs Technical Expert Panel, 2013

Anne Cohen, Health and Disability Policy Consultant, Disability Health Access, LLC

Patti Killingsworth, Assistant Commissioner and Chief of LTSS, Bureau of TennCare

Jennifer Lenz, Executive Director, State and Corporate Services, Health Services Advisory Group

Bonnie Marsh, Executive Director, State and Corporate Services, Health Services Advisory Group

Diane McComb, ANCOR Liaison with State Associations

Margaret A. Nygren, Executive Director and CEO, American Association on Intellectual and Developmental Disabilities

Joseph Ouslander, Professor of Clinical Biomedical Science, Florida Atlantic University

Pamela J. Parker, Manager, Special Needs Purchasing, State of Minnesota Department of Human Services

Cheryl Phillips, Senior VP Public Policy and Advocacy, Leading Age

D.E.B. Potter, Senior Survey Statistician, Agency for Healthcare Research and Quality

Juliana Preston, Utah Executive Director, HealthInsight

Genie Pritchett, Sr. Vice President Medical Services, Colorado Access

Alice Lind, Aging and Long Term Support Division, Washington State Department of Social and Health Services

Ad.2. Year the Measure Was First Released

Not applicable. This measure is still under development.

Ad.3. Month and Year of Most Recent Revision

Not applicable. This measure is still under development.

Ad.4. What is your frequency for review/update of this measure?

Not applicable. This measure is still under development.

Ad.5. When is your next scheduled review/update for this measure?

Not applicable. This measure is still under development.

Ad.6. Copyright Statement

Not applicable. This measure is still under development.

Ad.7. Disclaimers

Not applicable. This measure is still under development.

Ad.8. Additional Information/Comments

Not applicable.

Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "dual enrollees"
- People receiving long-term services and supports (LTSS) through Medicaid managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program.

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on August 12, 2016.

Measure Name: Comprehensive LTSS Care Plan and Update

Descriptive Information

Measure Name (Measure Title De.2.)

Comprehensive Long Term Services and Supports (LTSS) Care Plan and Update

Measure Type De.1.

Process

Brief Description of Measure De.3.

The percentage of Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees who have documentation of a comprehensive LTSS care plan within the appropriate time frame (within 120 days of enrollment or annually).

If Paired or Grouped De.4.

This measure is grouped with two other measures that assess the continuum of assessment, care planning and care coordination. This continuum of care is described in greater detail in the accompanying Measure Justification Form.

- Comprehensive LTSS Assessment
- Shared Care Plan measure.

Subject/Topic Areas De.5.

- See Crosscutting Areas

Crosscutting Areas De 6.

- Health and Functional Status: Health and Functional Status
- Health and Functional Status: Development/Wellness
- Health and Functional Status: Functional Status
- Prevention: Prevention
- Prevention: Social Determinants
- Care Coordination: Care Coordination
- Functional Status
- Safety: Safety

Measure Specifications

Measure-specific Web Page S.1.

Not applicable. This measure is still under development.

If This Is an eMeasure S.2a.

Not applicable. This is not an eMeasure.

Data Dictionary, Code Table, or Value Sets S.2b.
Not applicable. This measure is still under development.

For Endorsement Maintenance S.3.
Not applicable. This measure is still under development.

Numerator Statement S.4.
Medicaid MLTSS enrollees who had either of the following:

- A comprehensive care plan documented within 120 days of enrollment for new enrollees, or
- A comprehensive care plan documented during the measurement year for all other enrollees.

Note: Numerator statement may change as this measure is still under development.

Time Period for Data S.5.
16 months (September 1 of the year prior to the measurement year to December 31 of the measurement year).

Numerator Details S.6.
Definitions *Note: Numerator definitions and details may change as this measure is still under development.)*

Care plan: A document or electronic record which identifies enrollee needs, preferences, and risks, and contains a list of the services and supports planned to meet those needs while reducing risks. The care plan must document all of the following [at a minimum]: (1) results of the assessment, (2) care planned to meet enrollee medical, functional, emotional, social, and cognitive needs, (3) services and supports being provided currently or planned in the next month (both paid and unpaid), (4) enrollee goals and preferences for care, and (5) coordination and follow-up plan, and an emergency back-up plan. Each domain is described in greater detail below. There must be documentation that the care plan was created with input from the enrollee during a face-to-face encounter between the individual responsible for creating the care plan (care manager) and enrollee. The assessment and development of the care plan may be done during the same face-to-face encounter or during different encounters. A care plan may be called a service plan in certain Medicaid MLTSS plans.

Care manager: Person responsible for developing the care plan with the enrollee.

Summary of assessment: A summary of the needs, risks, and preferences identified in the assessment. This may include any of the following: physical functioning and disability,

medical conditions, mental and behavioral health, needs, risks, social support, preferences, and use of services.

Plan to meet needs: A plan for addressing needs. Must include documentation of whether the enrollee needs services and supports and the care and services planned to meet identified needs in at least five areas: medical, functional, emotional, social, and cognitive. If no need is identified in a specific domain, the care plan does not need to identify services in that domain.

LTSS Services and supports: Documentation of current LTSS services and supports the enrollee receives or is expected to receive in the next month. Must include a list of all services the enrollee receives, or is expected to receive in the home (paid or unpaid) or in other settings (e.g., adult day health center, nursing facility), including the provider's name, amount, frequency, and duration.

Goals and preferences: Enrollee (and family as appropriate) individualized goals. Must include documentation of at least one enrollee goal, barriers to meeting goal(s), plan for assessing progress towards goal(s), and desired level of involvement in care planning. Enrollees who refuse to participate in care planning are excluded from this requirement but not from the other care plan requirements.

Coordination: A plan for follow-up and communication with the care manager. Must include documentation of follow-up and communication schedule with care manager, contact information for all providers, and first point of contact for enrollees.

Emergency back-up: Plan for ensuring enrollee needs are met if an emergency occurs (e.g., if a personal care assistant or home health aide is unable to get to home, natural disaster). Must include at a minimum the name of an individual to contact in case of an emergency.

<u>Numerator Details</u>

Enrollees who had either of the following:

- A comprehensive care plan documented within 120 days of enrollment for enrollees newly enrolled in the plan between September 1 of the year prior to the measurement year to August 31 of the measurement year, or
- A comprehensive care plan documented during the measurement year for enrollees enrolled in the plan prior to September 1 of the year prior to the measurement year.

The comprehensive care plan must include documentation of all of the following components:

- Care plan that documents all of the following [at a minimum]: (1) results of the assessment; (2) services provided currently or planned in the next month; (3) goals

and preferences for care; (4) LTSS services and supports to meet enrollee's medical, functional, emotional, social and cognitive needs; (5) coordination and follow-up plan; and (6) an emergency back-up plan. Enrollees who refuse to participate in care planning are excluded from the requirement of having goals and preferences documented but are not excluded from the other care plan requirements.
- Date of care plan completion or appeal.
- Documentation of whether family or friend caregiver(s) were involved in the development of the care plan and contact information for said caregiver(s).
- Signature of the enrollee or proxy, guardian, or power of attorney if enrollee is unable to sign for themselves OR documentation of enrollee appeal of care plan to MLTSS plan. Enrollees who refuse to participate in care planning are excluded from this requirement but not from the other care plan requirements.

Note: Numerator details may change as this measure is still under development.

Denominator Statement S.7.
Medicaid MLTSS enrollees age 18 years and older.

Note: Denominator statement may change as this measure is still under development.

Target Population Category S.8.

- Populations at Risk: Populations at Risk
- Populations at Risk: Dual-Eligible Enrollees

Denominator Details S.9.
A systematic sample drawn from the eligible population, which includes Medicaid enrollees:

- Who are 18 years and older as of the first day of the measurement year.
- Who are enrolled in an MLTSS plan for at least 120 days between September 1 of the year prior to the measurement year and August 31 of the measurement year. This timeframe allows for assessment within 90 days of enrollment and development of a care plan within 30 days of assessment.
- Who have either of the following benefits: 1) long-term services and supports: home and community based or 2) long-term services and supports: facility based.

Note: Denominator details may change as this measure is still under development.

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10.
Enrollees who refuse care planning are excluded from the requirement of having goals and preferences documented and enrollee signature.

Note: Denominator exclusions may change as this measure is still under development.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11.

Enrollees who refuse care planning are excluded from the requirement of having goals and preferences documented and enrollee signature. All other domains must be documented regardless of enrollee engagement in care planning process.

Note: Denominator exclusion details may change as this measure is still under development.

Stratification Details/Variables S.12.

Consideration of stratification by the following variables:

- Ages 18-64
- Ages 65+
- Community dwelling non-home and community-based services (HCBS) users
- Community dwelling HCBS users
- Non-community dwelling population (e.g., nursing facility and intermediate care facility residents)

Note: Stratification details may change as this measure is still under development.

Risk Adjustment Type S.13.

Not applicable.

Statistical Risk Model and Variables S.14.

Not applicable.

Detailed Risk Model Specifications S.15.

Not applicable.

Type of Score S.16.

Rate/proportion

Interpretation of Score S.17.

A higher score denotes better performance.

Calculation Algorithm/Measure Logic S.18.

Step 1. Determine the eligible population.

Step 2. From the eligible population, draw a systematic sample.

Step 3a. From the systematic sample, identify all enrollees who were newly enrolled in the plan between September 1 of the year prior to the measurement year and August 31 of the measurement year.

Step 3b. Identify if these enrollees have a comprehensive care plan completed and documented within 120 days of enrollment.

Step 3c. From the systematic sample, identify all enrollees who were enrolled prior to September 1 of the year prior to the measurement year.

Step 3d. Identify if these enrollees have documentation of an update to a comprehensive care plan or development of a new care plan during the measurement year.

Step 4. Add the number of enrollees from Steps 3b and d.

Step 5. Divide the total number of enrollees from Step 4 by the number of enrollees from Step 2 to calculate the rate.

Note: Calculation algorithm/measure logic may change as this measure is still under development. Specifically, we are exploring whether all elements of the comprehensive care plan need to be documented to meet the numerator criteria (i.e. "all-or-nothing") or if the measure will look for a certain proportion of care plan elements to be documented.

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.
Not applicable.

Sampling S.20.
The approach for sampling will be determined during the measure testing phase.

Survey/Patient-Reported Data S.21.
Not applicable.

Missing Data S.22.
The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23.

- Electronic Clinical Data: Electronic Health Record
- Paper Medical Records
- Other: Care Management Records

Data Source or Collection Instrument S.24.
Not applicable.

Data Source or Collection Instrument (Reference) S.25.
Not applicable.

Level of Analysis S.26.
Health plan

Care Setting S.27.

Home Health; Hospital/Acute Care Facility; Post-Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; Post-Acute/Long Term Care Facility: Inpatient Rehabilitation Facility; Post-Acute/Long Term Care Facility: Long Term Acute Care Hospital; Other (Home)

Composite Performance Measure S.28.

Not applicable.

Measure Justification Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "dual enrollees"
- People receiving long-term services and supports (LTSS) through Medicaid managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program.

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on August 12, 2016.

Measure Name

Comprehensive Long Term Services and Supports (LTSS) Care Plan and Update

Type of Measure

Process

Importance

1a—Opportunity for Improvement (H3)

1a.1. This is a measure of process. It is the rate of Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees who have documentation of a comprehensive LTSS care plan within the appropriate timeframe (within 120 days of enrollment or annually).

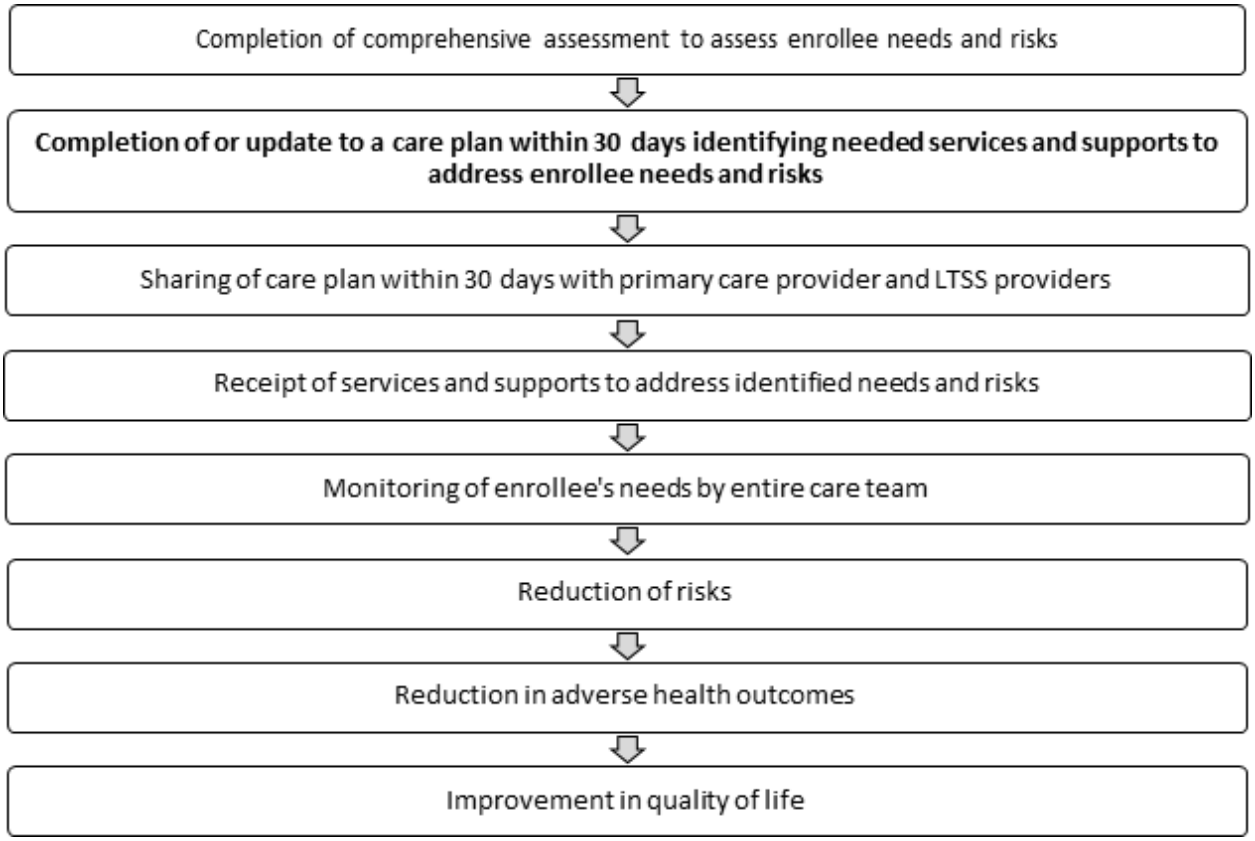
1a.2.—Linkage

Not applicable.

1a.2.1 Rationale

Not applicable.

1a.3.—Linkage



1a.3.1. Source of Systematic Review

- Clinical Practice Guideline recommendation – ***complete sections 1a.4, and 1a.7***
- US Preventive Services Task Force Recommendation – ***complete sections 1a.5 and 1a.7***
- Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections 1a.6 and 1a.7***

✓ Other – complete section 1a.8

1a.4.—Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation

Not applicable.

1a.4.2. Specific Guideline

Not applicable.

1a.4.3. Grade

Not applicable.

1a.4.4. Grades and Associated Definitions

Not applicable.

1a.4.5. Methodology Citation

Not applicable.

1a.4.6. Quantity, Quality, and Consistency

Not applicable.

1a.5.—United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation

Not applicable.

1a.5.2. Specific Recommendation

Not applicable.

1a.5.3. Grade

Not applicable.

1a.5.4. Grades and Associated Definitions

Not applicable.

1a.5.5. Methodology Citation

Not applicable.

1a.6.—Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation

Not applicable.

1a.6.2. Methodology Citation

Not applicable.

1a.7.—Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review

Not applicable.

1a.7.2. Grade

Not applicable.

1a.7.3. Grades and Associated Definitions

Not applicable.

1a.7.4. Time Period

Not applicable.

1a.7.5. Number and Type of Study Designs

Not applicable.

1a.7.6. Overall Quality of Evidence

Not applicable.

1a.7.7. Estimates of Benefit

Not applicable.

1a.7.8. Benefits Over Harms

Not applicable.

1a.7.9. Provide for Each New Study

Not applicable.

1a.8.—Other Source of Evidence

The Medicaid MLTSS enrollee population includes individuals with complex health and social support needs, such as individuals with physical, cognitive, and mental disabilities and older adults with multiple functional limitations and chronic conditions. [1,2] Given their complex needs, Medicaid MLTSS enrollees require high levels of care coordination.[3] Delivering effective care coordination for complex populations, such as Medicaid MLTSS enrollees, begins with conducting and regularly updating a comprehensive assessment to identify

[1] Medicaid and CHIP Payment and Access Commission (MACPAC). (2016). Users of long-term services and supports. Available at https://www.macpac.gov/subtopic/long-term-services-and-supports-population/.
[2] Kaiser Family Foundation (KFF). (2015). Medicaid and Long-Term Services and Supports: A Primer. Available at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.
[3] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

enrollees' needs and then developing and regularly updating an individualized care plan to dictate what care is to be provided.[4]

Variation in How Care Plans are Defined and Conducted

State Medicaid agencies have implemented numerous Medicaid MLTSS care coordination models that include care planning components.[5] Similarly, numerous other programs relevant to Medicaid MLTSS enrollees require care plans, including patient-centered medical homes, Medicare managed care plans (e.g., Special Needs Plans, Financial Alignment Initiative dual eligible enrollee demonstration plans), state Medicaid home and community-based services 1915(c) waiver programs, the Program for All-Inclusive Care for the Elderly (PACE), and Medicaid Health Homes. Despite such widespread use, uniform specifications regarding the development of care plans do not exist, and performance measures used to evaluate the quality of care plans developed are not well-established. An environmental scan conducted under a previous CMS contract (Prime Contract No. HHSM-500-2010-00026I/HHSM-500-T0011) highlights the lack of standardization in how care plans are defined across populations using LTSS (included as Appendix 1: Environmental Scan of Assessment and Care Planning Measures).

This measure would address the lack of standardization by assessing the percentage of MLTSS enrollees who have a care plan addressing specified domains: current and expected services, goals and preferences, a plan for follow up and communication, and a plan for and a point of contact in case of an emergency. In addition, documentation of the care plan must include the date of care plan signature, whether a family or friend caregiver was involved and their contact information, and signature of the enrollee or proxy.

Evidence to Support Impact of Care Planning on Outcomes

Although no uniform specifications exist, care coordination experts agree that care plans should be based on comprehensive assessments; address items related but not limited to individuals' health and functional status and their goals, preferences, and values; and clearly

[4] Agency for Research and Healthcare Quality (AHRQ). (2012). Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Available at https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf.

[5] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

specify what care is to be provided and by which care team member. Care plans should also be reviewed on a frequent basis and updated as health and social support needs change.[6]

Well-developed care plans are associated with numerous positive outcomes, including improving patient-provider and provider-provider communication, encouraging care team accountability, flagging potential concerns for future evaluation, and promoting individuals' and caregivers' self-management.[7] Documenting goals alone has been linked to numerous positive health outcomes. The use of structured goal-setting approaches to self-manage has been shown to significantly improve HbA1c levels and maintain improvements for one year in primary care-based diabetes group clinics.[8] Goal-setting has also been linked to more positive outcomes and improvements in health and functioning in a variety of other populations, such as those with dementia,[9] coronary heart disease,[10] stroke,[11] end stage renal disease,[12] and rehabilitation needs.[13] As for the use of care plans, in a recently published Australian study, researchers found that using a care plan as a single document for sharing information across multiple settings demonstrated clinically-significant improvement in depression and improved 10-year cardiovascular risk, exercise rates, and referrals to exercise programs and mental-health clinicians.[14]

Given the large and growing body of evidence, goal-oriented care planning has become recognized as vital to improving the quality and delivery of care for dual eligible enrollees. This is evidenced by the recommendations from numerous National Quality Forum work

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[6] AHRQ. (2012). Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Available at https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf.

[7] AHRQ. (2012). Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Available at https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf.

[8] Naik, A. D., Palmer, N., Petersen, N. J., Street, R. L., Jr., Rao, R., Suarez-Almazor, M., & Haidet, P. (2011). Comparative effectiveness of goal setting in diabetes mellitus group clinics: randomized clinical trial. *Archives of Internal Medicine, 171*(5), 453-459.

[9] Clare, L., Nelis, S. M., Jones, I. R., Hindle, J. V., Thom, J. M., Nixon, J. A., Whitaker, C. J. (2015). The Agewell trial: a pilot randomised controlled trial of a behaviour change intervention to promote healthy ageing and reduce risk of dementia in later life. *BMC Psychiatry*, 15, 25.

[10] Janssen, V., De Gucht, V., Dusseldorp, E., & Maes, S. (2013). Lifestyle modification programmes for patients with coronary heart disease: a systematic review and meta-analysis of randomized controlled trials. *European Journal of Preventive Cardiology, 20*(4), 620-640.

[11] Warner, G., Packer, T., Villeneuve, M., Audulv, A., & Versnel, J. (2015). A systematic review of the effectiveness of stroke self-management programs for improving function and participation outcomes: self-management programs for stroke survivors. *Disability and Rehabilitation*, 1-23.

[12] Kauric-Klein, Z. (2012). Improving blood pressure control in end stage renal disease through a supportive educative nursing intervention. *Nephrology Nursing Journal, 39*(3), 217-228.

[13] Muller, M., Strobl, R., & Grill, E. (2011). Goals of patients with rehabilitation needs in acute hospitals: goal achievement is an indicator for improved functioning. *Journal of Rehabilitation Medicine, 43*(2), 145-150.

[14] Morgan, M.A.J., Coates, M.J., & Dunbar, J.A. (2015). Using Care Plans to Better Manage Multimorbidity. *AMJ,* 8(6), 208–215.

groups, its inclusion in almost every care coordination model, and its identification as a priority for measure development by the stakeholders we interviewed for this project.

Identifying the Domains for the Care Plan

To identify the appropriate domains for inclusion in this measure, we conducted a scan of care plan domains required for the following programs/assessment which focus on high need populations: Special Needs Plans, Medicare-Medicaid Integrated Health Plans, Medicaid 1915c waivers, Medicaid Balancing Incentive Program, Medicare Home Health OASIS, Continuity Assessment Record and Evaluation, Nursing Facility Minimum Data Set, and the Program of All Inclusive Care for the Elderly. To augment our environmental scan, we conducted one-on-one interviews with key stakeholders and Technical Expert Panel (TEP) members to solicit additional care plan domains.

We identified four domains (summary of assessment, services and care, goals and preferences, and care coordination plan) made up of 23 elements. To prioritize domains and elements we conducted a survey of the TEP members and selected items that were supported by 75 percent or more of TEP members for inclusion the measure. Complete details of the voting process and the results can be found in Appendix 2.

1a.8.1. Process Used

In the absence of a systematic review, the project team conducted a targeted literature review to gather evidence in support of this measure. We searched for academic journal articles, gray literature, and federal and state agency reports published in the last 23 years using PubMed, Google, and Google Scholar. We also convened a TEP in 2013 to provide insight into the priority areas for measurement and the usefulness and feasibility of the identified measures for MLTSS plans. The TEP was comprised of individuals representing multiple perspectives from the MLTSS community, including consumers, practitioners, health plans, the federal government, and state governments. We also built upon an environmental scan of Assessment and Care Planning measures conducted under a previous CMS contract (Prime Contract No. HHSM-500-2010-00026I/HHSM-500-T0011) and included here in Appendix 1.

1a.8.2. Citation

See footnotes from Section 1a.8.1 above.

1b.—Evidence to Support Measure Focus

1b.1. Rationale

The Medicaid MLTSS enrollee population includes individuals with complex health and social support needs.[15,16] Given their complex needs, they require high levels of care coordination.[17] Effective care coordination for complex populations, such as MLTSS enrollees, includes developing individualized care plans, which are associated with numerous positive health outcomes.[18] Since many MLTSS enrollees receive benefits from both Medicare and Medicaid and typically see multiple providers, there must be a shared understanding of their needs and goals across providers and settings. The vehicle for that shared understanding is the care plan. The creation of a proactive plan of care tailored to the individual, based on a comprehensive assessment, should form the foundation for all care coordination efforts.[19]

1b.2. Performance Scores

Not applicable.

1b.3. Summary of Data Indicating Opportunity

Care plans based on comprehensive assessments serve as the foundation for providing high quality and well-coordinated care. While almost all MLTSS plans require care plans be developed for their members, there is little data on the rate of care plan development among the MLTSS enrollee population. A central challenge to measuring the rate of care planning is the variation in the way care plans are defined across states and health plans.

In May 2016, CMS issued a final rule[20] that included provisions for Medicaid managed care programs to be implemented no later than July 1, 2017. More specifically, the rule requires "mechanisms to detect both underutilization and overutilization of services and the quality and appropriateness of care furnished to enrollees with special health care needs" and "quality assessment and performance improvement programs for plans offering LTSS must

[15] MACPAC. (2016). Users of long-term services and supports. Available at https://www.macpac.gov/subtopic/long-term-services-and-supports-population/.
[16] KFF. (2015). Medicaid and Long-Term Services and Supports: A Primer. Available at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.
[17] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.
[18] AHRQ. (2012). Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Available at https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf.
[19] AHRQ. (2014). Care Coordination Measures Atlas Update. Rockville, MD: Agency for Healthcare Research and Quality.
[20] CMS. (2016). 42 CFR Parts 431, 433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

include assessments of care between care settings and comparisons of services and supports received with those set forth in the enrollee's treatment/service plan."[21]

In January 2014, CMS also issued a final rule[22] that established person-centered service planning requirements for persons in home and community based services (HCBS) settings. More specifically, it requires person-centered service plans:

- Be developed through a person-centered planning process driven by the individual that includes people chosen by the individual, provides support to the individual to ensure that the individual directs the process to the maximum extent possible, and is timely and occurs at times/locations of convenience to the individual.
- Reflect cultural considerations, use plain language, include strategies for solving disagreement, offer choices to the individual regarding services and supports the individual receives and from whom, and provide a method to request updates.
- Reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.
- Identify the strengths, preferences, needs (clinical and support), and desired outcomes of the individual.
- Include individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, and other areas.
- Include risk factors and plans to minimize them.
- Be signed by all individuals and providers responsible for its implementation. A copy of the plan must be provided to the individual and his/her representative.
- Follow specific documentation requirements.

Despite this guidance, uniformity regarding the evaluation of care plans is not well-established across state LTSS programs. This measure will reduce some of the variation in care plan definition by evaluating the percentage of Medicaid MLTSS enrollees who have a care plan developed that includes clearly specified domains. Through testing we will explore the rate of care planning and variation between MLTSS plans and states.

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[21] Integrated Care Resource Center (ICRC). (2016). Spotlight: CMS Medicaid Managed Care Final Rule – Provisions Related to Integrated Programs for Medicare-Medicaid Enrollees. Available at http://www.integratedcareresourcecenter.com/PDFs/2016%2005%2012%20Medicaid%20Managed%20Care%20Regulations.pdf

[22] CMS. (2014). Final Rule Medicaid HCBS. Disabled and Elderly Health Programs Group. Center for Medicaid and CHIP Services. Available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/final-rule-slides-01292014.pdf.

1b.4. and 1b.5. Disparities

There is little research on potential disparities in the use of care plans among the MLTSS enrollee population. Studies have identified persistent racial and ethnic disparities regarding advanced care planning.[23,24,25] However, most other research focuses on the identification of disparities in the need for and use of LTSS more broadly, which highlight the need for detailed and well-documented comprehensive assessments and care plans.

The Congressional Budget Office identified racial and ethnic disparities in the need for LTSS. More specifically, it found that older black and Hispanic individuals have higher rates of functional impairment than whites. [26]

Another report identified disparities in care coordination and access of care for newly transitioned Medicaid managed care enrollees with complex needs. More specifically, it found that primary care providers in California felt unprepared and untrained for the level of effort required to coordinate care for newly transitioned seniors and persons with disabilities. It also found that fewer than 60 percent of newly transitioned seniors and persons with disabilities were successfully contacted and administered a health risk assessment, a less intensive assessment than required by this measure that might lead to incomplete care plans.[27]

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

- Affects large numbers
- High resource use
- Patient/social consequences of poor quality

[23] Barwise, A., M. Wilson, R. Kashyap, O. Gajic, & B. W. Pickering. (2016). Disparities in Advanced Care Planning in The ICU and End of Life Decision Making. Available at http://www.atsjournals.org/doi/abs/10.1164/ajrccm-conference.2016.193.1_MeetingAbstracts.A7926.

[24] Effiong, A. & D. Myrick. (2012). H.R. 1589: addressing racial and ethnic disparities in advance care planning among Medicare enrollees. *BMJ Supportive & Palliative Care*, 2, 181.

[25] Garrido, M. M., S. T. Harrington, & H. G. Prigerson. (2014). End-of-life treatment preferences: a key to reducing ethnic/racial disparities in advance care planning? *Cancer*, 120(24), 3981-3986.

[26] Congressional Budget Office. (2013). Rising Demand for Long-Term Services and Supports for Elderly People. Washington, DC: Congressional Budget Office.

[27] KFF. (2013). Issue Brief. Transitioning Enrollees with Complex Care Needs to Medicaid Managed Care: Insights from California. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/06/8453-transitioning-beneficiaries-with-complex-care-needs2.pdf.

1c.3. Epidemiologic or Resource Use Data

Although criteria vary by state, individuals are generally eligible for Medicaid LTSS if they need assistance with at least one, and often more activities of daily living or instrumental activities of daily living. The MLTSS enrollee population who receives LTSS is diverse. It includes individuals with complex health and social support needs who often receive care from multiple providers and settings. Older adults and adults with physical disabilities are the most common groups receiving LTSS.[28] As of 2012, adults with intellectual or development disabilities and children with disabilities were also covered in half of MLTSS state programs.[29] It also includes individuals who are also more likely to be Medicare-Medicaid enrollees. As of 2013, approximately one-third of dual eligible enrollees were receiving LTSS nationwide.[30]

Medicaid covers LTSS in institutional settings, such as skilled nursing facilities, intermediate care facilities, and mental health facilities. It also covers LTSS in the home and community settings, where enrollees receive home and community based services (HCBS) that allow them to reside in the community but still receive assistance. HCBS are designed to prevent or delay institutionalization and generally include home health, personal care, medical equipment, assistive devices, rehabilitative therapy, adult day care, targeted case management, home modifications, transportation, and respite care for caregivers.[31,32] Roughly half of MLTSS programs include only enrollees at the institutional level of care (HCBS programs and institutions), which account for 25 percent of enrollment nationwide.[33] In fiscal year (FY) 2012, 43.4 percent of Medicaid expenditures ($169.2 billion) were spent on

[28] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.
[29] Saucier, P. K. (2012). *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Centers for Medicare & Medicaid Services.
[30] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.
[31] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.
[32] The Lewin Group & General Dynamics Information Technology. (2013). Evaluating Medicaid Long-Term Services and Supports Utilization.
[33] Saucier, P. K. (2012). *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Centers for Medicare & Medicaid Services.

LTSS users, even though LTSS users comprised only 6.2 percent (4.3 million) of Medicaid enrollees.[34]

As payment models shift away from fee-for-service, state Medicaid agencies are moving their LTSS enrollees into managed care plans, either stand-alone MLTSS plans, or comprehensive managed care plans that provide both LTSS and medical care. As of 2014, 17 states provide LTSS through managed care programs and the number of Medicaid enrollees using, or at risk of needing, LTSS who were enrolled in managed care programs covering LTSS grew from about 916,000 in 2013 to more than 1.6 million in 2014.[35]

MLTSS enrollees often experience highly fragmented care and are at risk for numerous adverse health care utilization patterns and outcomes. [36,37,38,39,40,41,42] At its best, managed care offers the promise of delivering community-based coordinated care by integrating medical care, behavioral health care, and LTSS across providers and settings. At its worst, it could disrupt longstanding relationships (e.g., if patients' providers are not part of the managed care plan's network) and create additional barriers to obtaining needed care (e.g., through gatekeeping or coverage restrictions). Because the range of potential outcomes from these shifts in care delivery is so broad, it is necessary to systematically monitor the quality of care delivered to people in MLTSS plans.

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[34] Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. MACStats: Medicaid and CHIP data book. December 2015. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2015.pdf.

[35] Centers for Medicare & Medicaid Services. 2015. Medicaid Managed Care Enrollment and Program Characteristics, 2014. Mathematica Policy Research, prepared for CMS. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf.

[36] Naylor, M. D., E. T. Kurtzman, & M. V. Pauly. (2009). Transitions of Elders Between Long-Term Care and Hospitals. *Policy, Politics, and Nursing Practice*, 10(3), 187-194.

[37] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

[38] Freedman, V. & B. C. Spillman. (2014). Disability and Care Needs Among Older Americans. *The Milbank Quarterly*, 92(3), 509-541.

[39] Allen, S. M., E. R. Piette, & V. Mor. (2014). The Adverse Consequences of Unmet Need Among Older Persons Living in the Community: Dual-Eligible Versus Medicare-Only Enrollees. *The Journals of Gerontology: Psychological Sciences*, 69(1), S51-S58.

[40] Komisar, H. L., J. Feder, & J. D. Kasper. (2005). Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles. *Inquiry*, 42(2), 171-182.

[41] Sands, L. P., Y. Wang, G. P. McCabe, K. Jennings, C. Eng, & K. E. Covinsky. (2006). Rates of Acute Care Admissions for Frail Older People Living with Met Versus Unmet Activity of Daily Living Needs. *Journal of the American Geriatrics Society*, 53(2), 339-344.

[42] Gaugler, J. E., S. Duval, K. A. Anderson, & R. L. Kane. (2007). Predicting Nursing Home Admission in the U.S.: A Meta-Analysis. *BMC Geriatrics*, 7(1), 1.

To assess the care provided during this time of transition, most states have incorporated LTSS specific measures into their managed care plans quality management programs. However, the lack of a nationally endorsed set of measures has resulted in highly unique approaches that vary by state.

1c.4. Citations.

See footnotes included above in Section 1c.3.

1c.5. Patient-Reported Outcome Performance Measure (PRO-PM)

Not applicable.

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.2. Identify the Specific Dataset

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.3. What are the Dates of the Data Used in Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.4. What Levels of Analysis Were Tested?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.7. Sample Differences, if Applicable

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.2. Method of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.3. Statistical Results from Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.4. Interpretation

Not applicable. Reliability will be determined during the measure testing phase.

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.2. Method of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.3. Statistical Results from Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.4. Interpretation

Not applicable. Validity will be determined during the measure testing phase.

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.2. Statistical Results From Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.3. Interpretation

Not applicable. Exclusions will be determined during the measure testing phase.

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable.

2b4.2. Rationale why Risk Adjustment is not Needed

Not applicable.

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable.

2b4.4. Statistical Results

Not applicable.

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable.

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R^2)

Not applicable.

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable.

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable.

2b4.9. Results of Risk Stratification Analysis

Not applicable.

2b4.10. Interpretation

Not applicable.

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable.

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method for determining

Not applicable. Differences will be determined during the measure testing phase.

2b5.2. Statistical Results

Not applicable. Differences will be determined during the measure testing phase.

2b5.3. Interpretation

Not applicable. Differences will be determined during the measure testing phase.

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable. Comparability will be determined during the measure testing phase.

2b6.2. Statistical Results

Not applicable. Comparability will be determined during the measure testing phase.

2b6.3. Interpretation

Not applicable. Comparability will be determined during the measure testing phase.

Feasibility

3a.1. How are the data elements needed to compute measure scores generated

Data elements will be generated through routine care and collected from MLTSS care management records. Feasibility will be determined during the measure testing phase.

3b.1. Are the data elements needed for the measure as specified available electronically

We do not anticipate all data elements will be available electronically to all MLTSS plans. The availability of data elements in structured electronic fields will be evaluated in testing.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable. This is not an eMeasure.

3c.1. Describe what you have learned or modified as a result of testing

Not applicable. Measure is under development.

3c.2. Describe any fees, licensing, or other requirements

No fees, licensing, or other requirements at this phase.

Usability and Use

4.1—Current and Planned Use

Use	Planned	Current	For current use, provide Program Name and URL
a. Public Reporting	X		
b. Public Health/Disease Surveillance			
c. Payment Program			
d. Regulatory and Accreditation Programs			
e. Professional Certification or Recognition Program			
f. Quality Improvement with Benchmarking (external benchmarking to multiple organizations)	X		
g. Quality Improvement (Internal to the specific	X		
h. Not in use			
i. Use Unknown			

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients

Not applicable. This is a new measure.

4a.2. If not publicly reported or used for accountability, reasons

Not applicable. Usability will be determined during the measure testing phase.

4a.3. If not, provide a credible plan for implementation

This measure is intended for use by states to monitor and improve the quality of care provided for the Medicaid MLTSS enrollee population. A measure implementation plan will be proposed for CMS review following testing.

4b.1. Progress on improvement

Not applicable. This is a new measure.

4b.2. If no improvement was demonstrated, what are the reasons

Not applicable. This is a new measure.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. Related measure titles and NQF numbers are listed here:

- Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)
- HBIPS-6 Post Discharge Continuing Care Plan Created (NQF #0557)
- HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge (NQF #0558)

5.1b. If the measures are not NQF-endorsed, indicate the measure title

A complete review of existing care plan measures can be found in Appendix 1.

There are many measures that assess use of care plans in various state and federal programs. However, to our knowledge there is no standardized definition and many measures cannot be used to compare across states. Within the Medicare-Medicaid Coordination Office Financial Alignment Initiative demonstration projects, we found many similar but slightly different measures. Examples include:

- Individualized Care Plans: Percent of members with care plans by specified timeframe. (CMS Financial Alignment Initiative Core Measure and CA, IL, MA, MI, NY, OH, SC, VA)
- Demonstrated use of person centered planning using defined Department of Community Health person-centered planning principles: Number of all enrollees with person-centered plans reported to be developed in accordance with person centered planning principles. (MI)
- Person-Centered Care or Service Plan: Percent of participants with care plans within 30 days of initial assessment. (RI, NY)

- Plan of Care and Documentation of Care Goals: Proportion of enrollees at each risk level (high-, medium-, low-) with Individual Care Plan (ICP) developed within specified timeframes compared to total enrollees at each risk level requiring ICPs. (SC, VA)

Many of these measures lack detailed specifications that define the core elements of the care plan and how those data elements should be measured. When such details do exist, there is significant variation across the measures (see Appendix 1 for more details on variation across care plan measures).

5a—Harmonization

5a.1. Are the measure specifications completely harmonized

No. The measure elements are not completely harmonized; however, we will aim to align the measure with existing measures to the greatest extent possible through testing.

5a.2. If not completely harmonized, identify the differences rationale, and impact

This measure is under development. A summary of the differences between this measure and existing measures of assessment will be provided after the measure is finalized.

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures

Not applicable.

Additional Information

Co.1.—Measure Steward Point of Contact

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services
Roxanne Dupert-Frank
7500 Security Boulevard, Mail Stop: S3-02-01
Baltimore, MD
Roxanne.Dupert-Frank@cms.hhs.gov
(410) 786-9667

Co.2.—Developer Point of Contact (indicate if same as Measure Steward Point of Contact

Mathematica Policy Research
Debra Lipson
DLipson@Mathematica-Mpr.com
(202) 484-9220

Ad.1. Workgroup/Expert Panel Involved in Measure Development

Development of Assessment and Care Planning Measures for Use in Medicaid Managed Long Term Services and Supports (MLTSS) Programs Technical Expert Panel, 2013

Anne Cohen, Health and Disability Policy Consultant, Disability Health Access, LLC

Patti Killingsworth, Assistant Commissioner and Chief of LTSS, Bureau of TennCare

Jennifer Lenz, Executive Director, State and Corporate Services, Health Services Advisory Group

Bonnie Marsh, Executive Director, State and Corporate Services, Health Services Advisory Group

Diane McComb, ANCOR Liaison with State Associations

Margaret A. Nygren, Executive Director and CEO, American Association on Intellectual and Developmental Disabilities

Joseph Ouslander, Professor of Clinical Biomedical Science, Florida Atlantic University

Pamela J. Parker, Manager, Special Needs Purchasing, State of Minnesota Department of Human Services

Cheryl Phillips, Senior VP Public Policy and Advocacy, Leading Age

D.E.B. Potter, Senior Survey Statistician, Agency for Healthcare Research and Quality

Juliana Preston, Utah Executive Director, HealthInsight

Genie Pritchett, Sr. Vice President Medical Services, Colorado Access

Alice Lind, Aging and Long Term Support Division, Washington State Department of Social and Health Services

Ad.2. Year the Measure Was First Released

Not applicable. This measure is still under development.

Ad.3. Month and Year of Most Recent Revision

Not applicable. This measure is still under development.

Ad.4. What is your frequency for review/update of this measure?

Not applicable. This measure is still under development.

Ad.5. When is your next scheduled review/update for this measure?

Not applicable. This measure is still under development.

Ad.6. Copyright Statement

Not applicable. This measure is still under development.

Ad.7. Disclaimers

Not applicable. This measure is still under development.

Ad.8. Additional Information/Comments

Not applicable.

Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "dual enrollees"
- People receiving long-term services and supports (LTSS) through Medicaid managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program.

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on August 12, 2016.

Measure Name: Shared Care Plan

Descriptive Information

Measure Name (Measure Title De.2.)
Shared Care Plan

Measure Type De.1.
Process

Brief Description of Measure De.3.
The percentage of Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees with a care plan for whom all or part of the care plan was transmitted to key LTSS providers and the primary care provider within 30 days of development or update.

If Paired or Grouped De.4.
This measure is grouped with two other measures that assess the continuum of assessment, care planning and care coordination. This continuum of care is described in greater detail in the accompanying Measure Justification Form.

- Comprehensive LTSS Assessment
- Comprehensive LTSS Care Plan measures.

Subject/Topic Areas De.5.

- See crosscutting areas

Crosscutting Areas De 6.

- Care Coordination: Care Coordination

Measure Specifications

Measure-specific Web Page S.1.
Not applicable. This measure is still under development.

If This Is an eMeasure S.2a.
Not applicable. This is not an eMeasure.

Data Dictionary, Code Table, or Value Sets S.2b.
Not applicable. This measure is still under development.

For Endorsement Maintenance S.3.
Not applicable. This measure is still under development.

Numerator Statement S.4.

Medicaid MLTSS enrollees who have a care plan that was transmitted to identified key providers within 30 days of date of completion of a care plan or update to care plan.

Note: Numerator statement may change as this measure is still under development.

Time Period for Data S.5.

16 months (September 1 of the year prior to the measurement year to December 31 of the measurement year).

Numerator Details S.6.

Definitions (*Note: Numerator definitions and details may change as this measure is still under development.)*

Care plan: A document or electronic tool which identifies beneficiary needs, preferences, risks, and contains a list of the services and supports planned to meet those needs while reducing risks. The care plan documents any of the following domains: (1) results of the assessment, (2) care planned to meet beneficiary medical, functional, emotional, social, and cognitive needs, (3) services and supports being provided currently or planned in the next month, (4) beneficiary goals and preferences for care, and (5) coordination and follow-up plan, and an emergency back-up plan. The entire care plan does not need to be transmitted to meet the numerator criteria. Plans may select portions of the care plan that are most relevant to key providers or provide a summary.

Transmitted: Care plan may be transmitted to providers via fax, secure e-mail, or mutual access to an electronic health record (EHR).

Key long-term services and supports (LTSS) providers: Providers listed in the care plan providing physical or occupational therapy, skilled nursing, residential and habilitation (vocational/day center) or personal care in the home. Note: Meal delivery, medical supply delivery, homemaker and other services not providing hands-on care are excluded.

Primary Care Provider (PCP): A physician, non-physician (e.g. nurse practitioner, physician assistant), or group of providers who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.

Numerator Details

Medicaid MLTSS enrollees who have a care plan that was transmitted to key LTSS providers and the primary care provider within 30 days of completion of the care plan or update to care plan.

Evidence of a transmitted care plan should meet the following criteria:

- How the care plan was transmitted (via fax, secure e-mail, or notification through an electronic health record (EHR) system).
- Who care plan was transmitted to.

- Date of transmittal.
- The domains of the care plan that were transmitted.

Evidence of mutual access to a shared EHR alone is not sufficient for numerator criteria. There must be documentation that the provider was notified of the updated or newly developed care plan.

If the enrollee is not receiving LTSS, the care plan does not need to be shared with LTSS providers.

Note: Numerator details may change as this measure is still under development.

Denominator Statement S.7.
Medicaid MLTSS enrollees age 18 years and older who had a care plan developed in the measurement year.

Note: Denominator statement may change as this measure is still under development.

Target Population Category S.8.

- Populations at Risk: Populations at Risk
- Populations at Risk: Dual-Eligible Enrollees

Denominator Details S.9.
A systematic sample drawn from the eligible population, which includes enrollees:

- Who are 18 years and older as of the first day of the measurement year.
- Who are enrolled in an MLTSS plan for at least 120 days between September 1 of the year prior to the measurement year and December 1 of the measurement year.
- Who have either of the following benefits: 1) long-term services and supports: home and community based or 2) long-term services and supports: facility based.
- Who have a care plan developed or updated between November 30 of the year prior to the measurement year and December 1 of the measurement year.

Note: Denominator details may change as this measure is still under development.

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10.
None.

Note: Denominator exclusions may change as this measure is still under development.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11.
None.

Note: Denominator exclusion details may change as this measure is still under development.

Stratification Details/Variables S.12.
Consideration of stratification by the following variables:

- Ages 18-64
- Ages 65+
- Community dwelling non-home and community-based services (HCBS) users
- Community dwelling HCBS users
- Non-community dwelling population (e.g., nursing facility and intermediate care facility residents)

Note: Stratification details may change as this measure is still under development.

Risk Adjustment Type S.13.
Not applicable.

Statistical Risk Model and Variables S.14.
Not applicable.

Detailed Risk Model Specifications S.15.
Not applicable.

Type of Score S.16.
Rate/proportion

Interpretation of Score S.17.
A higher score denotes better performance.

Calculation Algorithm/Measure Logic S.18.
Step 1. Determine the eligible population.

Step 2. From the eligible population, draw a systematic sample.

Step 3. From the systematic sample, identify all enrollees with a care plan for whom all or part of the care plan was transmitted to key LTSS providers and the primary care provider within 30 days of completion or update.

Step 4. Divide the number of enrollees from Step 3 by the number of enrollees from Step 2 to calculate the rate.

Note: Calculation algorithm/measure logic may change as this measure is still under development.

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.
Not applicable.

Sampling S.20.
The approach for sampling will be determined during the measure testing phase.

Survey/Patient-Reported Data S.21.
Not applicable.

Missing Data S.22.
Not applicable. The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23.

- Electronic Clinical Data: Electronic Health Record
- Paper Medical Records
- Other (Care management records)

Data Source or Collection Instrument S.24.
Not applicable.

Data Source or Collection Instrument (Reference) S.25.
Not applicable.

Level of Analysis S.26.
Health plan

Care Setting S.27.
Home Health; Hospital/Acute Care Facility; Post-Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; Post-Acute/Long Term Care Facility: Inpatient Rehabilitation Facility; Post-Acute/Long Term Acute Care Hospital; Other (Home)

Composite Performance Measure S.28.
Not applicable.

Measure Justification Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "dual enrollees"
- People receiving long-term services and supports (LTSS) through Medicaid managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program.

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on August 12, 2016.

Measure Name

Shared Care Plan

Type of Measure

Process

Importance

1a—Opportunity for Improvement

1a.1. This is a measure of process. It is the rate of Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees with a care plan for whom all or part of the care plan was transmitted to key LTSS providers and the primary care provider within 30 days of development or update.

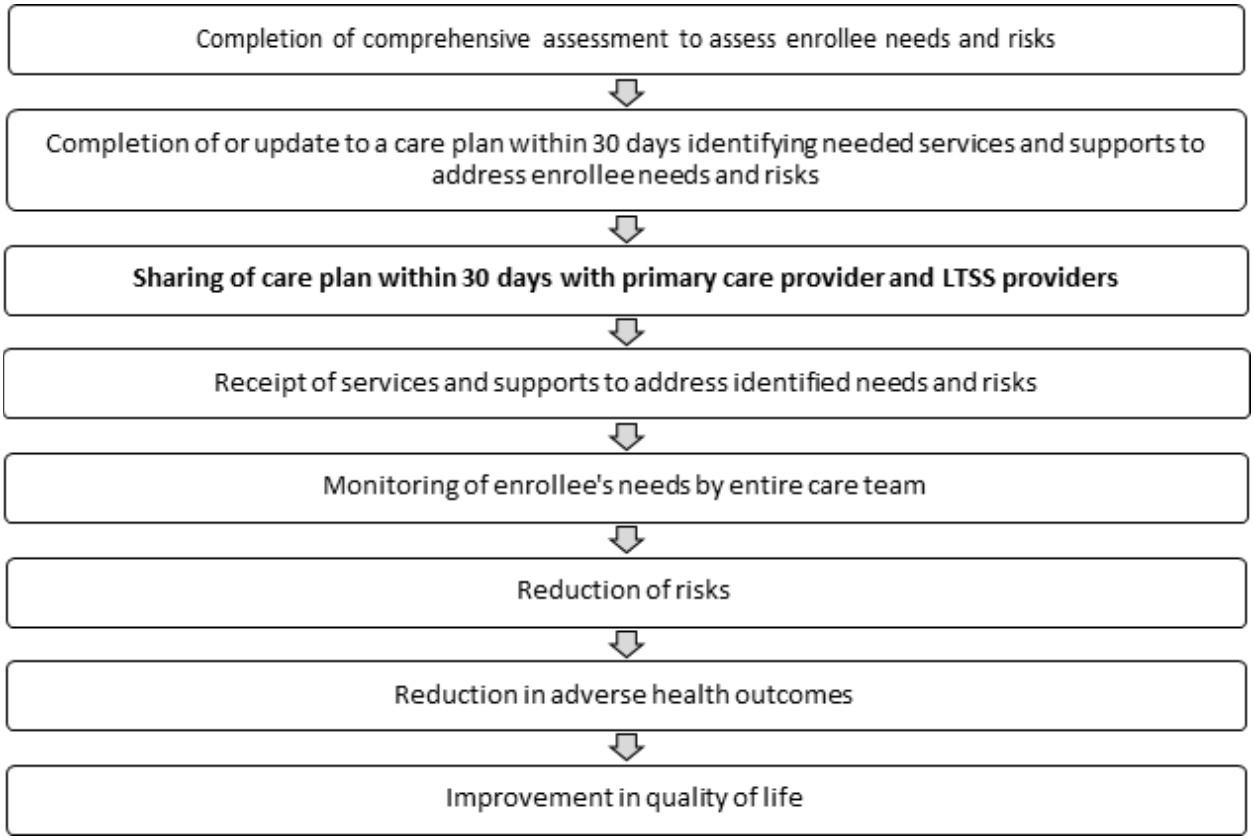
1a.2.—Linkage

Not applicable.

1a.2.1 Rationale

Not applicable.

1a.3.—Linkage



1a.3.1. Source of Systematic Review

- Clinical Practice Guideline recommendation – ***complete sections 1a.4, and 1a.7***
- US Preventive Services Task Force Recommendation – ***complete sections 1a.5 and 1a.7***
- Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections 1a.6 and 1a.7***

✓ Other – complete section 1a.8

1a.4.—Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation

Not applicable.

1a.4.2. Specific Guideline

Not applicable.

1a.4.3. Grade

Not applicable.

1a.4.4. Grades and Associated Definitions

Not applicable.

1a.4.5. Methodology Citation

Not applicable.

1a.4.6. Quantity, Quality, and Consistency

Not applicable.

1a.5.—United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation

Not applicable.

1a.5.2. Specific Recommendation

Not applicable.

1a.5.3. Grade

Not applicable.

1a.5.4. Grades and Associated Definitions

Not applicable.

1a.5.5. Methodology Citation

Not applicable.

1a.6.—Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation

Not applicable.

1a.6.2. Methodology Citation

Not applicable.

1a.7.—Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review

Not applicable.

1a.7.2. Grade

Not applicable.

1a.7.3. Grades and Associated Definitions

Not applicable.

1a.7.4. Time Period

Not applicable.

1a.7.5. Number and Type of Study Designs

Not applicable.

1a.7.6. Overall Quality of Evidence

Not applicable.

1a.7.7. Estimates of Benefit

Not applicable.

1a.7.8. Benefits Over Harms

Not applicable.

1a.7.9. Provide for Each New Study

Not applicable.

1a.8.—Other Source of Evidence

The Medicaid MLTSS enrollee population includes individuals with complex health and social support needs, such as individuals with physical, cognitive, and mental disabilities and older adults with multiple functional limitations and chronic conditions.[1,2] Given their complex needs, MLTSS enrollees require high levels of care coordination.[3] Effective care coordination for complex populations, such as MLTSS enrollees, begins with conducting and regularly updating comprehensive assessments to identify enrollees' needs, developing and regularly

[1] Medicaid and CHIP Payment and Access Commission (MACPAC). (2016). Users of long-term services and supports. Available at https://www.macpac.gov/subtopic/long-term-services-and-supports-population/.
[2] Kaiser Family Foundation (KFF). (2015). Medicaid and Long-Term Services and Supports: A Primer. Available at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.
[3] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

updating care plans to dictate care to be provided, and sharing care plans to inform care team members of care to be coordinated.[4]

State Medicaid agencies have implemented numerous MLTSS care coordination models,[5] and most require the development of a care plan at initial enrollment and on a regular basis thereafter and the use of team based care to implement the care plan. Numerous other programs that deliver care to individuals who are similar to (or in some cases the same as) Medicaid MLTSS enrollees require care plans and team based care, including patient-centered medical homes, Medicare managed care plans (e.g., Special Needs Plans, Financial Alignment Initiative dual eligible enrollee demonstration plans), state Medicaid home and community-based services 1915(c) waiver programs, the Program for All-Inclusive Care for the Elderly (PACE), and Medicaid Health Homes. In order for team-based care to be effective, providers must share the care plan and communicate changes and updates to the care plan so that all members of the care team have a complete picture of the person's needs, preferences, and services and supports provided.

Well-developed care plans are associated with numerous positive outcomes, including improving patient-provider and provider-provider communication, encouraging care team accountability, flagging potential concerns for future evaluation, and promoting individuals' and caregivers' self-management.[6] Documenting goals alone has been linked to numerous positive health outcomes across different care settings, such as greater improvements in health and functioning, in a variety of MLTSS-related populations, such as those with

[4] AHRQ. (2012). Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Available at https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf.

[5] Saucier, P., & B. Burwell. "Care Coordination in Managed Long-Term Services and Supports." AARP Public Policy Institute, 2015. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

[6] AHRQ. (2012). Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Available at https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf.

dementia,[7] coronary heart disease,[8] stroke,[9] end stage renal disease,[10] and rehabilitation needs.[11]

In all of the above studies, the care plan was shared with the clinicians providing care. The sharing of information between providers (both LTSS and medical care providers) is the key step to providing coordinated person-centered care and breaking down the silos that exist between medical care and LTSS providers.

Evidence to Support Sharing of Information with Primary Care Providers (PCP)

There no direct evidence of the impact of sharing LTSS care plan information with the PCP on outcomes. However, there is related evidence demonstrating the importance of sharing information between specialists and PCPs.

Primary care has been demonstrated to be associated with better health outcomes and a decrease in hospital admissions and emergency department visits.[12] Nonetheless, communication between PCPs and specialists is lacking.[13,14,15,16] Research teams have evaluated the form and direction of communication, and have found a quality gap. In one study, [17] 28 percent of PCPs expressed dissatisfaction with the content of information they receive in PCP/specialist communications. Fifty percent of PCPs were dissatisfied with the timeliness of information they received; within two weeks of referral visits, 40 percent of PCPs received no information from the specialists, and four weeks after the referral visit, 25

[7] Clare, L., Nelis, S. M., Jones, I. R., Hindle, J. V., Thom, J. M., Nixon, J. A., . . . Whitaker, C. J. (2015). The Agewell trial: a pilot randomised controlled trial of a behaviour change intervention to promote healthy ageing and reduce risk of dementia in later life. *BMC Psychiatry*, 15, 25.

[8] Janssen, V., De Gucht, V., Dusseldorp, E., & Maes, S. (2013). Lifestyle modification programmes for patients with coronary heart disease: a systematic review and meta-analysis of randomized controlled trials. *European Journal of Preventive Cardiology, 20*(4), 620-640.

[9] Warner, G., Packer, T., Villeneuve, M., Audulv, A., & Versnel, J. (2015). A systematic review of the effectiveness of stroke self-management programs for improving function and participation outcomes: self-management programs for stroke survivors. *Disability and Rehabilitation*, 1-23.

[10] Kauric-Klein, Z. (2012). Improving blood pressure control in end stage renal disease through a supportive educative nursing intervention. *Nephrology Nursing Journal, 39*(3), 217-228.

[11] Muller, M., Strobl, R., & Grill, E. (2011). Goals of patients with rehabilitation needs in acute hospitals: goal achievement is an indicator for improved functioning. *Journal of Rehabilitation Medicine, 43*(2), 145-150.

[12] Shi, L. (2012). The impact of primary care: a focused review. *Scientifica (Cairo), 2012*, 432892.

[13] Gandhi, T. K., Sittig, D. F., Franklin, M., Sussman, A. J., Fairchild, D. G., & Bates, D. W. (2000). Communication breakdown in the outpatient referral process. *Journal of General Internal Medicine, 15*(9), 626-631.

[14] Hanlon, C. (2013). Measuring and Improving Care Coordination: Lessons from ABCD III. Portland, ME: The National Academy for State Health Policy.

[15] O'Malley, A. S., & Cunningham, P. J. (2009). Patient experiences with coordination of care: the benefit of continuity and primary care physician as referral source. *Journal of General Internal Medicine, 24*(2), 170-177.

[16] O'Malley, A. S., & Reschovsky, J. D. (2011). Referral and consultation communication between primary care and specialist physicians: finding common ground. *Archives of Internal Medicine, 171*(1), 56-65.

[17] Gandhi, T. K., Sittig, D. F., Franklin, M., Sussman, A. J., Fairchild, D. G., & Bates, D. W. (2000). Communication breakdown in the outpatient referral process. *Journal of General Internal Medicine, 15*(9), 626-631.

percent of PCPs still had no information. In a second study,[18] 81 percent of specialists said they "always" or "most of the time" send referring PCPs notification of results and advice to patients, but only 62 percent of PCPs say they receive this information. Those PCPs who do not consistently receive communication from specialists were significantly more likely to report that their ability to provide high quality care was jeopardized.

LTSS providers are in a unique position to provide PCPs with valuable information about an individual's risks due to their frequent presence in the patient's home. LTSS care managers frequently conduct in-home assessments and communicate with home based care providers. They can directly observe issues such as home safety risks, potential for medication errors due to disorganized, expired or incorrect medications, food and nutrition concerns, and environmental hazards. Direct care workers, such as personal care aides, may make even more frequent home visits, sometimes daily, to provide hands-on assistance with ADLs, which gives them greater opportunity to observe changes in an individual's health and functional status. However, LTSS providers may not be in a position to modify a medical care plan based on their observations. Therefore, coordination between LTSS providers and medical care providers is critical to avoid potentially negative outcomes for individuals using LTSS care.

Evidence to Support Coordination between LTSS and Medical Care Providers

The process of developing and updating care plans should involve all members of the care team; specifically, each key LTSS and medical care provider.[19] However, recent research conducted in organizations providing care coordination for LTSS services found that care is often delivered in silos with medical and LTSS systems operating independently. Coordination, when it occurs, is idiosyncratic and often depends on the efforts of the care coordinator to communicate with all relevant parties and to arrange for information to flow.[20]

Medicaid MLTSS enrollees often have conditions and needs that require a wide variety of health and other long-term services and supports, so coordinating their care requires attention to a broader set of services than is typically offered by a medical provider alone. Even medical providers, such as PCPs or geriatricians, trained to conduct comprehensive

[18] O'Malley, A. S., & Reschovsky, J. D. (2011). Referral and consultation communication between primary care and specialist physicians: finding common ground. *Archives of Internal Medicine, 171*(1), 56-65.
[19] AHRQ. (2012). Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Available at https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf.
[20] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

assessments of complex patients will often need to tap into additional knowledge and resources to develop realistic care plans for those patients. In addition, medical providers do not typically determine which LTSS someone may qualify for and may not even be aware of the various benefits available. These functions of the care team are best addressed through collaboration with LTSS providers and should be reflected within a shared care plan.

1a.8.1. Process Used

In the absence of a systematic review, the project team conducted a targeted literature review to gather evidence in support of this measure. We searched for academic journal articles, gray literature, and federal and state agency reports published in the last 23 years using PubMed, Google, and Google Scholar. We also convened a technical expert panel (TEP) in 2013 to provide insight into the priority areas for measurement and the usefulness and feasibility of the identified measures for MLTSS plans. The TEP was comprised of individuals representing multiple perspectives from the MLTSS community including consumers, practitioners, health plans, the federal government, and state governments.

We also built upon an environmental scan of Assessment and Care Planning measures conducted under a previous CMS contract (Contract No. HHSM-500-2010-00026I/HHSM-500-T0011) and included here in Appendix 1.

1a.8.2. Citation

See footnotes from Section 1a.8.1 above.

1b.—Evidence to Support Measure Focus

1b.1. Rationale

This measure would address the lack of coordination between LTSS and medical care providers by ensuring a patient's care plan is shared with all key providers including a PCP. The MLTSS enrollee population includes individuals with complex health and social support needs.[21,22] Given their complex needs, they require high levels of care coordination.[23] Effective care coordination for complex populations, such as MLTSS enrollees, includes

[21] MACPAC. (2016). Users of long-term services and supports. Available at https://www.macpac.gov/subtopic/long-term-services-and-supports-population/.
[22] KFF. (2015). Medicaid and Long-Term Services and Supports: A Primer. Available at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.
[23] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

developing and sharing individualized care plans, which are associated with numerous positive health outcomes.[24]

1b.2. Performance Scores

Not applicable.

1b.3. Summary of Data Indicating Opportunity

There is no direct estimate for the rate of sharing care plan information between providers. However, evidence does suggest coordination and communication between LTSS providers and medical care providers is a critical gap. Among many dual eligible enrollees, which make up a large portion of MLTSS enrollees, LTSS care is received through a state Medicaid program and medical care is received through Medicare either FFS or in a managed care arrangement. Recent research conducted in organizations providing care coordination for LTSS services found that even when financing for both Medicaid and Medicare services is integrated, care is often delivered in silos with medical and LTSS systems operating independently. One study found that establishing relationships between providers is critical for ensuring information exchange, and although technology supports such exchanges, coordinating care remains a "high touch activity." In addition, EHRs have not been widely adopted by LTSS providers, and furthermore, existing EHRs do not incorporate the type of information needed by LTSS providers. Finally, confusion regarding regulations protecting patient health information can often hinder necessary information exchange.[25] Coordination, when it occurs, is idiosyncratic and often depends on the efforts of the care coordinator to communicate with all relevant parties and to arrange for information to flow.[26]

Technology is one critical barrier to coordination between LTSS and medical care providers. In a case study of eight organizations financially responsible for both medical and LTSS care, only one site had a fully integrated EHR system that was accessible to both medical care and LTSS care providers. Six of the sites used separate systems for care management and medical records that are not interoperable, and one site used paper records for medical and care

[24] AHRQ. (2012). Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Available at https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf.

[25] McGinn-Shapiro, M., S. Mitchell, E. G. Walsh, M. Ignaczak, & L. Bercaw. (2015). Information exchange in integrated care models: final report. Available at https://aspe.hhs.gov/basic-report/information-exchange-integrated-care-models-final-report.

[26] Saucier, P., and B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

management services and had access to the EHR at one coordinating hospital.[27,28] This barrier to coordination was echoed by stakeholders in our interviews; they stressed the importance of the care coordinator role and the need for this person to be the communication hub between all of an individual's providers.

1b.4. and 1b.5. Disparities

There is little research on potential disparities in the sharing of care plans among the MLTSS enrollee population. Studies have identified persistent racial and ethnic disparities regarding advanced care planning.[29,30,31] However, most other research focuses on the identification of disparities in the need for and use of LTSS more broadly, which highlight the need for shared care plans.

The Congressional Budget Office identified racial and ethnic disparities in the need for LTSS. More specifically, it found that older black and Hispanic individuals have higher rates of functional impairment than whites.[32]

Another report identified disparities in care coordination and access of care for newly transitioned Medicaid managed care enrollees with complex needs. More specifically, it found that primary care providers in California felt unprepared and untrained for the level of effort required to coordinate care for newly transitioned seniors and persons with disabilities. It also found that fewer than 60 percent of newly transitioned seniors and persons with disabilities were successfully contacted and administered a health risk assessment, a less intensive assessment than required by this measure that might lead to incomplete care plans.[33]

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[27] Giovannetti, E.R., Anderson, E., Henry M., Ng, J., Scholle S.H., French, J.B. (2014). Escaping the Silos: Current Practices in Integrated Care for Vulnerable Populations. (*Paper in progress*).

[28] National Committee for Quality Assurance (NCQA). Policy Approaches to Advancing Person-Centered Outcome Measurement. 2015. The John A. Hartford Foundation and The SCAN Foundation. Available at https://www.ncqa.org/Portals/0/HEDISQM/Research/Policy%20Report_Final%20Report_TSF%202-1.pdf.

[29] Barwise, A., M. Wilson, R. Kashyap, O. Gajic, & B. W. Pickering. (2016). Disparities in Advanced Care Planning in The ICU and End of Life Decision Making. Available at http://www.atsjournals.org/doi/abs/10.1164/ajrccm-conference.2016.193.1_MeetingAbstracts.A7926.

[30] Effiong, A. & D. Myrick. (2012). H.R. 1589: addressing racial and ethnic disparities in advance care planning among Medicare beneficiaries. *BMJ Supportive & Palliative Care*, 2, 181.

[31] Garrido, M. M., S. T. Harrington, & H. G. Prigerson. (2014). End-of-life treatment preferences: a key to reducing ethnic/racial disparities in advance care planning? *Cancer*, 120(24), 3981-3986.

[32] Congressional Budget Office. (2013). Rising Demand for Long-Term Services and Supports for Elderly People. Washington, DC: Congressional Budget Office.

[33] KFF. (2013). Issue Brief. Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Insights from California. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/06/8453-transitioning-beneficiaries-with-complex-care-needs2.pdf.

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

- Affects large numbers
- High resource use
- Patient/social consequences of poor quality

1c.3. Epidemiologic or Resource Use Data

Although criteria vary by state, individuals are generally eligible for Medicaid LTSS if they need assistance with at least one, and often more activities of daily living or instrumental activities of daily living. The MLTSS enrollee population who receives LTSS is diverse. It includes individuals with complex health and social support needs who often receive care from multiple providers and settings. Older adults and adults with physical disabilities are the most common groups receiving LTSS.[34] As of 2012, adults with intellectual or development disabilities were also covered in half of MLTSS state programs.[35] MLTSS enrollees are also very likely to be Medicare-Medicaid enrollees. As of 2013, approximately one-third of dual eligible enrollees were receiving LTSS nationwide.[36]

Medicaid covers LTSS in institutional settings, such as skilled nursing facilities, intermediate care facilities, and mental health facilities. It also covers LTSS in the home and community settings, where enrollees receive home and community based services (HCBS) that allow them to reside in the community but still receive assistance. HCBS are designed to prevent or delay institutionalization and generally include home health, personal care, medical equipment, assistive devices, rehabilitative therapy, adult day care, targeted case management, home modifications, transportation, and respite care for caregivers.[37,38] Roughly half of MLTSS programs include only enrollees at the institutional level of care

[34] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.
[35] Saucier, P. K. (2012). *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Centers for Medicare & Medicaid Services.
[36] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.
[37] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.
[38] The Lewin Group & General Dynamics Information Technology. (2013). Evaluating Medicaid Long-Term Services and Supports Utilization.

(HCBS programs and institutions), which account for 25 percent of enrollment nationwide.[39] In fiscal year (FY) 2012, 43.4 percent of Medicaid expenditures ($169.2 billion) were spent on LTSS users, even though LTSS users comprised only 6.2 percent (4.3 million) of Medicaid enrollees.[40]

As payment models shift away from fee-for-service, state Medicaid agencies are moving their LTSS enrollees into managed care plans, either stand-alone MLTSS plans, or comprehensive managed care plans that provide both LTSS and medical care. As of 2014, 17 states provide LTSS through managed care programs and the number of Medicaid enrollees using, or at risk of needing, LTSS who were enrolled in managed care programs covering LTSS grew from about 916,000 in 2013 to more than 1.6 million in 2014.[41]

MLTSS enrollees often experience highly fragmented care and are at risk for numerous adverse health care utilization patterns and outcomes. [42,43,44,45,46,47,48] At its best, managed care offers the promise of delivering community-based coordinated care by integrating medical care, behavioral health care, and LTSS across providers and settings. At its worst, it could disrupt longstanding relationships (e.g., if patients' providers are not part of the managed care plan's network) and create additional barriers to obtaining needed care (e.g., through gatekeeping or coverage restrictions). Because the range of potential outcomes

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[39] Saucier, P. K. (2012). *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Centers for Medicare & Medicaid Services.

[40] Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. MACStats: Medicaid and CHIP data book. December 2015. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2015.pdf.

[41] Centers for Medicare & Medicaid Services. 2015. Medicaid Managed Care Enrollment and Program Characteristics, 2014. Mathematica Policy Research, prepared for CMS. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf.

[42] Naylor, M. D., E. T. Kurtzman, & M. V. Pauly. (2009). Transitions of Elders Between Long-Term Care and Hospitals. *Policy, Politics, and Nursing Practice*, 10(3), 187-194.

[43] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

[44] Freedman, V. & B. C. Spillman. (2014). Disability and Care Needs Among Older Americans. *The Milbank Quarterly*, 92(3), 509-541.

[45] Allen, S. M., E. R. Piette, & V. Mor. (2014). The Adverse Consequences of Unmet Need Among Older Persons Living in the Community: Dual-Eligible Versus Medicare-Only Beneficiaries. *The Journals of Gerontology: Psychological Sciences*, 69(1), S51-S58.

[46] Komisar, H. L., J. Feder, & J. D. Kasper. (2005). Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles. *Inquiry*, 42(2), 171-182.

[47] Sands, L. P., Y. Wang, G. P. McCabe, K. Jennings, C. Eng, & K. E. Covinsky. (2006). Rates of Acute Care Admissions for Frail Older People Living with Met Versus Unmet Activity of Daily Living Needs. *Journal of the American Geriatrics Society*, 53(2), 339-344.

[48] Gaugler, J. E., S. Duval, K. A. Anderson, & R. L. Kane. (2007). Predicting Nursing Home Admission in the U.S.: A Meta-Analysis. *BMC Geriatrics*, 7(1), 1.

from these shifts in care delivery is so broad, it is necessary to systematically monitor the quality of care delivered to people in MLTSS plans.

To assess the care provided during this time of transition, most states have incorporated LTSS specific measures into their managed care plans quality management programs. However, the lack of a nationally endorsed set of measures has resulted in highly unique approaches that vary by state.

1c.4. Citations.

See footnotes included above in Section 1c.3.

1c.5. Patient-Reported Outcome Performance Measure (PRO-PM)

Not applicable.

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.2. Identify the Specific Dataset

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.3. What are the Dates of the Data Used in Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.4. What Levels of Analysis Were Tested?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.7. Sample Differences, if Applicable

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.2. Method of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.3. Statistical Results from Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.4. Interpretation

Not applicable. Reliability will be determined during the measure testing phase.

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.2. Method of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.3. Statistical Results from Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.4. Interpretation

Not applicable. Validity will be determined during the measure testing phase.

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.2. Statistical Results From Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.3. Interpretation

Not applicable. Exclusions will be determined during the measure testing phase.

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable.

2b4.2. Rationale why Risk Adjustment is not Needed

Not applicable.

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable.

2b4.4. Statistical Results

Not applicable.

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable.

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R2)

Not applicable.

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable.

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable.

2b4.9. Results of Risk stratification Analysis

Not applicable.

2b4.10. Interpretation

Not applicable.

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable.

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method for determining

Not applicable. Differences will be determined during the measure testing phase.

2b5.2. Statistical Results

Not applicable. Differences will be determined during the measure testing phase.

2b5.3. Interpretation

Not applicable. Differences will be determined during the measure testing phase.

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable. Comparability will be determined during the measure testing phase.

2b6.2. Statistical Results

Not applicable. Comparability will be determined during the measure testing phase.

2b6.3. Interpretation

Not applicable. Comparability will be determined during the measure testing phase.

Feasibility

3a.1. How are the data elements needed to compute measure scores generated

Data elements will be generated through routine care and collected from MLTSS care management records. Feasibility will be determined during the measure testing phase.

3b.1. Are the data elements needed for the measure as specified available electronically

We do not anticipate all data elements will be available electronically to all MLTSS plans. The availability of data elements in structured electronic fields will be evaluated in testing.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable. This is not an eMeasure.

3c.1. Describe what you have learned or modified as a result of testing

Not applicable. Feasibility will be determined during the measure testing phase.

3c.2. Describe any fees, licensing, or other requirements

Not applicable. No fees, licensing, or other requirements at this phase.

Usability and Use

4.1—Current and Planned Use

Use	Planned	Current	For current use, provide Program Name and URL
a. Public Reporting	X	X	
b. Public Health/Disease Surveillance	X	X	
c. Payment Program			
d. Regulatory and Accreditation Programs			
e. Professional Certification or Recognition Program			
f. Quality Improvement with Benchmarking (external benchmarking to multiple organizations)			
g. Quality Improvement (Internal to the specific	X		
h. Not in use			
i. Use Unknown			

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients

Not applicable. This is a new measure.

4a.2. If not publicly reported or used for accountability, reasons

Not applicable. Usability will be determined during the measure testing phase.

4a.3. If not, provide a credible plan for implementation

This measure is intended for use by states to monitor and improve the quality of care provided for the Medicaid MLTSS enrollee population. A measure implementation plan will be proposed for CMS review following testing.

4b.1. Progress on improvement

Not applicable. This is a new measure.

4b.2. If no improvement was demonstrated, what are the reasons

Not applicable. This is a new measure.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. The measure titles and NQF numbers are listed here:

- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0648)
- HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge (NQF #0558)

5.1b. If the measures are not NQF-endorsed, indicate the measure title

Not applicable.

5a—Harmonization

5a.1. Are the measure specifications completely harmonized

No. The measure elements are not completely harmonized; however, we will aim to align the measure with existing measures to the greatest extent possible through testing.

5a.2. If not completely harmonized, identify the differences rationale, and impact

This measure is under development. A summary of the differences between this measure and existing measures of assessment will be provided after the measure is finalized.

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures

Not applicable.

Additional Information

Co.1.—Measure Steward Point of Contact

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services
Roxanne Dupert-Frank
7500 Security Boulevard, Mail Stop: S3-02-01
Baltimore, MD
Roxanne.Dupert-Frank@cms.hhs.gov
(410) 786-9667

Co.2.—Developer Point of Contact (indicate if same as Measure Steward Point of Contact

Mathematica Policy Research
Debra Lipson
DLipson@Mathematica-Mpr.com
(202) 484-9220

Ad.1. Workgroup/Expert Panel Involved in Measure Development

Development of Assessment and Care Planning Measures for Use in Medicaid Managed Long Term Services and Supports (MLTSS) Programs Technical Expert Panel, 2013

Anne Cohen, Health and Disability Policy Consultant, Disability Health Access, LLC

Patti Killingsworth, Assistant Commissioner and Chief of LTSS, Bureau of TennCare

Jennifer Lenz, Executive Director, State and Corporate Services, Health Services Advisory Group

Bonnie Marsh, Executive Director, State and Corporate Services, Health Services Advisory Group

Diane McComb, ANCOR Liaison with State Associations

Margaret A. Nygren, Executive Director and CEO, American Association on Intellectual and Developmental Disabilities

Joseph Ouslander, Professor of Clinical Biomedical Science, Florida Atlantic University

Pamela J. Parker, Manager, Special Needs Purchasing, State of Minnesota Department of Human Services

Cheryl Phillips, Senior VP Public Policy and Advocacy, Leading Age

D.E.B. Potter, Senior Survey Statistician, Agency for Healthcare Research and Quality

Juliana Preston, Utah Executive Director, HealthInsight

Genie Pritchett, Sr. Vice President Medical Services, Colorado Access

Alice Lind, Aging and Long Term Support Division, Washington State Department of Social and Health Services

Ad.2. Year the Measure Was First Released

Not applicable. This measure is still under development.

Ad.3. Month and Year of Most Recent Revision

Not applicable. This measure is still under development.

Ad.4. What is your frequency for review/update of this measure?

Not applicable. This measure is still under development.

Ad.5. When is your next scheduled review/update for this measure?

Not applicable. This measure is still under development.

Ad.6. Copyright Statement

Not applicable. This measure is still under development.

Ad.7. Disclaimers

Not applicable. This measure is still under development.

Ad.8. Additional Information/Comments

Not applicable.

Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "dual enrollees"
- People receiving long-term services and supports (LTSS) through Medicaid managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program.

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on August 12, 2016.

Measure Name: Re-Assessment and Care Plan Update After Discharge

Descriptive Information

Measure Name (Measure Title De.2.)

Re-Assessment and Care Plan Update After Discharge

Measure Type De.1.

Process

Brief Description of Measure De.3.

The percentage of discharges from inpatient facilities in the measurement year for Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees resulting in a re-assessment and care plan update within 30 days of discharge.

If Paired or Grouped De.4.

This measure is not currently paired or grouped.

Subject/Topic Areas De.5.

- See crosscutting areas

Crosscutting Areas De 6.

- Health and Functional Status: Health and Functional Status
- Health and Functional Status: Development/Wellness
- Health and Functional Status: Functional Status
- Prevention: Prevention
- Prevention: Social Determinants
- Care Coordination: Care Coordination
- Functional Status
- Safety: Safety

Measure Specifications

Measure-specific Web Page S.1.

Not applicable. This measure is still under development.

If This Is an eMeasure S.2a.

Not applicable. This is not an eMeasure.

Data Dictionary, Code Table, or Value Sets S.2b.

See attached Value Sets for Inpatient Stays and Nonacute Inpatient Stays.

For Endorsement Maintenance S.3.

Not applicable. This measure is still under development.

Numerator Statement S.4.

Medicaid MLTSS plan enrollees who have a re-assessment and update of the care plan documented within 30 days of discharge.

Note: Numerator statement may change as this measure is still under development.

Time Period for Data S.5.

12 months (January 1 to December 31 of the measurement year).

Numerator Details S.6.

Definitions (*Note: Numerator definitions and details may change as this measure is still under development.)*

Re-Assessment: A face-to-face discussion with the beneficiary in the home using a structured or semi-structured tool that addresses the current status of, and any changes to, the beneficiary's status and needs in the following domains since the last assessment: physical functioning and disability, medical conditions, mental and behavioral health, needs, risks, social support, preferences and use of services.

Care Plan: A document or electronic tool which identifies beneficiary needs, preferences, risks, and defines the services and supports planned to meet those needs while reducing risks. The care plan must document at a minimum: (1) results of the assessment, (2) care planned to meet beneficiary medical, functional, emotional, social, and cognitive needs, (3) services being provided currently or planned in the next month, (4) beneficiary goals and preferences for care, and (5) coordination and follow-up plan, and an emergency back-up plan. There must be documentation that the care plan was created with input from the beneficiary during a face-to-face encounter with the individual in charge of creating the care plan (care manager) and beneficiary. The assessment and development of the care plan may be done during the same face-to-face encounter or during different encounters.

Numerator Details

Medicaid MLTSS plan enrollees who have a re-assessment and update of the care plan documented within 30 days of discharge.

Re-Assessment:

- Re-assessment or assessment of enrollee status and needs in the following domains: physical functioning and disability, medical conditions, mental and behavioral health, needs, risks, social support, preferences, and use of services.
- Date of re-assessment completion.
- Identification of whether any family or friend caregivers are providing assistance to the enrollee (assistance with activities of daily living, instrumental activities of daily living, health care related tasks, or emotional support).
- Contact information for one or more family or friend caregiver.

Updated Care Plan:

- Care plan that documents all of the following: current services being provided; services and supports to meet enrollee health, function, emotional, social and cognitive needs; goals and preferences for care; coordination and follow-up plan; and an emergency back-up plan.
- Date of care plan signature or completion.
- Documentation of whether family or friend caregiver(s) were involved in the development or update of the care plan and contact information for said caregiver(s).
- Signature of the enrollee or proxy, guardian, or power of attorney if enrollee is unable to sign for themselves.

Denominator Statement S.7.

Acute and non-acute inpatient facility discharges for Medicaid MLTSS enrollees age 18 years and older. The denominator is based on discharges, not enrollees. Enrollees may appear more than once in a sample.

Note: Denominator statement may change as this measure is still under development.

Target Population Category S.8.

- Populations at Risk: Populations at Risk
- Populations at Risk: Dual-Eligible Enrollees

Denominator Details S.9.

A systematic sample drawn from all qualifying discharges from acute and non-acute inpatient facilities (e.g., hospitals, skilled nursing facilities, inpatient rehabilitation, custodial nursing facilities, inpatient psychiatric care facilities) between January 1 and December 1 of the measurement year for Medicaid enrollees who meet the following criteria:

- Who are 18 years and older as of the first day of the measurement year.
- Who are enrolled in a Medicaid MLTSS plan for at least 120 days of the measurement year.
- Who have either of the following benefits: 1) long-term services and supports: home and community based or 2) long-term services and supports: facility based.
- Who have the inpatient facility care benefit.

The time frame for the denominator allows for 30 days to conduct the re-assessment and care plan update in the measurement year. The denominator for this measure is based on

discharges, not enrollees. If enrollees have more than one discharge, include all discharges in the measurement year.

Discharges can be identified using the value sets Inpatient Stay and Nonacute Inpatient Stay included as attachments with this Measure Information Form.

Note: Denominator details may change as this measure is still under development.

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10.

- Pregnancy-related or other perinatal hospital discharges are excluded.
- Enrollees who refuse re-assessment are excluded.
- Enrollees who refuse care planning are excluded from the requirement of having goals and preferences documented and enrollee signature.

Note: Denominator exclusions may change as this measure is still under development.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11.

- Hospital stays with a principal diagnosis of pregnancy or condition originating in the perinatal period are excluded.
- Enrollees who refuse re-assessment are excluded, but there must be documentation that the enrollee refused assessment after discharge to meet this exclusion. Documentation that the enrollee could not be reached is not sufficient.
- Enrollees who refuse care planning are excluded from the requirement of having goals and preferences documented and enrollee signature. All other domains must be documented regardless of enrollee engagement in care planning process.

Note: Denominator exclusion details may change as this measure is still under development.

Stratification Details/Variables S.12.

Consideration of stratification by the following variables:

- Ages 18-64
- Ages 65+
- Community dwelling non-home and community-based services (HCBS) users
- Community dwelling HCBS users

Note: Stratification details may change as this measures is still under development.

Risk Adjustment Type S.13.

Not applicable.

Statistical Risk Model and Variables S.14.

Not applicable.

Detailed Risk Model Specifications S.15.

Not applicable.

Type of Score S.16.
Rate/proportion

Interpretation of Score S.17.
A higher score denotes better performance.

Calculation Algorithm/Measure Logic S.18.
Step 1. Determine the eligible population of discharges.

Step 2. From the eligible population, draw a systematic sample of discharges that occur between January 1 and December 1 of the measurement year.

Step 3. Exclude discharges for pregnancy-related or other perinatal hospital stays.

Step 4. From the remaining discharges, identify if the enrollee had a re-assessment and updated care plan documented through medical or care management record review within 30 days of discharge.

Step 5. Divide the number of discharges in Step 4 by the remaining number of discharges in Step 3 to calculate the rate.

Note: Calculation algorithm/measure logic may change as this measure is still under development.

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.
Not applicable.

Sampling S.20.
The approach for sampling will be determined during the measure testing phase.

Survey/Patient-Reported Data S.21.
Not applicable.

Missing Data S.22.
Not applicable. The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23.

- Electronic Clinical Data: Electronic Health Record
- Paper Medical Records
- Other (Care management records)

Data Source or Collection Instrument S.24.

Not applicable.

Data Source or Collection Instrument (Reference) S.25.
Not applicable.

Level of Analysis S.26.
Health plan

Care Setting S.27.
Home Health; Hospital/Acute Care Facility; Post-Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; Post-Acute/Long Term Care Facility: Inpatient Rehabilitation Facility; Post-Acute/Long Term Acute Care Hospital; Other (Home)

Composite Performance Measure S.28.
Not applicable.

Measure Justification Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid enrollees:

- People eligible for both Medicare and Medicaid, or "dual enrollees"
- People receiving long-term services and supports (LTSS) through Medicaid managed care organizations
- People with substance use disorders, enrollees with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program.

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on August 12, 2016.

Measure Name

Re-Assessment and Care Plan Update After Discharge

Type of Measure

Process

Importance

1a—Opportunity for Improvement

1a.1. This is a measure of process. It is the rate of discharges from acute and non-acute inpatient facilities in the measurement year for Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees who have a re-assessment and care plan update within 30 days of discharge.

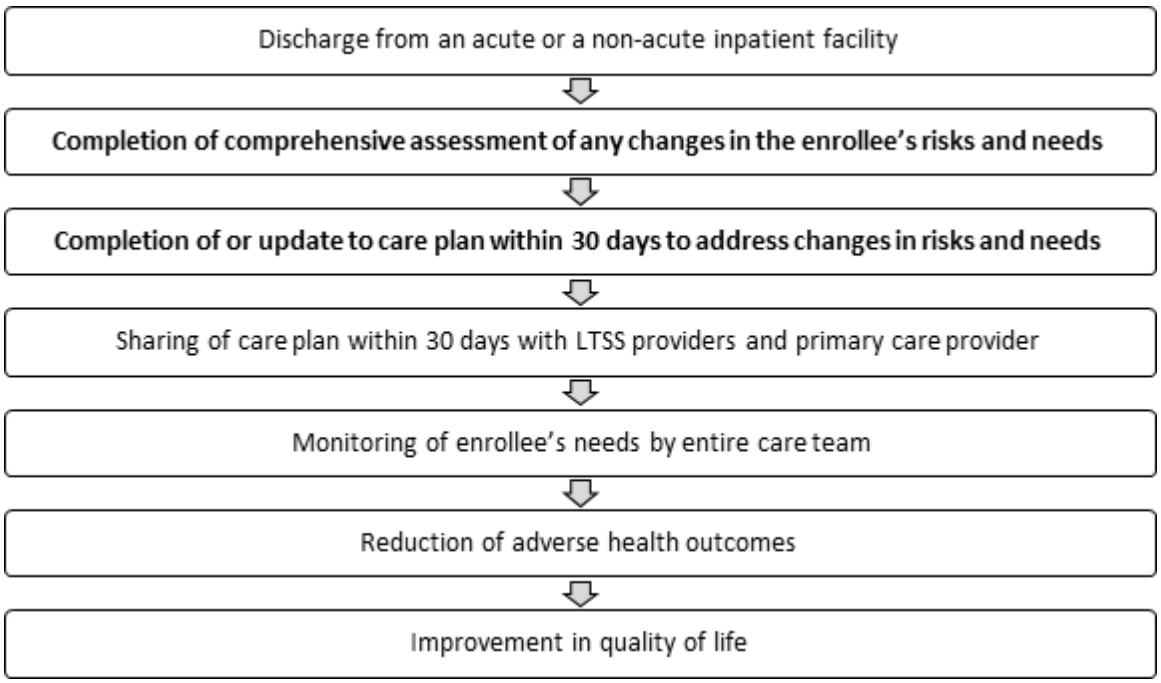
1a.2.—Linkage

Not applicable.

1a.2.1 Rationale

Not applicable.

1a.3.—Linkage



1a.3.1. Source of Systematic Review

- Clinical Practice Guideline recommendation – ***complete sections 1a.4, and 1a.7***
- US Preventive Services Task Force Recommendation – ***complete sections 1a.5 and 1a.7***
- Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections 1a.6 and 1a.7***
- ✓ Other – complete section 1a.8

1a.4.—Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation

Not applicable.

1a.4.2. Specific Guideline

Not applicable.

1a.4.3. Grade

Not applicable.

1a.4.4. Grades and Associated Definitions

Not applicable.

1a.4.5. Methodology Citation

Not applicable.

1a.4.6. Quantity, Quality, and Consistency

Not applicable.

1a.5.—United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation

Not applicable.

1a.5.2. Specific Recommendation

Not applicable.

1a.5.3. Grade

Not applicable.

1a.5.4. Grades and Associated Definitions

Not applicable.

1a.5.5. Methodology Citation

Not applicable.

1a.6.—Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation

Not applicable.

1a.6.2. Methodology Citation

Not applicable.

1a.7.—Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review

Not applicable.

1a.7.2. Grade

Not applicable.

1a.7.3. Grades and Associated Definitions

Not applicable.

1a.7.4. Time Period

Not applicable.

1a.7.5. Number and Type of Study Designs

Not applicable.

1a.7.6. Overall Quality of Evidence

Not applicable.

1a.7.7. Estimates of Benefit

Not applicable.

1a.7.8. Benefits Over Harms

Not applicable.

1a.7.9. Provide for Each New Study

Not applicable.

1a.8.—Other Source of Evidence

The Medicaid MLTSS enrollee population includes individuals with complex health and social support needs, such as individuals with physical, cognitive, and mental disabilities and older adults with multiple functional limitations and chronic conditions.[1,2] Given their complex needs, they often receive care from multiple providers and settings.[3] MLTSS enrollees are also more likely to be Medicare-Medicaid enrollees, whose benefits are not aligned.[4,5] As a result, they often experience highly fragmented care and are at risk for numerous adverse health care utilization patterns and outcomes, including hospitalizations and readmissions.[6,7,8,9,10,11,12,13,14]

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[1] Medicaid and CHIP Payment and Access Commission (MACPAC). (2016). Users of long-term services and supports. Available at https://www.macpac.gov/subtopic/long-term-services-and-supports-population/.

[2] Kaiser Family Foundation (KFF). (2015). Medicaid and Long-Term Services and Supports: A Primer. Available at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-prime r/.

[3] Ujvari, K., W. Fox-Grage, & L Hendrickson. (2015). Effective transitions between settings. Washington, DC: AARP Public Policy Institute. Available at http://longtermscorecard.org/~/media/Microsite/Files/2015/AARP987_EffectiveCareTransitions_June2015.pdf.

[4] MACPAC. (2014). Report to the Congress on Medicaid and CHIP. Chapter 2. Medicaid's Role in Providing Assistance with Long-Term Services and Supports.

[5] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

[6] Ujvari, K., W. Fox-Grage, & L Hendrickson. (2015). Effective transitions between settings. Washington, DC: AARP Public Policy Institute. Available at http://longtermscorecard.org/~/media/Microsite/Files/2015/AARP987_EffectiveCareTransitions_June2015.pdf.

[7] Toles, M. P., Abbott, K. M., Hirschman, K. B., & Naylor, M. D. (2012). Transitions in Care among Older Adults Receiving Long Term Services and Supports. *Journal of Gerontological Nursing*, *38*(11), 40–47. http://doi.org/10.3928/00989134-20121003-04

[8] Naylor, M. D., E. T. Kurtzman, & M. V. Pauly. (2009). Transitions of Elders Between Long-Term Care and Hospitals." *Policy, Politics, and Nursing Practice*, 10(3), 187-194.

[9] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

[10] Freedman, V., & B. C. Spillman. (2014). Disability and Care Needs Among Older Americans. *The Milbank Quarterly*, 92(3), 509-541.

[11] Allen, S. M., E. R. Piette, & V. Mor. (2014). The Adverse Consequences of Unmet Need Among Older Persons Living in the Community: Dual-Eligible Versus Medicare-Only Enrollees. *The Journals of Gerontology: Psychological Sciences*, 69(1), S51-S58.

[12] Komisar, H. L, J. Feder, & J. D. Kasper. (2005). "Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles." *Inquiry*, (42)2, 171-182.

[13] Sands, L. P., Y. Wang, G. P. McCabe, K. Jennings, C. Eng, & K. E. Covinsky. (2006). Rates of Acute Care Admissions for Frail Older People Living with Met Versus Unmet Activity of Daily Living Needs. *Journal of the American Geriatrics Society*, 53(2), 339-344.

[14] Gaugler, J. E., S. Duval, K. A. Anderson, & R. L. Kane. (2007). Predicting Nursing Home Admission in the U.S.: A Meta-Analysis." *BMC Geriatrics*, 7(1), 1.

To adequately meet their needs, MLTSS enrollees require high levels of care coordination.[15] Effective care coordination for complex populations, such as MLTSS enrollees, begins with conducting and regularly updating comprehensive assessments to identify enrollees' needs, developing and regularly updating care plans to dictate care to be provided, and sharing care plans to inform care team members of care to be coordinated.[16] CMS and other care coordination experts agree that service decisions for MLTSS enrollees should be based on current assessments and fully developed care plans, particularly during care transitions.[17,18]

Evidence to Support Care Transition Interventions from Hospital to Home

We were unable to find a systematic review assessing the impact of re-assessment and care plan update after a transition of care on outcomes. However, there is extensive evidence to support interventions following a transition of care that include risk-assessment and care planning.

Transitions of care interventions such as risk assessment, transition plans, timely follow-up, and self-management support have been shown in numerous studies to reduce hospital readmissions and lower overall healthcare costs.[19] One meta-analysis including 18 studies among patients with congestive heart failure demonstrated that comprehensive discharge planning and post-discharge support reduced readmission rates by 25 percent.[20,21] A randomized controlled trial among 750 community-dwelling older adults found that individuals receiving care coordination encouraging "continuity across settings and guidance from a transition coach" experienced a reduction in re-hospitalization at 30 days (8.3

[15] Saucier, P., & B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

[16] Agency for Research and Healthcare Quality (AHRQ). (2012). Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Available at https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf

[17] Ujvari, K., W. Fox-Grage, & L Hendrickson. (2015). Effective transitions between settings. Washington, DC: AARP Public Policy Institute. Available at http://longtermscorecard.org/~/media/Microsite/Files/2015/AARP987_EffectiveCareTransitions_June2015.pdf.

[18] Centers for Medicare & Medicaid Services (CMS). (2013). Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs. Available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf.

[19] Coleman, E.A., Parry, C., Chalmers, S., et al. (2006). The Care Transitions Intervention: Results of A Randomized Controlled Trial. *Arch Intern Med*.166(17):1822-8.

[20] Epstein, A.M. (2009). Revisiting Admissions – Changing the Incentives for Shared Accountability. *New England Journal of Medicine*. 360(14)1457-59.

[21] Phillips, C.O., Wright, S.M., Kern, D.E., Singa, R.M., Shepperd, S., Rubin, H.R. (2004). Comprehensive Discharge Planning with Post Discharge Support for Older Patients with Congestive Heart Failure: A Meta-Analysis. *Journal of the American Medical Association*. 291:1358-67.

percent versus 11.9 percent, p=0.048) and 90 days (16.7 percent versus 22.5 percent, p=0.04) and lower mean hospital costs ($2058 versus $2546) than controls.[22] Additional randomized trials found that "nurse-led transition care programs" can reduce preventable readmission rates by up to 56 percent.[23,24,25,26,27]

Successful care transitions can prevent duplicative medical services, medical errors, and avoidable hospitalizations, but too often these transitions are not successful.[28,29] An inpatient admission can be followed by multiple care setting transitions in a short period of time, and each transition risks a disruption in the enrollee's care. Poor communication between inpatient and outpatient clinicians, medication changes (both intentional and unintentional), discharge with incomplete diagnostic work-ups and inadequate enrollee understanding of diagnoses, medication, and follow up needs contribute to ineffective care transitions.[30] A number of care transition models have been developed and implemented in the past decade, such as the Transitional Care Model,[31] Care Transitions Program,[32] Project

[22] Coleman, E.A., Parry, C., Chalmers, S., et al. (2006). The Care Transitions Intervention: Results of A Randomized Controlled Trial. *Archives of Internal Medicine,* 166(17), 1822-1828.
[23] Parry, C., Coleman, E.A., Smith, J.D., Frank, J., Kramer, A.M. (2003). The Care Transitions Intervention: A Patient-Centered Approach to Ensuring Effective Transfers Between Sites of Geriatric Care. *Home Health Care Services Quarterly*. 22(3):1-17.
[24] Parry, C., Mahoney, E., Chalmers, S.A., Coleman, E.A. (2008) Assessing the Quality of Transitional Care: Further Applications of the Care Transitions Measure. *Medical Care,* 46(3), 317-322.
[25] Naylor, M.D., Brooten, D.A., Campbell, R., et al. (2003). Comprehensive Discharge Planning and Home Follow-Up of Hospitalized Elders. *Journal of the American Medical Association.* 281:613-20.
[26] Naylor, M.D., Brooten, D.A., Campbell, R.L., Maislin, G., McCauley, K.M., Schwartz, J.S. (2004). Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial. *Journal of the American Geriatrics Society*. 52:675-84.
[27] Naylor, M.D. (2003). Transitional Care of Older Adults*. Annual Review of Nursing Research*. 20:127-47
[28] Coleman, E.A., Berenson, R.A. (2004). Lost in Transition: Challenges and Opportunities for Improving the Quality of Transitional Care. *Annals of Internal Medicine,* 141(7), 533-536.
[29] Arbaje, A.I., Kansagara, D.L., Salanitro, A.H., Englander, H.L., Kripalani, S., Jencks, S.F., Lindquist, L.A. (2014). Regardless of Age: Incorporating Principles from Geriatric Medicine to Improve Care Transitions for patients with Complex Needs. *Journal of General Internal Medicine,* 29(6), 932-939.
[30] Rennke, S., Nguyen, O.K., Shoeb, M.H., Magan, Y., Wachter, R.M., Ranji, S.R. (2013). Hospital-Initiated Transitional Care Interventions as a Patient Safety Strategy: A Systematic Review. *Annals of Internal Medicine,* 158(5, Part 2), 433-440.
[31] Naylor, M.D., Brooten, D.A., Campbell, R., et al. (2003). Comprehensive Discharge Planning and Home Follow-Up of Hospitalized Elders. *Journal of the American Medical Association.* 281:613-20. Naylor, M.D. (2003). Transitional Care of Older Adults*. Annual Review of Nursing Research*. 20:127-47.
[32] Coleman, E.A., Parry, C., Chalmers, S., et al. (2006). The Care Transitions Intervention: Results of A Randomized Controlled Trial. *Archives of Internal Medicine,* 166(17):1822-8.

RED,[33] and Project BOOST,[34] in an effort to combat negative trends in cost and outcomes. Research is ongoing to identify the exact components of these transitional care models that best improve outcomes for at-risk populations.[35]

For MLTSS enrollees, transitions are a particularly vulnerable time due to the level of care they may require in the home following a discharge, such as personal care assistance, home modifications, durable medical equipment, home health services, meal and transportation assistance, and overall coordination of care across providers.[36] Poor transitions increase the risk of readmission to an acute facility. In order to ensure continuity of care, it is critical that LTSS providers: 1) know a enrollee is being discharged, 2) proactively assess any changes in the enrollee's physical, mental, and social health needs, and 3) develop a care plan that documents changes in the enrollee goals, preferences, needs, and the services that will be provided to address those needs. This measure will address these critical steps in care coordination for MLTSS enrollees.

Evidence to Support Care Transition Interventions from Non-Acute Settings to Home

While transitions from hospital to home are the focus of many studies and interventions, a large proportion of LTSS enrollees are discharged into post-acute care settings. In 2013, among Medicare enrollees, 20 percent of discharges were to skilled nursing facilities, 4 percent were to inpatient rehabilitation facilities, and 1 percent was to long term care hospitals. This suggests that among older adults one-in-four are not discharged directly from the hospital to home but receive care in another acute or non-acute care facility.[37] The rate of post-acute care use is likely to be higher among Medicaid MLTSS enrollees, including those who are dually eligible, who are often frailer and more complex than Medicare enrollees. For example, in 2011, dual eligible enrollees had higher use of certain FFS

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[33] Berkowitz, R. E., Fang, Z., Helfand, B. K., Jones, R. N., Schreiber, R., & Paasche-Orlow, M. K. (2013). Project ReEngineered Discharge (RED) lowers hospital readmissions of patients discharged from a skilled nursing facility. *Journal of the American Medical Directors Association*, *14*(10), 736-740.

[34] Hansen, L. O., Greenwald, J. L., Budnitz, T., Howell, E., Halasyamani, L., Maynard, G., & Williams, M. V. (2013). Project BOOST: effectiveness of a multihospital effort to reduce rehospitalization. *Journal of Hospital Medicine*, *8*(8), 421-427.

[35] Patient-Centered Outcomes Research Institute (PCORI). (2015). Project ACHIEVE (Achieving Patient-Centered Care and Optimized Health in Care Transitions by Evaluating the Value of Evidence. Available at http://www.pcori.org/research-results/2014/project-achieve-achieving-patient-centered-care-and-optimized-health-care.

[36] Alliance for Home Health Quality and Innovation. (2014). Improving Care Transitions Between Hospital and Home Health: A Home Health Model of Care Transitions. Available at http://ahhqi.org/images/uploads/AHHQI_Care_Transitions_Tools_Kit_r011314.pdf.

[37] MACPAC. (2015). Chapter 7. Medicare's post-acute care: Trends and ways to rationalize payments. Available at http://www.medpac.gov/docs/default-source/reports/chapter-7-online-only-appendixes-medicare-s-post-acute-care-trends-and-ways-to-rationalize-payments-.pdf?sfvrsn=0.

Medicare services, such as home health and other outpatient services (e.g., durable medical equipment), resulting in higher spending for these services than non-dual Medicare enrollees.[38]

Transitions from the non-acute setting to home can be equally risky for MLTSS enrollees. Many of the same potential risks of hospital to home transitions apply to nursing facility to home transitions, such as poor communication, incomplete transfer of information, inadequate education of patients and their caregivers, limited access to essential services, and the absence of a single point of contact.[39] Unsuccessful transitions from a nursing facility to home increase the risk of a hospital admission, or re-admission to a nursing facility. A study in New Jersey of 1,354 long-term nursing home residents who were transitioned to the community found that the highest predictors of nursing home readmission were being male, single, dissatisfied with one's living situation, and falling within eight to 10 weeks after discharge.[40] The study authors concluded that transition care managers should work one-on-one with nursing facility residents to understand their unique needs and situations and identify where particular services, such as falls risk prevention programs, are necessary.

Justice in Aging and the Disability Rights Education & Defense Fund highlighted the importance of support during transitions from the non-acute setting to community settings in their MLTSS Toolkit. The MLTSS Toolkit provides suggested protections for LTSS enrollees in MLTSS contracts with states. The report represents expert opinion about the potential quality gaps MLTSS enrollees may experience and the best processes to protect enrollees. This report recommends that enrollees transitioning from the nursing facility to home be presented with the full range of appropriate and available home and community based services. They recommend a full assessment and plan of care be developed prior to an individual's discharge.[41]

1a.8.1. Process Used

In the absence of a systematic review, the project team conducted a targeted literature review to gather evidence in support of this measure. We searched for academic journal articles, gray literature, and federal and state agency reports published in the last 23 years using PubMed, Google, and Google Scholar. We also convened a technical expert panel (TEP)

[38] MedPAC and MACPAC. (2016). Data Book. Enrollees Dually Eligible for Medicare and Medicaid. Available at https://www.macpac.gov/wp-content/uploads/2015/01/Dually-Eligible-Beneficiares-DataBook.pdf.
[39] Naylor, M., & S. A. Keating. (2008). Transitional care: moving patients from one care setting to another. *The American Journal of Nursing*, 108(9 Suppl), 58.
[40] Howell, S., et al. (2007). Determinants of remaining in the community after discharge: Results from New Jersey's nursing home transition program. *The Gerontologist*, 47(4), 535-547.
[41] Justice in Aging and the Disability Rights Education & Defense Fund. (2012). Long-Term Services and Supports: Enrollee Protections in a Managed Care Environment. Available at http://dualsdemoadvocacy.org/wp-content/uploads/2012/06/Special-Report-LTSS-June-2012-Final.pdf.

in 2013 to provide insight into the priority areas for measurement and the usefulness and feasibility of the identified measures for MLTSS plans. The TEP was comprised of individuals representing multiple perspectives from the MLTSS community including consumers, practitioners, health plans, the federal government, and state governments.

1b.—Evidence to Support Measure Focus

1b.1. Rationale

This measure addresses continuity of care following a discharge from an acute or non-acute inpatient setting for Medicaid MLTSS enrollees. The MLTSS enrollee population includes individuals with complex health and social support needs.[42,43] Given their complex needs, they require high levels of care coordination.[44] Re-assessment and the updating of a care plan following discharge is a critical step in ensuring enrollees return to the community with the needed services and supports that address their goals, preferences, and needs.

1b.2. Performance Scores

Not applicable.

1b.3. Summary of Data Indicating Opportunity

There is no direct data indicating the rate of discharges from acute and non-acute facilities where re-assessment and care plan update occur within 30 days. Through testing we will explore the performance on this measure to determine the extent which there is a quality gap.

1b.4. and 1b.5. Disparities

There is little research on potential disparities in the use of comprehensive assessments and the development and sharing of care plans among the MLTSS enrollee population post hospitalization. However, most other research focuses on the identification of disparities in the need for and use of LTSS more broadly, which highlight MLTSS enrollees' vulnerabilities during care transitions.

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[42] MACPAC. (2016). Users of long-term services and supports. Available at https://www.macpac.gov/subtopic/long-term-services-and-supports-population/.
[43] KFF. (2015). Medicaid and Long-Term Services and Supports: A Primer. Available at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.
[44] Saucier, P., and B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf .

The Congressional Budget Office identified racial and ethnic disparities in the need for LTSS. More specifically, it found that older black and Hispanic individuals have higher rates of functional impairment than whites.[45]

Another report identified disparities in care coordination and access to care for newly transitioned Medicaid managed care enrollees with complex needs. It found that primary care providers in California felt unprepared and untrained for the level of effort required to coordinate care for newly transitioned seniors and persons with disabilities. It also found that fewer than 60 percent of newly transitioned seniors and persons with disabilities were successfully contacted and administered a health risk assessment, a much less intensive assessment than required by this measure.[46]

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

- Affects large numbers
- High resource use
- Patient/social consequences of poor quality

1c.3. Epidemiologic or Resource Use Data

Although criteria vary by state, individuals are generally eligible for Medicaid LTSS if they need assistance with at least one, and often more activities of daily living or instrumental activities of daily living. The MLTSS enrollee population who receives LTSS is diverse. It includes individuals with complex health and social support needs who often receive care from multiple providers and settings. Older adults and adults with physical disabilities are the most common groups receiving LTSS.[47] As of 2012, adults with intellectual or developmental disabilities and children with disabilities were also covered in half of MLTSS state programs.[48] It also includes individuals who are also more likely to be Medicare-

[45] Congressional Budget Office. (2013). Rising Demand for Long-Term Services and Supports for Elderly People. Washington, DC: Congressional Budget Office.

[46] KFF. (2013). Issue Brief. Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Insights from California. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/06/8453-transitioning-beneficiaries-with-complex-care-needs2.pdf.

[47] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.

[48] Saucier, P. K. (2012). *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Centers for Medicare & Medicaid Services.

Medicaid enrollees. As of 2013, approximately one-third of dual eligible enrollees were receiving LTSS nationwide.[49]

Medicaid covers LTSS in institutional settings, such as skilled nursing facilities, intermediate care facilities, and mental health facilities. It also covers LTSS in the home and community settings, where enrollees receive home and community based services (HCBS) that allow them to reside in the community but still receive assistance. HCBS are designed to prevent or delay institutionalization and generally include home health, personal care, medical equipment, assistive devices, rehabilitative therapy, adult day care, targeted case management, home modifications, transportation, and respite care for caregivers.[50,51] Roughly half of MLTSS programs include only enrollees at the institutional level of care (HCBS programs and institutions), which account for 25 percent of enrollment nationwide.[52] In fiscal year (FY) 2012, 43.4 percent of Medicaid expenditures ($169.2 billion) were spent on LTSS users, even though LTSS users comprised only 6.2 percent (4.3 million) of Medicaid enrollees.[53]

As payment models shift away from fee-for-service, state Medicaid agencies are moving their LTSS enrollees into managed care plans, either stand-alone MLTSS plans, or comprehensive managed care plans that provide both LTSS and medical care. As of 2014, 17 states provide LTSS through managed care programs and the number of Medicaid enrollees using, or at risk of needing, LTSS who were enrolled in managed care programs covering LTSS grew from about 916,000 in 2013 to more than 1.6 million in 2014.[54]

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[49] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.

[50] KFF. (2013). Issue Paper. Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf

[51] The Lewin Group and General Dynamics Information Technology. (2013). Evaluating Medicaid Long-Term Services and Supports Utilization.

[52] Saucier, P. K. (2012). *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Centers for Medicare & Medicaid Services.

[53] Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. MACStats: Medicaid and CHIP data book. December 2015. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2015.pdf.

[54] Centers for Medicare & Medicaid Services. 2015. Medicaid Managed Care Enrollment and Program Characteristics, 2014. Mathematica Policy Research, prepared for CMS. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf.

MLTSS enrollees often experience highly fragmented care and are at risk for numerous adverse health care utilization patterns and outcomes. [55,56,57,58,59,60,61] At its best, managed care offers the promise of delivering community-based coordinated care by integrating medical care, behavioral health care, and LTSS across providers and settings. At its worst, it could disrupt longstanding relationships (e.g., if patients' providers are not part of the managed care plan's network) and create additional barriers to obtaining needed care (e.g., through gatekeeping or coverage restrictions). Because the range of potential outcomes from these shifts in care delivery is so broad, it is necessary to systematically monitor the quality of care delivered to people in MLTSS plans.

To assess the care provided during this time of transition, most states have incorporated LTSS specific measures into their managed care plans quality management programs. However, the lack of a nationally endorsed set of measures has resulted in highly unique approaches that vary by state.

1c.4. Citations.

See footnotes included above in Section 1c.3.

1c.5. Patient-Reported Outcome Performance Measure (PRO-PM)

Not applicable.

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

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[55] Naylor, M. D., E. T. Kurtzman, & M. V. Pauly. (2009). Transitions of Elders Between Long-Term Care and Hospitals. *Policy, Politics, and Nursing Practice*, 10(3), 187-194.
[56] Saucier, P., and B. Burwell. (2015). Care Coordination in Managed Long-Term Services and Supports. Washington, DC: AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.
[57] Freedman, V. & B. C. Spillman. (2014). Disability and Care Needs Among Older Americans. *The Milbank Quarterly*, 92(3), 509-541.
[58] Allen, S. M., E. R. Piette, & V. Mor. (2014). The Adverse Consequences of Unmet Need Among Older Persons Living in the Community: Dual-Eligible Versus Medicare-Only Enrollees. *The Journals of Gerontology: Psychological Sciences*, 69(1), S51-S58.
[59] Komisar, H. L., J. Feder, & J. D. Kasper. (2005). Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles. *Inquiry*, 42(2), 171-182.
[60] Sands, L. P., Y. Wang, G. P. McCabe, K. Jennings, C. Eng, & K. E. Covinsky. (2006). Rates of Acute Care Admissions for Frail Older People Living with Met Versus Unmet Activity of Daily Living Needs. *Journal of the American Geriatrics Society*, 53(2), 339-344.
[61] Gaugler, J. E., S. Duval, K. A. Anderson, & R. L. Kane. (2007). Predicting Nursing Home Admission in the U.S.: A Meta-Analysis. *BMC Geriatrics*, 7(1), 1.

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.2. Identify the Specific Dataset

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.3. What are the Dates of the Data Used in Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.4. What Levels of Analysis Were Tested?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.7. Sample Differences, if Applicable

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.2. Method of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.3. Statistical Results from Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.4. Interpretation

Not applicable. Reliability will be determined during the measure testing phase.

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.2. Method of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.3. Statistical Results from Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.4. Interpretation

Not applicable. Validity will be determined during the measure testing phase.

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.2. Statistical Results From Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.3. Interpretation

Not applicable. Exclusions will be determined during the measure testing phase.

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable.

2b4.2. Rationale why Risk Adjustment is not Needed

Not applicable.

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable.

2b4.4. Statistical Results

Not applicable.

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable.

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R2)

Not applicable.

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable.

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable.

2b4.9. Results of Risk stratification Analysis

Not applicable.

2b4.10. Interpretation

Not applicable.

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable.

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method for determining

Not applicable. Differences will be determined during the measure testing phase.

2b5.2. Statistical Results

Not applicable. Differences will be determined during the measure testing phase.

2b5.3. Interpretation

Not applicable. Differences will be determined during the measure testing phase.

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable. Comparability will be determined during the measure testing phase.

2b6.2. Statistical Results

Not applicable. Comparability will be determined during the measure testing phase.

2b6.3. Interpretation

Not applicable. Comparability will be determined during the measure testing phase.

Feasibility

3a.1. How are the data elements needed to compute measure scores generated

Data elements will be generated through routine care and collected from MLTSS care management records. Feasibility will be determined during the measure testing phase.

3b.1. Are the data elements needed for the measure as specified available electronically

We do not anticipate all data elements will be available electronically to all MLTSS plans. The availability of data elements in structured electronic fields will be evaluated in testing.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable. This is not an eMeasure.

3c.1. Describe what you have learned or modified as a result of testing

Not applicable. Feasibility will be determined during the measure testing phase.

3c.2. Describe any fees, licensing, or other requirements

Not applicable. No fees, licensing, or other requirements at this phase.

Usability and Use

4.1—Current and Planned Use

Use	Planned	Current	For current use, provide Program Name and URL
a. Public Reporting	X		
b. Public Health/Disease Surveillance			
c. Payment Program			
d. Regulatory and Accreditation Programs			
e. Professional Certification or Recognition Program			
f. Quality Improvement with Benchmarking (external benchmarking to multiple organizations)	X		

Use	Planned	Current	For current use, provide Program Name and URL
g. Quality Improvement (Internal to the specific	X		
h. Not in use			
i. Use Unknown			

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients

Not applicable. This is a new measure.

4a.2. If not publicly reported or used for accountability, reasons

Not applicable. Usability will be determined during the measure testing phase.

4a.3. If not, provide a credible plan for implementation

This measure is intended for use by states to monitor and improve the quality of care provided for the Medicaid MLTSS enrollee population. A measure implementation plan will be proposed for CMS review following testing.

4b.1. Progress on improvement

Not applicable. This is a new measure.

4b.2. If no improvement was demonstrated, what are the reasons

Not applicable. This is a new measure.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. The measure titles and NQF numbers are listed here:

- Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)
- HBIPS-6 Post Discharge Continuing Care Plan Created (NQF #0557)
- HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge (NQF #0558)

5.1b. If the measures are not NQF-endorsed, indicate the measure title

Not applicable.

5a—Harmonization

5a.1. Are the measure specifications completely harmonized

No. The measure elements are not completely harmonized; however, we will aim to align the measure with existing measures to the greatest extent possible through testing.

5a.2. If not completely harmonized, identify the differences rationale, and impact

This measure is under development. A summary of the differences between this measure and existing measures of assessment will be provided after the measure is finalized.

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures

Not applicable.

Additional Information

Co.1.—Measure Steward Point of Contact

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services
Roxanne Dupert-Frank
7500 Security Boulevard, Mail Stop: S3-02-01
Baltimore, MD
Roxanne.Dupert-Frank@cms.hhs.gov
(410) 786-9667

Co.2.—Developer Point of Contact (indicate if same as Measure Steward Point of Contact

Mathematica Policy Research
Debra Lipson
DLipson@Mathematica-Mpr.com
(202) 484-9220

Ad.1. Workgroup/Expert Panel Involved in Measure Development

Development of Assessment and Care Planning Measures for Use in Medicaid Managed Long Term Services and Supports (MLTSS) Programs Technical Expert Panel, 2013

Anne Cohen, Health and Disability Policy Consultant, Disability Health Access, LLC

Patti Killingsworth, Assistant Commissioner and Chief of LTSS, Bureau of TennCare

Jennifer Lenz, Executive Director, State and Corporate Services, Health Services Advisory Group

Bonnie Marsh, Executive Director, State and Corporate Services, Health Services Advisory Group

Diane McComb, ANCOR Liaison with State Associations

Margaret A. Nygren, Executive Director and CEO, American Association on Intellectual and Developmental Disabilities

Joseph Ouslander, Professor of Clinical Biomedical Science, Florida Atlantic University

Pamela J. Parker, Manager, Special Needs Purchasing, State of Minnesota Department of Human Services

Cheryl Phillips, Senior VP Public Policy and Advocacy, Leading Age

D.E.B. Potter, Senior Survey Statistician, Agency for Healthcare Research and Quality

Juliana Preston, Utah Executive Director, HealthInsight

Genie Pritchett, Sr. Vice President Medical Services, Colorado Access

Alice Lind, Aging and Long Term Support Division, Washington State Department of Social and Health Services

Ad.2. Year the Measure Was First Released

Not applicable. This measure is still under development.

Ad.3. Month and Year of Most Recent Revision

Not applicable. This measure is still under development.

Ad.4. What is your frequency for review/update of this measure?

Not applicable. This measure is still under development.

Ad.5. When is your next scheduled review/update for this measure?

Not applicable. This measure is still under development.

Ad.6. Copyright Statement

Not applicable. This measure is still under development.

Ad.7. Disclaimers

Not applicable. This measure is still under development.

Ad.8. Additional Information/Comments

Not applicable.

Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations (MLTSS-Managed Long Term Services and Supports Plans)
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on July 22, 2016.

Measure Name

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

Descriptive Information

Measure Name (Measure Title De.2.)

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

Note: This measure is identified by the National Quality Forum (NQF) by number #0101 as a provider level measure. We will be testing revisions to the measure to specify it for MLTSS plan level reporting.

Measure Type De.1.

Process

Brief Description of Measure De.3.

This is a clinical process measure that assesses falls prevention in MLTSS enrolled older and disabled adults. The measure has three rates:

A) Screening for Future Fall Risk:
Percentage of MLTSS enrollees aged 18 years and older and disabled who were screened for future fall risk at least once within 12 months

B) Falls Risk Assessment:
Percentage of MLTSS enrollees aged 18 years and older and disabled with a history of falls who had a risk assessment for falls completed within 12 months

C) Plan of Care for Falls:
Percentage of MLTSS enrollees aged 18 years and older and disabled with a history of falls who had a plan of care for falls documented within 12 months

If Paired or Grouped De.4.

Not applicable

Subject/Topic Areas De.5.

Musculoskeletal: Musculoskeletal
Musculoskeletal: Osteoarthritis
Musculoskeletal: Osteoporosis
Musculoskeletal: Hip/Pelvic Fracture
Prevention: Prevention
Prevention: Physical Activity
Prevention: Screening

Crosscutting Areas De 6.

Health and Functional Status: Health and Functional Status

Prevention: Prevention
Safety: Safety

Measure Specifications

Measure-specific Web Page S.1.
http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/geriatrics-ws.pdf

If This Is an eMeasure S.2a.
Not applicable

Data Dictionary, Code Table, or Value Sets S.2b.
No data dictionary/code table – all information provided in the submission form

For Endorsement Maintenance S.3.
No major changes.

Numerator Statement S.4.
This measure has three rates. The numerators for the three rates are as follows:

A) Screening for Future Fall Risk: MLTSS enrollees who were screened for future fall* risk** at least once within the measurement period

B) Falls Risk Assessment: MLTSS enrollees who had a risk assessment*** for falls completed within 12 months

C) Plan of Care for Falls: MLTSS enrollees with a plan of care**** for falls documented within 12 months.

*A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.

**Screening for Future Fall Risk: Assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure, however potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test

***Risk assessment is comprised of balance/gait assessment AND one or more of the following assessments: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months.

****Plan of care must include consideration of vitamin D supplementation AND balance, strength and gait training.

Time Period for Data S.5.

A twelve-month measurement period

Numerator Details S.6.

This measure has three rates. The numerator for each rate is met by documentation in the medical record as follows:

A) **Screening for Future Fall Risk:** Documentation of whether an MLTSS enrolled individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure, however potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test.

This measure is also collected in the Physician Quality Reporting System using CPT Category II codes specific to the quality measure rates:

- 1100F - Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year
- 1101F - Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year

B) Falls Risk Assessment: Documentation of a falls risk assessment completed in the 12 month measurement period comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months. All components do not need to be completed during a single patient visit, but should be documented in the medical record as having been performed within the past 12 months.

- Balance/gait: (1) Documentation of observed transfer and walking, or (2) Use of a standardized scale (e.g., Get Up & Go, Berg, Tinetti), or (3) Documentation of referral for assessment of balance/gait
- Postural blood pressure: Documentation of blood pressure values in standing and supine positions
- Vision: (1) Documentation that patient is functioning well with vision or not functioning well with vision based on discussion with the patient, or (2) Use of a standardized scale or assessment tool (e.g., Snellen), or (3) Documentation of referral for assessment of vision
- Home fall hazards: (1) Documentation of counseling on home falls hazards, or (2) Documentation of inquiry of home fall hazards, or (3) referral for evaluation of home fall hazards.
- Medications: Documentation of whether the patient's current medications may or may not contribute to falls.

This measure is also collected in the Physician Quality Reporting System using CPT Category II codes specific to the quality measure rates: 3288F - Falls risk assessment documented

C) Plan of Care to Prevent Future Falls: Documentation of a plan of care for fall risks completed in the 12 month measurement period comprised of consideration of vitamin D supplementation AND balance, strength and gait training. All components do not need to be completed during a single patient visit, but should be documented in the medical record as having been performed within the past 12 months.

- Consideration of vitamin D supplementation: Documentation that vitamin D supplementation was advised or considered, or referral for evaluation for vitamin D supplementation advice
- Balance, strength, and gait training: Documentation that balance, strength, and gait training/instructions were provided, or referral to an exercise program, which includes at least one of the three components: balance, strength or gait or referral to physical therapy.

This measure is also collected in the Physician Quality Reporting System using CPT Category II codes specific to the quality measure rates: 0518F - Falls plan of care documented

Denominator Statement S.7.

A) Screening for Future Fall Risk: All MLTSS enrollees aged 18 years and older.

B & C) Falls Risk Assessment & Plan of Care for Falls: All MLTSS enrollees aged 18 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year).

Target Population Category S.8.

Populations at Risk: Populations at Risk
Senior Care
Dual Eligible
New Category: Disabled

Denominator Details S.9.

The Screening for Futures Fall Rate is used to identify the denominator for the remaining two rates, Falls Risk Assessment and Falls Plan of Care.

A) Screening for Future Fall Risk: MLTSS enrollees are included in the denominator if they have been enrolled in the MLTSS plan for at least 12 months.

B & C) Falls Risk Assessment & Plan of Care for Falls: MLTSS enrollees are included in the denominator if they have been enrolled in the MLTSS plan for at least 12 months and have

a documented history of falls (two or more falls or one fall with injury in the past year). Documentation of patient reported history of falls is sufficient.

This measure is also collected in the Physician Quality Reporting System using a CPT Category II code specific to the quality measure to identify the denominator for Falls Risk Assessment & Plan of Care for Falls:
1100F: Patient screened for future fall risk; documentation of two or more falls in the past year.

> *Note: During testing we will explore a minimum length of enrollment in the MLTSS plan (i.e. continuous enrollment criteria) as part of the denominator definition.*

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10.
Patients who have documentation of medical reason(s) for not screening for future fall risk, undergoing a risk-assessment or having a plan of care (e.g., patient is not ambulatory) are excluded from this measure.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11.
Patients are considered to be excluded from measurement if there is documentation of a medical reason(s) for not screening for future fall risk, undergoing a risk-assessment or having a plan of care, including: Patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair.

In the Physician Quality Reporting System CPT Category II codes specific to the quality measure are used to identify exclusions:
1100F–1P OR 1101F–1P: Documentation of medical reason(s) for not screening for future fall risk
3288F with 1P: Documentation of medical reason(s) for not completing a risk assessment for falls
0518F with 1P: Documentation of medical reason(s) for no plan of care for falls

Stratification Details/Variables S.12.
Not applicable

Risk Adjustment Type S.13.
No risk adjustment or risk stratification

Statistical Risk Model and Variables S.14.
Not applicable

Detailed Risk Model Specifications S.15.
Not applicable

Type of Score S.16.
Rate/Proportion

Interpretation of Score S.17.
Better quality = Higher score

Calculation Algorithm/Measure Logic S.18.
This measure is reported at three rates calculated by creating a fraction with the following components: Denominator, Numerator, and Exclusions.

Step 1: Determine the eligible population. The eligible population is all MLTSS enrolled patients aged 18 years and older.

Step 2: Determine number of patients meeting the denominator criteria for (A) screening for future fall risk as specified in Section S.9 above. The denominator includes all patients 18 and up.

Step 3: Identify patients with valid exclusions and remove from the denominator (step 2). Patients with documented medical reason(s) for not screening for fall risk (e.g., patient is not ambulatory) are excluded from to the denominator.

Step 4: Determine the number of patients who meet the numerator criteria for (A) screening for future fall risk as specified in section S.6 above. The numerator includes all patients in the denominator population (step 3) who were screened for future fall risk as least once within a twelve-month period.

Step 5: Determine the number of patients from Step 3 who meet the denominator criteria for (B) risk assessment for falls and (C) plan of care for falls as specified in sectionS.9.

Step 6: Identify patients with valid exclusions and remove from the denominator (step 5). Patients with documented medical reason(s) for not screening for fall risk (e.g., patient is not ambulatory) and not having a plan of care to prevent future falls are excluded from to the denominator.

Step 7: Determine the number of patients who meet the numerator criteria for (B) risk assessment for falls as specified in section S.6 above. The numerator includes all patients in the denominator (step 6) who received a risk assessment within 12 months.

Step 8: Determine the number of patients who meet the numerator criteria for (C) plan of care for falls as specified in section S.6 above. The numerator includes all patients in the denominator (step 6) population with a documented plan of care for falls within 12 months.

Step 9: Calculate rates as follows (A) screening for future fall risk = step 4/step 3; (B) risk assessment for falls= step 7/step 6; (C) plan of care for falls = step 8/step 6.

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.
No diagram provided

Sampling S.20.
Not applicable

Survey/Patient-Reported Data S.21.
Not applicable

Missing Data S.22.
Not applicable

Data Source S.23.
Administrative Claims
Electronic Clinical Data: Electronic Clinical Data
Paper Medical Records

Data Source or Collection Instrument S.24.
This measure is based on case management and medical record documentation collected in the course of providing care to MLTSS enrollees to identify the numerator.

In the Physician Quality Reporting System (PQRS) program this measure is coded using CPT Category II specific to quality measurement.

Data Source or Collection Instrument (Reference) S.25.
No data collection instrument provided

Level of Analysis S.26. Health Plan
Integrated Delivery System

Care Setting S.27.
Ambulatory Care: Clinician Office/Clinic
Home Health
Post-Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility
Post-Acute/Long Term Care Facility: Inpatient Rehabilitation Facility
New Category: Home Care

Composite Performance Measure S.28.
Not applicable

Measure Justification Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations (MLTSS-Managed Long Term Services and Supports Plans)
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

- Information included is current on July 22, 2016.

Measure Name

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

Note this measure is listed in the National Quality Forum as #0101.

Type of Measure

Process

Importance

1a—Opportunity for Improvement

1a.1. This is a Measure of

Process: preventing future falls

1a.2. —Linkage

1a.2.1 Rationale

Not applicable

1a.3. —Linkage

1a.3.1. Source of Systematic Review

- ✓ Clinical Practice Guideline recommendation – ***complete sections 1a.4, and 1a.7***
- ✓ US Preventive Services Task Force Recommendation – ***complete sections 1a.5 and 1a.7***
- Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections 1a.6 and 1a.7***
- ✓ **Other – *complete section 1a.8***

  Note: Evidence for this measure is presented in two sections. Evidence for fall prevention in <u>older adults</u> is presented in sections 1a.4 and 1. a7. Evidence for fall prevention in <u>younger adults with disability</u> is presented in section 1a.8.

1a.4. —Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation

The American Geriatrics Society. AGS Clinical Practice Guideline: Prevention of Falls in Older Persons (2010).

http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/prevention_of_falls_summary_of_recommendations

The U.S. Preventive Services Task Force. Fall Prevention in Older Adults: Counseling and Preventive Medicine. May 2012. Accessed 7/20/16. http://www.uspreventiveservicestaskforce.org/uspstf/uspsfalls.htm

American Medical Directors Association (AMDA). Falls and fall risk in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2011. 23 p. [45 references]

1a.4.2. Specific Guideline

Table 1 identifies the specific guidelines on fall prevention that are relevant to the MLTSS population. The AGS and USPSTF recommendations are specific to older adults (age 65 and over); the AMDA recommendations are specific to adults (age 18 and older) who reside in long term care facilities.

Table 1: Recommendations, Quality of Evidence and Grade

Guideline	Recommendation	Level of Evidence	Quality of Evidence	Grade
Measure Indicator: Screening for Future Fall Risk				
AGS	All older individuals should be asked whether they have fallen (in the past year). An older person who reports a fall should be asked about the frequency and circumstances of the fall(s). Older individuals should be asked if they experience difficulties with walking or balance. (Page 9)	NA	NA	NA

Guideline	Recommendation	Level of Evidence	Quality of Evidence	Grade
AMDA	Recognition: Does the patient have a history of falls? A history of falls is a strong predictor of future falls. Review the patient's record for evidence of previous falls. Ask the patient and the patient's caregiver or family if the patient has a history of falling. A history of one or more recent falls, for any reason, within 6 months should be listed as a problem in the patient's record. The potential for further falling should be addressed in the patient's care plan, either separately or in conjunction with care plans related to other risk factors associated with increased fall risk. *Note: This guideline is specific to adults in long term care facilities*	NA	NA	NA
Measure Indicator: Falls Risk Assessment				
AGS	Older persons who have fallen should have an assessment of gait and balance using one of the available evaluations. (Page 12) Performance tests of gait and balance are adequate for the detection of people at risk of falling. The tests we suggest are the Get Up and Go test, Timed Up and Go test, Berg Balance Scale or the Performance-Oriented Mobility Assessment.	I	Fair	B
AGS	Older persons who present for medical attention because of a fall, report recurrent falls in the past year, or report difficulties in walking or balance (with or without activity curtailment) should have a multifactorial fall risk assessment. Older persons who cannot perform or perform poorly on a standardized gait and balance test should be given a multifactorial fall risk assessment.	I	Good	A

Guideline	Recommendation	Level of Evidence	Quality of Evidence	Grade
AGS	A strategy to reduce the risk of falls should include multifactorial assessment of known fall risk factors and management of the risk factors identified. [A] (Page 17) The components most commonly included in efficacious interventions were: a. Adaptation or modification of home environment [A] b. Withdrawal or minimization of psychoactive medications [B] c. Withdrawal or minimization of other medications [C] d. Management of postural hypotension [C] e. Management of foot problems and footwear [C] f. Exercise, particularly balance, strength, and gait training [A] Effective multifactorial/multicomponent interventions include the following components: environmental adaptation and/or modification (9 studies out of 11); balance, strength, and gait training (7 out of 11); assistive devices; reducing psychoactive medications; reviewing and reducing other medications; managing vision problems; managing orthostasis; and addressing cardiovascular and other medical problems.	I	Good	A

Guideline	Recommendation	Level of Evidence	Quality of Evidence	Grade
USPSTF	The USPSTF does not recommend automatically performing an in-depth multifactorial risk assessment in conjunction with comprehensive management of identified risks to prevent falls in community-dwelling adults aged 65 years or older because the likelihood of benefit is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of the circumstances of prior falls, comorbid medical conditions, and patient values.			C
AMDA	Assessment: Evaluate the factors associated with the fall – Identifying the Causes of the Fall. Identifying and correcting the causes of falls can often reduce the risk of falling. For patients who have recurrent falls, continue to collect and evaluate information until either (1) the cause of the falling is identified or (2) it is determined that the cause cannot be found or that finding a cause would not change the outcome or the patient's management. If possible, document how it was concluded that certain factors contributed to or caused falling whereas others were not relevant. No further evaluation may be necessary if the fall is clearly the result of an obvious extrinsic factor that can be corrected. *Note: This guideline is specific to adults in long term care facilities*	NA	NA	NA

Guideline	Recommendation	Level of Evidence	Quality of Evidence	Grade
AMDA	Assessment: Evaluate the factors associated with the fall – Performing a Post-Fall Evaluation. After a fall, obtain relevant history regarding the circumstances. The patient's current medications, especially any recent changes, should also be reviewed. A postural blood pressure and pulse should be obtained along with a gait and balance evaluation.	NA	NA	NA
Measure Indicator: Plan of Care				
AGS	All older adults who are at risk of falling should be offered an exercise program incorporating balance, gait, and strength training. Flexibility and endurance training should also be offered, but not as sole components of the program. (Page 17)	NA	NA	NA
AGS	Exercise should be included as a component of multifactorial interventions for fall prevention in community-residing older persons. An exercise program that targets strength, gait and balance, such as Tai Chi or physical therapy, is recommended as an effective intervention to reduce falls (page 26)	I	Good-Fair	A
AGS	Vitamin D supplements of at least 800 IU per day should be provided to older persons residing in long-term care settings with proven or suspected vitamin D insufficiency. [A] (Page 41)	I	Good	A
AGS	Vitamin D supplements of at least 800 IU per day should be considered in older persons residing in long-term care settings who have abnormal gait or balance or who are otherwise at increased risk for falls. [B] (Page 41)	I	Fair	B

Guideline	Recommendation	Level of Evidence	Quality of Evidence	Grade
USPSTF	The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 18 years or older who are at increased risk for falls. No single recommended tool or brief approach can reliably identify older adults at increased risk for falls, but several reasonable and feasible approaches are available for primary care clinicians. *Note: This recommendation is currently being updated by the USPSTF.*		Moderate-High Certainty of Benefit	B

Guideline	Recommendation	Level of Evidence	Quality of Evidence	Grade
AMDA	Implement relevant general measures to address falling and falls risk. Various generic approaches (i.e., those that are not directed at specific causes) can have an impact on the prevention and management of falls. Coordinate clinical initiatives to prevent and manage falls with initiatives of the interdisciplinary team (IDT) and facility safety committee, reviews of falls by the quality improvement committee, and efforts to ensure a safe environment for wanderers. Examples of facility approaches to try to reduce falls or consequences of falls. • Activities program • Function-focused care philosophies (e.g., restorative care, exercise programs) • Patient education about safe sitting and standing • Program to help patients and families cope with and adapt to nonmodifiable risk factors for falling • Programs for patients who wander • Reduction in the use of physical restraints • Rehabilitation program (e.g., balance training, strengthening, gait training, assistive devices) • Staff education about fall risks and potentially helpful interventions • Toileting and continence programs or a timed voiding schedule • Hip protectors	NA	NA	NA

Level of Evidence I = At least one properly designed RCT

Quality of Evidence Good = High grade evidence directly linked to health outcome

Quality of Evidence Fair = High grade evidence linked to intermediate outcome OR Moderate grade evidence directly linked to health outcome

1a.4.3. Grade

AGS Definitions:

Grade A: A strong recommendation that the clinicians provide the intervention to eligible patients. Good evidence was found that the intervention improves health outcomes and the conclusion is that benefits substantially outweigh harm.

Grade B: A recommendation that clinicians provide this intervention to eligible patients. At least fair evidence was found that the intervention improves health outcomes and the conclusion is that benefits outweigh harm.

USPSTF Definitions:

Grade B: The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

Grade C: The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.

AMDA: The AMDA recommendations were not graded.

1a.4.4. Grades and Associated Definitions

AGS Definitions:

Grade C: No recommendation for or against the routine provision of the intervention is made. At least fair evidence was found that the intervention can improve health outcomes, but the balance of benefits and harms is too close to justify a general recommendation.

Grade D: Recommendation is made against routinely providing the intervention to asymptomatic patients. At least fair evidence was found that the intervention is ineffective or that harm outweighs benefits.

Grade I: Evidence is insufficient to recommend for or against routinely providing the intervention. Evidence that the intervention is lacking, or of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

USPSTF Definitions:

Grade A: The USPSTF recommends the service. There is high certainty that the net benefit is substantial.

Grade D: The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.

I Statement: The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

1a.4.5. Methodology Citation

Grade Definitions. U.S. Preventive Services Task Force. October 2014.

http://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions

1a.4.6. Quantity, Quality, and Consistency

Yes → complete section 1a.7

1a.5. —United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation

See 1a.4.1

1a.5.2. Specific Recommendation

See 1a.4.2

1a.5.3. Grade

See 1a.4.3

1a.5.4. Grades and Associated Definitions

See 1a.4.4

1a.5.5. Methodology Citation

See 1a.4.5

1a.6. —Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation

Not applicable

1a.6.2. Methodology Citation

Not applicable

1a.7. —Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review

The evidence below focuses on the benefits of multifactorial falls risk assessment (gait and balance assessment) and specific interventions (exercise therapy and vitamin D supplementation) in a population of older adults who have had a previous fall and are at risk of future falls.

Note: Evidence on fall risk prevention in younger disabled adults is presented in section 1a.8 below.

Two evidence reviews were conducted to support guidelines for fall risk prevention in older adults: one conducted by the AGS and another conducted by the USPSTF. Both reviews found sufficient evidence to recommend a plan of care for individuals with a history of falls that include consideration of Vitamin D and exercise therapy. The AGS found sufficient evidence to recommend a multifactorial risk assessment in older adults with a history of falls, whereas the USPSTF found only a small benefit to multifactorial risk assessment for falls and concluded the risk assessment may be of benefit to specific at-risk populations. Both AGS and USPSTF agree that all individuals should be asked about previous falls, as this is a leading indicator of future fall risk. The USPSTF evidence review is currently being updated and we will update this section when a new evidence review is published. Based on this evidence, this measure looks for the following clinical practices:

1) Identifying individuals at risk of future falls by assessing whether they have had a previous fall or problem with gait or balance (Screening for Future Falls Risk)

2) Evaluate individuals at risk of future falls for their falls risk factors (Risk Assessment)

3) Develop a plan of care for individuals at risk of future falls that includes consideration of Vitamin D therapy and exercise (Plan of Care).

1a.7.2. Grade

AGS: The evidence was rated by the AGS as fair-good. The specific evidence grade for each recommendation are listed in table 1 under 1a.4.2. The evidence was rated using a system based on the U.S. Preventative Services Task Force. The grade assigned by AGS for the strength of a recommendation depended on the overall quality of evidence and the magnitude of net benefit. AGS rated the overall level of evidence using the terms shown in Table 2 below. Based on these determinations of overall quality of evidence and magnitude of benefit for each intervention, the panel assigned a grade for each recommendation using the definitions in Table 3.

Table 2: AGS Level of Evidence

I	At least one properly done RCT
II-1	Well-designed controlled trial without randomization
II-2	Well-designed cohort or case-control analytic study, preferably from more than one source
II-3	Multiple time series evidence with/without intervention, dramatic results of uncontrolled experiment
III	Opinion of respected authorities, descriptive studies, case reports, and expert committees

Table 3: AGS Overall Quality of Evidence

Good	High grade evidence (I or II-1) directly linked to health outcome
Fair	High grade evidence (I or II-1) linked to intermediate outcome; Or Moderate grade evidence (II-2 or II-3) directly linked to health outcome
Poor	Level III evidence or no linkage of evidence to health outcome

USPSTF: The evidence was rated by the USPSTF as having high-moderate certainty of benefit.

- The USPSTF concludes with high certainty that exercise or physical therapy has moderate net benefit in preventing falls in older adults.
- The USPSTF concludes with moderate certainty that vitamin D supplementation has moderate net benefit in preventing falls in older adults.
- The USPSTF concludes with moderate certainty that multifactorial risk assessment with comprehensive management of identified risks has a small net benefit in preventing falls in older adults.

High Certainty of Benefit: The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.

Moderate Certainty of Benefit: The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as:

- The number, size, or quality of individual studies
- Inconsistency of findings across individual studies
- Limited generalizability of findings to routine primary care practice

- Lack of coherence in the chain of evidence

As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.

1a.7.3. Grades and Associated Definitions

AGS: all definitions are listed in section 1a.7.2

USPSTF Level of Certainty Definition:

Low: The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:

- The limited number or size of studies
- Important flaws in study design or methods
- Inconsistency of findings across individual studies
- Gaps in the chain of evidence
- Findings not generalizable to routine primary care practice
- Lack of information on important health outcomes

More information may allow estimate of effects on health outcomes.

1a.7.4. Time Period

AGS (2010): 2001-2009

USPSTF (2010): 2002-2009

1a.7.5. Number and Type of Study Designs

AGS (2010): A total of 91 studies were included in this review of the literature. Studies included meta-analyses, systematic literature reviews, randomized controlled trials (RCT), controlled before-and-after studies, and cohort studies. The guideline developers did not provide a breakdown of specific number of RCTs supporting each recommendation. Given the number of studies included in the systematic review, we did not feel comfortable re-conducting the evidence review and delineating all the RCTs for each recommendation. Instead we have identified where there were studies available to support each of the recommendations related to the measure components. This review is not comprehensive and represents only a portion of the research on this area.

- Multifactorial Risk Assessment for Falls:
    - Meta-analysis of 5 RCTs (Gillespie et al, 2003)
    - Meta-analysis of 40 (Chang et al, 2004)
    - 8 additional RCTs

- Plan of Care: exercise program that targets strength, gait and balance:
    - Meta-analysis of 40 (Chang et al, 2004)
    - 13 RCTs found an exercise program was effective in reducing falls
- Plan of Care: supplementation with Vitamin D:
    - 1 meta-analysis (Bischoff-Ferrari, 2004)
    - 1 RCT

USPSTF (2010):

- Key Question 1: Is there direct evidence that primary care interventions reduce fall-related injury, improve quality of life, reduce disability, or reduce mortality when used alone or in combination to reduce falling in community-dwelling older adults? – 36 RCTs
- Key Question 2: Do primary care interventions used alone or in combination in community-dwelling older adults prevent falling? – 51 articles represented 47 trials
- Key Question 3: What are the adverse effects associated with interventions to prevent falling? - 49 articles representing 48 trials and one systematic review
- Key Question 4: How are high-risk older adults identified for primary care interventions to prevent falling? – 51 articles represented 47 trials

1a.7.6. Overall Quality of Evidence

Risk Assessment: The AGS found fair-good evidence that conducting a multifactorial risk assessment for older adults who have fallen, including an assessment of gait and balance, reduced the number of future falls. This was based on evidence from multiple RCTs that looked at the impact of multifactorial risk assessment followed by intervention on the number of individuals reporting falls and the incidence of falls in community dwelling older adults. The USPSTF found fair-quality evidence to conclude that with moderate certainty that multifactorial risk assessment with comprehensive management of identified risks has a small net benefit in preventing falls in older adults. The USPSTF cited that the interventions and methods of fall ascertainment were heterogeneous across studies limiting the conclusions that could be drawn. They cited:

“Comprehensive multifactorial assessment and management interventions include assessment of multiple risk factors for falls and providing medical and social care to address factors identified during the assessment. It is possible that some combination of interventions in a select population could provide important benefits, but given the current evidence, the USPSTF is uncertain what that combination or population would be.”

Plan of Care – Exercise: The USPSTF found good quality evidence to conclude with high certainty that exercise or physical therapy has moderate net benefit in preventing falls in older adults. The AGS also found good quality evidence, based on multiple RCTs, to conclude

that exercise and physical therapy reduced the number of falls in older adults with a history of falls.

Plan of Care – Vitamin D: The USPSTF found adequate evidence to indicate that vitamin D supplementation has moderate benefit in preventing falls in this population. The AGS also found fair-good quality evidence, based on RCTs, to conclude that Vitamin D therapy reduced the rates of falls in older adults in long-term care settings.

1a.7.7. Estimates of Benefit

The evidence that screening and multifactorial risk assessment alone can prevent future falls is low. However, there is agreement that risk assessment followed by the appropriate intervention for people at risk of future falls can significantly affect the rate of fall prevention, although the size of the benefit varies across studies. There is consensus that all older adults should be asked about past falls and balance or gait problems. Individuals identified as being at risk of future falls risk should receive a multifactorial risk assessment and appropriate intervention to prevent future falls.

Risk Assessment:

- Meta-analysis of 5 RCTs found that "multidisciplinary, multifactorial, health/environmental risk factor screening and intervention programs" significantly reduced the number of participants falling and also reduced the incidence of falls among community-dwelling older people. (Gillespie et al, 2003)
- Meta-analysis of 40 RCTs demonstrated a significant reduction in the risk of falling (risk ratio, 0.88) in the assessment and intervention groups compared to “usual care” or control groups. Monthly rate of falling was also significantly lower (incidence rate ratio, 0.80). Multifactorial assessment and management programs were the most effective component in reducing fall risk (incidence rate ratio, 0.82; number needed to treat, 11). (Chang et al, 2004)
- “The USPSTF reviewed trials on multifactorial clinical assessment with varying levels of intensity of referral and management of identified fall-related concerns. Combining the results of the 6 studies of multifactorial clinical assessment with comprehensive management resulted in a nonstatistically significant reduced risk for falling after 12 months compared with usual care (pooled relative risk [RR], 0.89 [95% CI, 0.76 to 1.0]). An intervention was considered to have comprehensive management if it included multifactorial clinical assessment with referral to needed services, plus intervention based on results of the assessment. The heterogeneity of the populations and interventions in the studies led to substantial challenges in synthesizing and interpreting the evidence on multifactorial assessments as a whole. It is possible that some combination of interventions in a select population could provide important benefits, but given the current evidence, the USPSTF is uncertain what that combination or population would be. The largest of the studies on multifactorial clinical assessment was

a fair-quality randomized trial of 1559 adults with a mean age of 72.5 years that reported a 25% reduction in risk for falling in the intervention group compared with the control group (RR, 0.75 [CI, 0.64 to 0.88]). A small U.K. study of 200 older adults that was published after the USPSTF systematic review reported a decrease in the number of falls with multifactorial assessment and comprehensive management. The addition of this study to the meta-analysis may result in statistical significance, but the magnitude of benefit would continue to be small. Multifactorial clinical assessment with less-than-comprehensive follow-up does not seem to be effective in reducing the risk for falling (pooled RR, 0.994 [CI, 0.917 to 1.076])."

Plan of Care – Vitamin D: "The USPSTF reviewed 9 trials of vitamin D supplementation and found an approximate 17% reduction in risk for falling during 6 to 36 months of follow-up and a number needed to treat of 10."

Plan of Care – Exercise/Physical Therapy: "The USPSTF reviewed 18 studies of exercise or physical therapy in community-dwelling older adults and found that there was a statistically significant reduction in risk for falling (pooled RR, 0.87 [CI, 0.81 to 0.94]). The number needed to treat with exercise or physical therapy for a median of approximately 12 weeks to prevent 1 person from falling was 16. The benefit was greater in high-risk populations (pooled RR, 0.84 [CI, 0.78 to 0.91]) than in low-risk populations."

1a.7.8. Benefits Over Harms

The USPSTF found convincing evidence that the harms of multifactorial assessment with comprehensive management of identified risks are no greater than small.

The USPSTF found convincing evidence that the harms of vitamin D supplementation are no greater than small. Adequate evidence indicates that the harms of physical therapy or exercise are small. These harms include a paradoxical increase in falls and an increase in physician visits.

1a.7.9. Provide for Each New Study

We are not aware of studies published since the AGS and USPSTF guidelines that would change the recommendations related to this measure.

1a.8. —Other Source of Evidence

There is less direct evidence on how to prevent falls in younger adults with disabilities, a population that is eligible for enrollment in MLTSS plans. We were unable to identify any guidelines or systematic reviews on the prevention of falls in the younger physically disabled adults, adults with intellectual and developmental disabilities (IDD) or young adults using long term services and supports. A literature review conducted by the measure development team did identify some studies which support fall prevention processes in younger adults with IDD, and with activity of daily living limitations. This evidence is presented below:

Evidence for Fall Prevention in Younger Adults with IDD:

Adults with IDD are at higher risk for falls and related injuries than adults without IDD. In the largest study of falls in the IDD population age 18 and older (N=1,515), nearly 25% of adults reported having one or more fall in the past 12 months (Hsieh 2012). Other smaller cohort studies of different age ranges have shown a rate of falls from 34%-45% (Smulders 2013b; Cox 2010). In a cohort study of 511 community dwelling adults age 18 and older with intellectual disabilities, 12% of individuals experienced a fall with injury in the 12-month study period (Finlayson 2010). These rates are comparable to the rate of falls in older adults, where approximately 33% of adults age 65 and older will experience at least 1 fall and 6% experience an injurious fall (CDC 2015,2016).

Several physiological factors put adults with IDD at high risk for falls including impaired gait and balance, walking, and visuo-motor capacity (Enkelaar 2012, 2013). Behaviors such as hyperactivity-impulsiveness, limited hazard awareness, limited attentional focus are also risk factors for falls in this population (Enkelaar 2013; Cahhil 2014). Persons in residential care facilities requiring daily living activity assistance are more likely to experience injurious falls with one study showing a rate of 0.85 falls per person-year in younger adults with intellectual disabilities residing in a residential facility (Salb 2015).

There are no studies directly evaluating the impact of screening for fall risk or fall outcomes in this population. However, the high risk of falls in this population (similar if not greater than the risk in the general older adult population) suggests that the benefits of screening to assess if an individual has experienced a previous fall or has a balance or gait problem may outweigh the harms.

There are multiple recommendations for preventing falls in people with IDD that include physiotherapy intervention, multifactorial risk assessment, balance and gait training, and exercise. Although none of these interventions have been thoroughly evaluated in this population, their feasibility has been assessed.

A systematic review of 48 studies evaluating balance and gait characteristics in persons with IDD found consistently that balance and gait capacities are affected in persons with IDD compared to their age-matched peers. Problems with balance and gait start at a young age and remain present during the entire lifespan of persons. Furthermore, preliminary evidence suggests that balance and gait problems are related to increased falls risk and interventions to improve balance and gait are feasible in this population (Enkelaar 2012). One small study of 27 adults with mild to profound intellectual disability evaluated the feasibility of a physiotherapy intervention for people with IDD to improve balance. They found that exercises and physical activity was possible for all participants and that balance was significantly improved in the intervention population (Hale 2016). Other studies have also

shown that balance and gait are potentially trainable in persons with IDD and falls might be prevented with specific exercise interventions targeted at the IDD population (Enkelaar 2012).

Another small study (26 adults with intellectual disability and a history of falls) demonstrated the feasibility of using a multifactorial risk-assessment. Additionally, the adults in the study, as well as the staff, found the assessment useful (Smulders 2013a).

We were not able to identify any literature on use of vitamin D to prevent falls in the IDD population.

Despite the lack of direct evidence demonstrating the efficacy of fall prevention strategies for reducing incidence of falls and falls with injury in this population, the similarities between the risk of falls in the younger IDD population and older adult population suggest the benefits of exercise therapy, including attention to improving gait and balance, outweigh the harms. Similarly, given the multifactorial nature of falls in this population, a multifactorial risk assessment among those individuals with IDD who have experienced a fall is likely to improve outcomes when paired with the appropriate interventions.

Evidence for Fall Prevention in Younger Adults with Activity of Daily Living Limitations:

There is limited evidence on falls in younger adults. However, there is consistent evidence that activity of daily living limitations (ADL) are associated with increased risk of falls in the elderly (Nevitt 1989; Mamikonian-Zarpas 2015; Towne 2016). Given the eligibility requirements for MLTSS, the younger population receiving MLTSS is extremely likely to have at least one activity of daily living limitation. MLTSS programs serve three populations: younger adults with disability, adults with intellectual and developmental disability and older adults. In many states, individuals are eligible for MLTSS programs if they meet the criteria for institutional level-of-care, which is often defined by activity of daily living limitations (Burwell 2013). Despite the lack of direct evidence for fall prevention in the younger physically disabled population, the similarities between the younger disabled population and the older adult population in terms of ADL limitations and the recommendations cited above regarding fall prevention in the institutional population suggest the benefits of fall risk screening, assessment and plan of care outweigh the harms for this population.

1a.8.1. Process Used

The Project Team performed a targeted literature review to identify literature to support the measure concept. For our targeted literature review, we searched academic journal articles published from 2010 to 2015 using MEDLINE.

1a.8.2. Citation

Burwell, Brian, and Paul Saucier. "Managed long-term services and supports programs are a cornerstone for fully integrated care." *Generations* 37.2 (2013): 33-38.

Cahill, S., et al. "Reconstructing the fall: individual, behavioral and contextual factors associated with falls in individuals with intellectual disability." *Journal of Intellectual Disability Research* 58.4 (2014): 321-332.

Centers for Disease Control and Prevention (CDC), Home and Recreational Safety: Important Facts about Falls. http://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html. Updated September 21, 2015. Accessed July 21, 2016.

Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS) [online]. Accessed July 21, 2016.

Cox, C. R., et al. "Incidence of and risk factors for falls among adults with an intellectual disability." *Journal of Intellectual Disability Research* 54.12 (2010): 1045-1057.

Enkelaar, Lotte, et al. "A review of balance and gait capacities in relation to falls in persons with intellectual disability." *Research in developmental disabilities* 33.1 (2012): 291-306.

Enkelaar, Lotte, et al. "Prospective study on risk factors for falling in elderly persons with mild to moderate intellectual disabilities." *Research in developmental disabilities* 34.11 (2013): 3754-3765.

Finlayson, Janet, et al. "Injuries, falls and accidents among adults with intellectual disabilities. Prospective cohort study." *Journal of Intellectual Disability Research* 54.11 (2010): 966-980.

Hale, Leigh Anne, Brigit F. Mirfin-Veitch, and Gareth J. Treharne. "Prevention of falls for adults with intellectual disability (PROFAID): a feasibility study. *"Disability and rehabilitation* 38.1 (2016): 36-44.

Hsieh, Kelly, James Rimmer, and Tamar Heller. "Prevalence of falls and risk factors in adults with intellectual disability." *American journal on intellectual and developmental disabilities* 117.6 (2012): 442-454.

Mamikonian-Zarpas, Ani, and Luciana Laganá. "The Relationship between Older Adults' Risk for a Future Fall and Difficulty Performing Activities of Daily Living." *Journal of aging and gerontology* 3.1 (2015): 8.

Nevitt, Michael C., et al. "Risk factors for recurrent nonsyncopal falls: a prospective study." *Jama* 261.18 (1989): 2663-2668.

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Smulders, Ellen, et al. "Falls prevention in persons with intellectual disabilities: Development, implementation, and process evaluation of a tailored multifactorial fall risk assessment and intervention strategy. *"Research in developmental disabilities* 34.9 (2013a): 2788-2798.

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1b.—Evidence to Support Measure Focus

1b.1. Rationale

Identifying at-risk patients to target for comprehensive risk-assessment and intervention is the most important part of falls prevention. Health professionals, particularly care managers, have a pivotal role in screening older and disabled patients for risk of falls, and applying preventive strategies for patients at risk. Care managers who are often conducting home visits have the ability to conduct home hazard assessment and modification which may reduce falls, especially in those with a history of falling (Tinetti, 2009). Individually tailored interventions delivered by a health professional are more effective than standard or group delivered programs (Gillespie, 2003).

Gillespie LD, Gillespie WJ, Robertson MC, Lamb SE, Cumming RG, Rowe BH. Interventions for preventing falls in elderly people. Cochrane Database of Systematic Reviews 2003, Issue 4. Art. No.: CD000340. DOI: 10.1002/14651858.CD000340.

Tinetti ME, Kumar C. The Patient Who Falls: "It's Always a Trade-off". JAMA. 2010;303(3):258-266. doi:10.1001/jama.2009.2024.

1b.2. Performance Scores

The following data are extracted from the Physician Quality Reporting System (PQRS) and reflect claims data for services provided from January 1, 2013 through December 31, 2013 for Medicare beneficiaries age 65 and older. Currently PQRS is a pay-for-reporting incentive program that allows providers to choose which quality measures to report on. Data from Managed Long-Term Services and Supports (MLTSS) plans on adults age 18+ will be included after testing occurs.

Average performance data is summarized for the Risk Assessment and Plan of Care rates at the physician level and is summarized at the group practice level for the Falls Screening rate. The distribution of performance across all reporting providers is also described.

(A) Screening for Future Fall Risk:

This measure is used in the CMS Physician Quality Reporting System and reported through the group practice reporting option. In 2013, for group practices submitting data through the GPRO Web Interface, and Accountable Care Organizations submitting data for the Medicare Shared Savings Program and the Pioneer ACO Model, there were a total of 186,991 patients eligible for the measure. All patients who were eligible for the measure were reported on. The average performance and distribution of performance across all these group practices is below.

Mean|10th| 25th| 50th | 75th | 90th

41.5%|9.8% | 20.4% | 37.4% | 60.0% | 79.8%

Performance over time was available by group practice size for those group practices that submitted data through the GPRO Web Interface.

(B) Risk Assessment for Falls:

This measure is used in the CMS Physician Quality Reporting System and reported by providers using claims and registry options. In 2013, only providers who screened for falls risk were eligible to report on this measure. Of 566,962 eligible providers who screened for fall risk, only 5.2% chose to report on this measure. Therefore, the performance rates below are reflective of less than 6% of Medicare providers who were eligible to report the measure.

Mean|10th| 25th| 50th | 75th | 90th

95.5%|100% | 100% | 100% | 100% | 100%

(C) Plan of Care for Falls:

This measure is used in the CMS Physician Quality Reporting System and reported by providers using claims and registry options. In 2013, only providers who screened for falls risk were eligible to report on this measure. Of 566,962 eligible providers who screened for fall risk, only 5.2% chose to report on this measure. Therefore, the performance rates below are reflective of less than 6% of Medicare providers who were eligible to report the measure.

Mean|10th| 25th| 50th | 75th | 90th

94.3%|87.5% | 100% | 100% | 100% | 100%

1b.3. Summary of Data Indicating Opportunity

Not applicable

1b.4. and 1b.5. Disparities

CMS does not currently report stratified performance data in the PQRS program.

Disparities in in receiving screening, risk assessment, or plan of care to prevent future falls has not been studied. Women are more likely than men to sustain an injury during a fall, yet men are more likely to die as a result of a fall. In 2013, the fall fatality rate was 40% higher for men than women. Older whites are 2.7 times more likely to die as a result of a fall compared to African Americans and non-Hispanics are more likely than Hispanics to die as a result of a fall (CDC, 2015).

Centers for Disease Control and Prevention. Injury Prevention & Control: Division of Unintentional Injury Prevention. Falls Among Older Adults: An Overview. Accessed April 5, 2010.

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

Affects large numbers

A leading cause of morbidity/mortality

High resource use

1c.3. Epidemiologic or Resource Use Data

Falls in the Elderly:

Falls are one of the most common and significant health issues facing people aged 65 years or older (Schneider, Shubert & Harmon, 2010). Older adults are five times more likely to be hospitalization for fall-related injuries than any other cause-related injury. It is estimated that one in every three adults over 65 will fall each year (CDC, 2010). In those over age 80, the rate of falls increases to fifty percent (Doherty et al., 2009). Falls are also associated with substantial cost and resource use, approaching $30,000 per fall hospitalization (Woolcott, et al., 2011). Falls among elderly persons are a serious concern not simply due to the high incidence of falls but because of the susceptibility of injury and even death. Falls are the leading cause of death due to injury for the 65 and older population as well as the most common cause of nonfatal injuries and trauma related hospital admissions. In 2007, 18,000+ adults above the age of 64 died due to unintentional fall injuries. In 2008, over two million

older adults required emergency care as a result of a fall, 559,000 of which needed hospitalization (CDC, 2010).

Falls in the Intellectual and Developmental Disability Population:

Adults with IDD are at higher risk for falls and related injuries than adults without IDD. In the largest study of falls in the IDD population age 18 and older (N=1,515), nearly 25% of adults reported having one or more fall in the past 12 months (Hsieh 2012). Other smaller cohort studies of different age ranges have shown a rate of falls from 34%-45% (Smulders 2013b; Cox 2010). In a cohort study of 511 community dwelling adults age 18 and older with intellectual disabilities, 12% of individuals experienced a fall with injury in the 12-month study period (Finlayson 2010). These rates are comparable to the rate of falls in older adults, where approximately 33% of adults age 65 and older will experience at least 1 fall and 6% experience an injurious fall (CDC 2015,2016).

Consequences of Falls:

Between 20% and 30% of older adults who fall experience an injury (CDC, 2010). Roughly 10% of all falls cause major injuries such as fractures, serious soft tissue damage and traumatic brain injury (Tinetti, 2010). Lacerations are another common, and sometimes severe, injury incurred by falling. The majority of fractures among older adults are caused by falling, fracturing the spine, hip, forearm, leg, pelvis, upper arm, and/or hand (CDC, 2010). Of fall-related fractures, hip fractures are one of the more serious, often resulting in long-term functional limitation, nursing home admission and increased mortality. Over 90% percent of hip fractures result from falls (CDC, 2010). Hip fractures have a significant impact on older adults' independence and quality of life. Only half of older adults hospitalized for a hip fracture are able to return home or live independently after the injury (Wolinsky et al., 2009). Among adults with intellectual and developmental disabilities one study estimated that 11.5% of falls resulted in severe injuries, half of which were fractures (Smulder 2013).

Falls can also have serious psychological and social consequences. Developing a fear of falling is another common outcome even if no injury was sustained in the first fall. Living in fear of a fall can limit an older adult's quality of life because it causes them to limit their activities, leading to reduced mobility and loss of physical fitness, which ultimately increases their risk of falling (CDC, 2010). Recurrent falls are a common reason for long-term care admissions (Soriano et al., 2007). According a statistical brief released by the Agency for Healthcare Research and Quality, falls were a significant factor in 40.9 percent of admissions to long-term care facilities (Owens et al., 2009).

Falls have a significant economic cost. In 2005, total direct cost of fall injuries for adults age 65 and older was over $34 billion (NCOA, 2010). The direct costs for fall-related care include fees for hospital and nursing home care, doctors and other professional services,

rehabilitation, community-based services, use of medical equipment, prescription drugs, changes made to the home, and insurance processing. It is estimated that by 2020, the annual direct and indirect cost of fall injuries is expected to reach $54.9 billion (CDC, 2010).

1c.4. Citations

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1c.5. Patient-Reported Outcome Performance Measure (PRO-PM)

Not applicable

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

Not applicable

1.2. Identify the Specific Dataset

Not applicable

1.3. What are the Dates of the Data Used in Testing?

Not applicable

1.4. What Levels of Analysis Were Tested?

Not applicable

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable

1.7. Sample Differences, if Applicable

Not applicable

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable

2a2.2. Method of Reliability Testing

Not applicable

2a2.3. Statistical Results from Reliability Testing

Not applicable

2a2.4. Interpretation

Not applicable

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable

2b2.2. Method of Validity Testing

Not applicable

2b2.3. Statistical Results from Validity Testing

Not applicable

2b2.4. Interpretation

Not applicable

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable

2b3.2. Statistical Results From Testing Exclusions

Not applicable

2b3.3. Interpretation

Not applicable

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable

2b4.2. Rationale why Risk Adjustment is not Needed

Not applicable

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable

2b4.4. Statistical Results

Not applicable

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R2)

Not applicable

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable

2b4.9. Results of Risk Stratification Analysis

Not applicable

2b4.10. Interpretation

Not applicable

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method for determining

Not applicable

2b5.2. Statistical Results

Not applicable

2b5.3. Interpretation

Not applicable

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable

2b6.2. Statistical Results

Not applicable

2b6.3. Interpretation

Not applicable

Feasibility

3a.1. How are the data elements needed to compute measure scores generated?

Generated "or collected" by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, "depression score")

Coded by someone other than person obtaining original information (e.g., DRG, I CD-9 codes on claims)

Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

3b.1. Are the data elements needed for the measure as specified available electronically?

Some data elements are in defined fields in electronic sources.

To allow for widespread reporting across health plans, physicians and clinical practices, this measure is collected through multiple data sources (administrative data, case management records, electronic clinical data, and paper records). Some administrative data in the measure is captured through electronic systems. One rate in this measure (Screening for Future Falls Risk) has a separate specification for EHR reporting and is used in the EHR incentive program (MU2).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable

3c.1. Describe what you have learned or modified as a result of testing

While this measure has not been implemented in MLTSS plans specifically, the following has been learned from implementation in PQRS:

Feedback on use of this measure in CMS PQRS program has been positive with few questions raised by participating clinicians to the CMS vendor. The majority of questions have been about the fall screening rate regarding what counts as a screening for fall risk. In the 2017 PQRS specifications, NCQA clarified the measure specification to outline what counts as a fall

risk screen. NCQA works with the CMS vendor to review any questions or issues raised with the measure on a bi-weekly basis.

3c.2. Describe any fees, licensing, or other requirements

Broad public use and dissemination of these measures is encouraged and NCQA has agreed with CMS and NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

Usability and Use

4.1—Current and Planned Use

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients

The provider-level version of this measure is used in the Physician Quality Reporting System: This measure is used in the Physician Quality Reporting System (PQRS) claims and registry reporting option as well as the Group Practice Reporting Option (GPRO). The PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). Eligible professionals who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer) receive these payment incentives and adjustments. As a part of the GPRO, this measure is also reported by Medicare Shared Savings Accountable Care Organizations.

Through this project we will explore the feasibility of using this measure in Medicaid MLTSS plans for internal quality improvement, external quality improvement and public reporting.

4a.2. If not publicly reported or used for accountability, reasons

Not applicable

4a.3. If not, provide a credible plan for implementation

Not applicable

4b.1. Progress on improvement

Not applicable

4b.2. If no improvement was demonstrated, what are the reasons

The successful use of the provider-level measure in PQRS supports the feasibility and usability of the measure specification on a national scale. While the results indicate little to no improvement over time, the PQRS program does not reflect performance system-wide since physicians can choose which measures they want to report. We also see little variation in performance across the providers who choose to report these measures. As the PQRS program evolves and reporting increases, we expect to see more variation in performance and improvement in performance scores over time.

We will add information about MLTSS plans as it becomes available.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. The measure titles and NQF numbers are listed here

0035: Fall Risk Management

0141: Patient Fall Rate

0202: Falls with injury

0537: Multifactor Fall Risk Assessment Conducted in Patients 65 and Older

5.1b. If the measures are not NQF-endorsed, indicate the measure title

Not applicable

5a—Harmonization

5a.1. Are the measure specifications completely harmonized?

No

5a.2. If not completely harmonized, identify the differences rationale, and impact

NQF# 0141 measures patient fall rate in the hospital setting during one month. This measure is related but not competing. The target population is different (#0141 – adults in the hospital setting) and the measure concept is different (#0141 rate of falls outcome measure).

NQF #0202 measures patient fall with injury rate in the hospital setting. This measure is related but not competing. The target population is different (#0202 – adults in the hospital setting) and the measure concept is different (#0202 – rate of falls with injury outcome measure).

NQF #0537 measures risk assessment for falls in the home health setting. This measure is related but not competing. The target populations overlap; however, the level of analysis and data source are different. NQF #0537 focuses on patient in the home health setting and uses a survey data sources (OASIS) that is not available for patients in the outpatient ambulatory care setting.

NQF #0035 measures fall risk management for all older adults across all settings. This measure is related but not competing. The target population is similar (older adults in Medicare Advantage Plan); however, the data source is different. NQF #0035 uses patient reported information.

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures

No competing measures.

Additional Information

Co.1. —Measure Steward Point of Contact

Co.1.1. Organization

National Committee for Quality Assurance (NCQA)

Co.1.2. First Name

Bob

Co.1.3. Last Name

Rehm

Co.1.4. Email Address

rehm@ncqa.org

Co.1.5. Phone Number

(202) 955-1728

Co.2. —Developer Point of Contact (indicate if same as Measure Steward Point of Contact

Co.2.1. Organization

National Committee for Quality Assurance (NCQA)

Co.1.2. First Name

Bob

Co.1.3. Last Name

Rehm

Co.1.4. Email Address

rehm@ncqa.org

Co.1.5. Phone Number

(202) 955-1728

Ad.1. Workgroup/Expert Panel Involved in Measure Development

Development of Assessment and Care Planning Measures for Use in Medicaid Managed Long Term Services and Supports (MLTSS) Programs Technical Expert Panel, 2013.

Anne Cohen, Health and Disability Policy Consultant, Disability Health Access, LLC

Patti Killingsworth, Assistant Commissioner and Chief of LTSS, Bureau of TennCare

Jennifer Lenz, Executive Director, State and Corporate Services, Health Services Advisory Group

Bonnie Marsh, Executive Director, State and Corporate Services, Health Services Advisory Group

Diane McComb, ANCOR Liaison with State Associations

Margaret A. Nygren, Executive Director and CEO, American Association on Intellectual and Developmental Disabilities

Joseph Ouslander, Professor of Clinical Biomedical Science, Florida Atlantic University

Pamela J. Parker, Manager, Special Needs Purchasing, State of Minnesota Department of Human Services

Cheryl Phillips, Senior VP Public Policy and Advocacy, Leading Age

D.E.B. Potter, Senior Survey Statistician, Agency for Healthcare Research and Quality (AHRQ)

Juliana Preston, Utah Executive Director, HealthInsight

Genie Pritchett, Sr. Vice President Medical Services, Colorado Access

Alice Lind, Aging and Long Term Support Division, Washington State Department of Social and Health Services

Original Measure Development Advisory Panel (Joint American Medical Association/National Committee for Quality Assurance convened panel)

Caroline Blaum, MD (Work Group Co-Chair) (Geriatrics/Internal Medicine) Associate Professor of Internal Medicine, University of Michigan, Ann Arbor, MI

Carol M. Mangione, MD (Work Group Co-Chair) (Internal Medicine) Professor of Medicine, David Geffen School of Medicine at UCLA, Los Angeles, CA

Chris Alexander, III, MD, FACP (Methodology) Social Security Administration, Office of Hearings and Appeals, Earlysville, VA

Patricia P. Barry, MD, MPH (Internal Medicine) American College of Physicians, Gloucester Point, VA

Frederick W. Burgess, MD, PhD (Anesthesia) Rhode Island Hospital, Department of Anesthesia, Providence, RI

Gary S. Clark, MD, MMM, CPE (Physical Medicine & Rehabilitation) Professor and Chair, MetroHealth Medical Center, Dept. of PM&R, Cleveland, OH

Eric Coleman, MD, MPH (Geriatrics) Associate Professor, Division of Health Care Policy and Research, University of Colorado Health Services Center, Aurora, CO

Stephen R. Connor, PhD Vice President, Research and International Development, National Hospice and Palliative Care Organization, Alexandria, VA

Gail A. Cooney, MD (Neurology, Palliative Medicine) Hospice of Palm Beach County, West Palm Beach, FL

Roger Dmochowski, MD (Urology) Department of Urologic Surgery, Vanderbilt University, Nashville, TN

Catherine DuBeau, MD (Geriatrics) Associate Professor of Medicine, University of Chicago, Chicago, IL

Joyce Dubow Associate Director, AARP Policy Institute, Washington, DC

Mary Fermazin, MD, MPA (Internal Medicine) Vice President, Health Policy & Quality Measurement, Health Services Advisory Group, Inc., Phoenix, AZ

Sanford I. Finkel, MD (Geriatric Psychiatry) Professor of Clinical Psychiatry, University of Chicago Medical School, Wilmette, IL

Terry Fulmer, PhD Dean, NYU College of Nursing, New York, NY

Peter Hollmann, MD (Internal Medicine/Geriatrics) Blue Cross Blue Shield, Cranston, RI

David P. John, MD (Emergency Medicine) Chair Geriatric Section, ACEP, North Haven, CT

Peter Johnstone, MD, FACR (Radiation Oncology) Professor and Chair of Radiation Oncology, Indiana University School of Medicine, Department of Radiation Oncology, Indianapolis, IN

Flora Lum, MD American Academy of Ophthalmology, Director, Quality of Care & Knowledge Base Development, San Francisco, CA

Diane E. Meier, MD Professor, Director: Hertzberg Palliative Care Institute, Director: Center to Advance Palliative Care, Mount Sinai School of Medicine, Department of Geriatrics, New York, NY

Alvin "Woody" H. Moss, MD (Nephrology and Palliative Care) Professor of Medicine & Director, Center for Health Ethics & Law, Section of Nephrology, West Virginia University, Morgantown, WV

Jaya Rao, MD, MHS Associate Professor, Pharmaceutical Outcomes and Policy, UNC Eshelman School of Pharmacy, Chapel Hill NC

Sam J. W. Romeo, MD, MBA General Partner, Tower Health & Wellness Center, LP, Turlock, CA

David J. Satin, MD (Family Medicine/Bioethics) Assistant Professor, University of Minnesota, Minneapolis, MN

Gregory B. Seymann, MD (Internal Medicine/Hospital Medicine) Associate Professor, Division of Hospital Medicine, UCSD School of Medicine, San Diego, CA

Knight Steel, MD (Internal Medicine/Geriatrics) Chief, Geriatrics, Internist, Professor of Medicine Emeritus, Hackensack University Medical Center, Hackensack, NJ

Eric Tangalos, MD (Internal Medicine/Geriatrics) Co-Director, Program on Aging, Mayo Clinic, Rochester, MN

Joan M. Teno, MD, MS (Geriatrics/Palliative Care) Professor of Community Health and Medicine, Brown Medical School, Providence, RI

David J. Thurman, MD, MPH CDC, Atlanta, GA

Mary Tinetti, MD (Internal Medicine/Geriatrics) Gladys Phillips Crofoot Professor of Medicine, Epidemiology and Public Health, Yale University School of Medicine, Section of Geriatrics, New Haven, CT

Laura Tosi, MD (Orthopaedic Surgery) American Academy of Orthopaedic Surgery, Director, Bone Health Program, Washington, DC

Gregg Warshaw, MD Director, Office of Geriatric Medicine, University of Cincinnati College of Medicine, Cincinnati, OH

Neil S. Wenger, MD (Internal Medicine/Geriatrics) Professor of Medicine, UCLA, Los Angeles, CA

Ad.2. Year the Measure Was First Released

Measure #0101 was first released in 2010.

Ad.3. Month and Year of Most Recent Revision

The most recent revision of #0101 was in June 2016.

Ad.4. What is your frequency for review/update of this measure?

Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

Ad.5. When is your next scheduled review/update for this measure?

This measure is currently under update.

Ad.6. Copyright Statement

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

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Ad.7. Disclaimers

These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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Ad.8. Additional Information/Comments

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Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations (MLTSS- Managed Long Term Services and Supports Plan)
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on July 22, 2016.

Measure Name

Admission to an institution from the community among Managed Long-Term Services and Supports (MLTSS) beneficiaries.

Descriptive Information

Measure Name (Measure Title De.2.)

Admission to an institution from the community among MLTSS beneficiaries.

Measure Type De.1.

Outcome

Brief Description of Measure De.3.

The number of MLTSS enrollee admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) from the community that result in a short-term (less than 101 days) or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months.

The following rates are reported:

- Institution (nursing facility or ICF/IID) stay <101 days (short-term stay).
- Institution (nursing facility or ICF/IID) stay ≥101 days (long-term stay).

If Paired or Grouped De.4.

Not Applicable

Subject/Topic Areas De.5.

This measure is for a new topic area: institutional utilization - long-term services and supports (LTSS).

This new topic area is focused on increasing the ability of Medicaid beneficiaries receiving LTSS to live in integrated home or community-based settings and receive home and community-based services (HCBS)[1] rather than institutional care as long as possible.

Crosscutting Areas De 6.

Care Coordination: Care Coordination

Measure Specifications

Measure-specific Web Page S.1.

Not applicable. This measure is still under development.

If This Is an eMeasure S.2a.

Not applicable. This is not an eMeasure.

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[1] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/community-integration-ltss/ci-ltss.html

Data Dictionary, Code Table, or Value Sets S.2b.
Not applicable. This measure is still under development.

For Endorsement Maintenance S.3.
Not applicable. This measurement is still under development.

Numerator Statement S.4.
Number of admissions to an institution (nursing facility or ICF/IID) during the measurement year per 1,000 enrollee months for MLTSS beneficiaries 18 and older.

Two rates will be reported for this measure:

- Admissions that result in a short-term stay (less than 101 days)
- Admissions that result in a long-term stay (greater than or equal to 101 days)

During testing we may also explore reporting rates separately for the ICF/IID and nursing facility admissions.

Numerator statement may change, as this measure is still under development.

Time Period for Data S.5.
The proposed data period is 12 months.

However, the optimal data period will be determined during the measure testing phase.

Numerator Details S.6.
The number of MLTSS enrollee admissions to an institution (nursing facility or ICF/IID) from a community residence that result in 1) a short-term (less than 101 days) and 2) long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months.

Admissions that are a transfer from an institution, and admission from the hospital where the hospital admission originated from an institution, are not counted towards the numerator.

Admissions that result in death in the institution (or death in the hospital following a transfer from the institution) are not counted towards the numerator.

Note: This numerator exclusion will be further explored in testing.

All admissions directly from the community or from the hospital (where the hospital admission originated in the community) are considered qualified index admissions.

A beneficiary can be counted more than once in the numerator if the individual had more than one admission to an institution during eligible months of MLTSS enrollment during the measurement year.

Institutional facility: Medicaid- or Medicare- certified nursing facilities provide skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as "custodial care") or Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Community residence: Any residence that is not a Medicaid- or Medicare- certified nursing facility or ICF/IID.

Note: Individuals who were admitted to an institution from the hospital setting and who lived in the community prior to the hospital admission are considered residing in the community.

Value set codes constituting nursing facilities and ICF/IIDs will be revised over the course of testing.

Table NFU.A. Codes to Identify Institutions

UB -04 Type of Bill	Place of Service Codes	UB-04 Revenue Codes
021x, 022x, 023x, 028x	31, 32, 33	019x, 055x

Numerator details may change as this measure is still under development.

Denominator Statement S.7.

Number of enrollee months for MLTSS beneficiaries age 18 and older who have been enrolled in the MLTSS plan for a minimum length of time to be determined in testing.

Denominator statement may change as this measure is still under development.

Target Population Category S.8.

Populations at Risk: Populations at Risk
Populations at risk: Dual-eligible beneficiaries
Populations at risk: Individuals with multiple chronic conditions
Senior Care

Denominator Details S.9.

Enrollee months for MLTSS beneficiaries age 18 and older who have both medical and LTSS benefits in the plan (see below for description of how to calculate enrollee months). During

testing we will determine the minimum length of time a beneficiary must be enrolled in the MLTSS plan to be eligible for the measure.

Enrollee months: An enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year. To calculate enrollee months:

- **Step 1:** Determine enrollee months between September 1 of the year prior to the measurement year and August 31 of the measurement year using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the plan's administrative processes. The day selected must be consistent from person to person, month to month, and year to year. For example, if the plan tallies enrollment on the 15th of the month and an enrollee is enrolled in the MLTSS plan on January 15, the enrollee contributes one enrollee month in January.
- **Step 2:** Age stratification. Use the enrollee's age on the specified day of each month to determine to which age group the enrollee months will be contributed. For example, if the state tallies enrollees on the 15th of each month and an enrollee turns 65 on April 3 and is enrolled for the entire year, then the enrollee contributes three enrollee months to the 18–64 age group category and nine enrollee months to the 65-and-older age category.

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10.

To be determined. Denominator exclusions may be identified as this measure is still under development.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11.

To be determined. Denominator exclusion details may change as this measure is still under development.

Stratification Details/Variables S.12.

Potential strata include:
1. Age: 18 – 64 vs. 65 and older
2. Dual-eligible vs. Medicaid-only beneficiary

The need for stratification will be evaluated during the measure testing phase.

Risk Adjustment Type S.13.

The need and methods for risk-adjustment will be evaluated during the measure testing phase.

Statistical Risk Model and Variables S.14.

The need and methods for risk-adjustment will be evaluated during the measure testing phase.

Detailed Risk Model Specifications S.15.

The need and methods for risk-adjustment will be evaluated during the measure testing phase.

Type of Score S.16.

Rate/proportion

Interpretation of Score S.17.

Better quality is indicated by a lower rate. A higher rate of the number of admissions to an institution from the community per 1,000 beneficiary months is associated with lower access to needed services and supports, and potentially less care coordination. If MLTSS beneficiaries are receiving high quality community-based services, they should have fewer institutional admissions, a shorter length of stay in institutions, and longer time in home or community settings.

Calculation Algorithm/Measure Logic S.18.

Steps to Calculate Enrollee Months for the Eligible Population

Step 1

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

Step 2

Age stratification. Use the enrollee's age on the specified day of each month to determine to which age group the enrollee months will be contributed. For example, if the plan tallies enrollees on the 15th of each month and an enrollee turns 65 on April 3 and is enrolled for the entire year, then the enrollee contributes three enrollee months to the 18–64 age group category and nine enrollee months to the 65-and-older age category.

Identify qualified index admissions (Figure NFU.A)

Step 1

Identify all admissions to institutions between September 1 of the year prior to the measurement year and August 31 of the measurement year.

Note: The numerator for this measure is based on number of admissions. An enrollee may be counted more than once in the numerator if the individual had more than one admission to an institution followed by a discharge to the community during the measurement year.

Step 2
Exclude admissions that are transfers from an institution.

Step 3
Exclude admissions from the hospital where the hospital admission originated from an institution.

Step 4
All admissions directly from the community or from the hospital (where the hospital admission originated in the community) are considered qualified index admissions.

Calculate length of stay (LOS) for qualified index admissions (Figure NFU.B)

Step 1

- Identify all qualified index admissions.
- If the enrollee dies in the institution, exclude the admission from the qualified index admission. *Note: This step will be explored during testing.*
- If the enrollee is transferred from another institution, exclude the institution admission from the qualified index admission.

Step 2
Look for the location of the first discharge in the measurement year.

- If the enrollee is discharged to the community, calculate LOS as the date of institution discharge minus the index admission date.
- If there is no discharge, calculate LOS as the date of the last day of the measurement year minus the index admission date.
- If the enrollee is discharged to the hospital, look for the hospital discharge and location of discharge.
- If the enrollee dies in the hospital, exclude the admission from the qualified index admission.
- If the enrollee remains in the hospital at the end of the measurement year, exclude the admission from the qualified index admission.
- If the enrollee is discharged from the hospital to the community, calculate LOS as the date of institution discharge minus the index institution admission date.
- If the enrollee is discharged from the hospital to an institution, repeat step 2 to look for next possible discharge from the institution.
- If the enrollee is discharged to a different institution (i.e., a transfer), repeat step 2 to look for the next possible discharge from the subsequent facility.

Step 3

Classify LOS as short-term or long-term.

- Short-term stay: The LOS is <101 days.
- Long-term stay: The LOS is ≥101 days.
- When counting the duration of each stay in a measurement period, include the day of entry (admission) but not the day of discharge, unless the admission and discharge occurred on the same day. In this case, the number of days in the stay = 1.

Steps to Calculate Admission Rate

Calculate the admission rate by dividing the number of admissions by the number of enrollee months and multiply by 1,000 as follows:

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

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.

Figure NFU.A. Steps to Identify Qualified Index Admissions

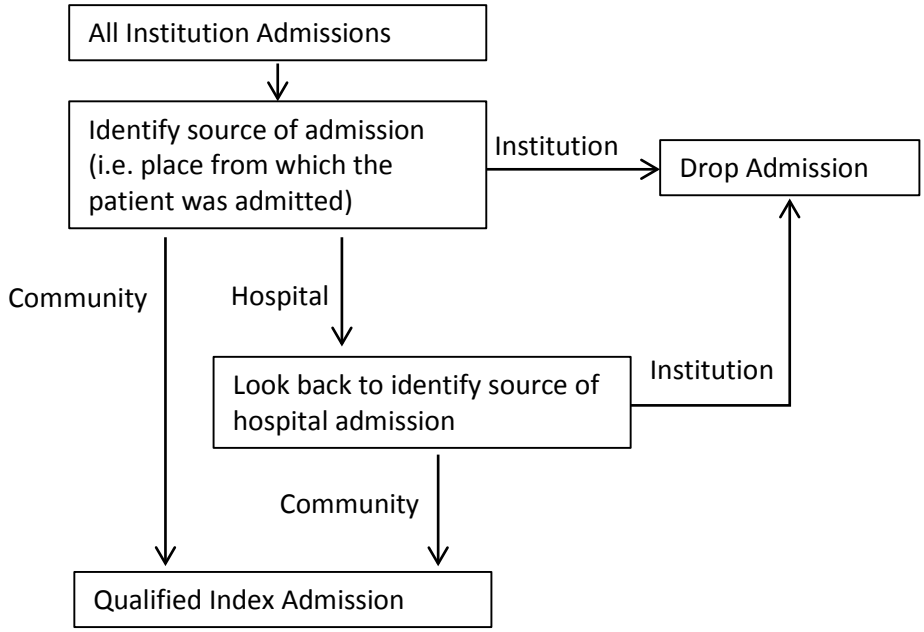
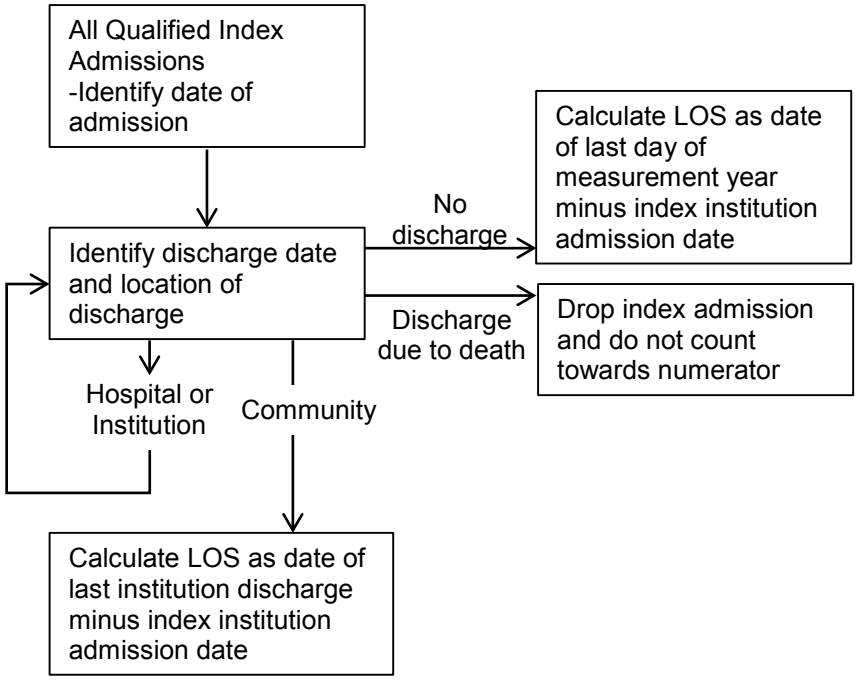


Figure NFU.B. Steps to Calculate Length of Stay (LOS)



Sampling S.20.
Not applicable

Survey/Patient-Reported Data S.21.
Not applicable

Missing Data S.22.
The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23.
Administrative Claims

Data Source or Collection Instrument S.24.
Both the numerator and denominator for this measure are based on administrative claims data.

Data Source or Collection Instrument (Reference) S.25.
No instrument provided.

Level of Analysis S.26.
Health Plan
Integrated Delivery System

Care Setting S.27.

Post-acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility
Other: ICF/IID
Other: Community Settings

Composite Performance Measure S.28.

Not applicable

Measure Justification Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

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- People eligible for both Medicare and Medicaid, or "Dual enrollees"
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- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on July 22, 2016.

Measure Name:

Admission to an institution from the community among Managed Long-Term Services and Supports (MLTSS) beneficiaries.

Type of Measure

Outcome

Importance

1a—Opportunity for Improvement

Beneficiaries receiving community-based long-term services and supports (LTSS), also called home and community-based services (HCBS), face fragmentation in care delivery when they receive services from multiple providers, and because they are more likely to be Medicare-Medicaid dual beneficiaries, whose benefits and payment policies are not aligned.[1,2] They are at high risk for institutional admissions and other adverse outcomes if they do not

[1] Medicaid and Chip Payment Advisory Commission (MACPAC). "Report to the Congress on Medicaid and CHIP. Chapter 2. Medicaid's Role in Providing Assistance with Long-Term Services and Supports." MACPAC, June 2014.

[2] Saucier, P., and B. Burwell. "Care Coordination in Managed Long-Term Services and Supports." AARP Public Policy Institute, 2015. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

receive timely HCBS, if they have unmet needs, if their care is uncoordinated, and when they make transitions across care settings.[3,4,5,6,7,8,9]

Higher state-level HCBS expenditures are associated with lower risk of nursing home admissions.[10] At the individual-level, one key study estimating the causal effect of home care use on the probability and costs of institutionalization found that among beneficiaries who were Medicaid eligible, greater home care use reduced the likelihood of a nursing home stay and reduced the number of days in a nursing home among those who were admitted. After addressing selection bias, the estimates suggest that a $1,000 increase in Medicaid home care expenditures per year reduces nursing facility stays by 2.75 days and nursing facility expenditures by $351.[11]

State Medicaid agencies are moving their LTSS beneficiaries into managed care plans, either stand-alone managed LTSS plans, or comprehensive managed care plans that provide both LTSS and medical care. According to Truven, the number of people receiving LTSS in managed care settings grew from 105,000 to 389,000 from 2004 to 2012.[12] As of 2015,

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[3] Naylor, Mary D., Ellen T. Kurtzman, and Mark V. Pauly. "Transitions of Elders Between Long-Term Care and Hospitals." *Policy, Politics, and Nursing Practice*, vol. 10, no. 3, 2009, pp. 187-194.

[4] Saucier, P., and B. Burwell. "Care Coordination in Managed Long-Term Services and Supports." AARP Public Policy Institute, 2015. Available at http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

[5] Freedman, Vicki and Brenda C. Spillman. "Disability and Care Needs Among Older Americans." *The Milbank Quarterly*, vol. 92, no. 3, 2014, pp. 509-541.

[6] Allen, Susan M., Elizabeth R. Piette, and Vincent Mor. "The Adverse Consequences of Unmet Need Among Older Persons Living in the Community: Dual-Eligible Versus Medicare-Only Beneficiaries." *The Journals of Gerontology: Psychological Sciences*, vol. 69, no. 1, 2014, pp. S51-S58.

[7] Komisar, Harriet L, Judith Feder, and Judith D. Kasper. "Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles." *Inquiry*, vol. 42, no. 2, 2005, pp. 171-182.

[8] Sands, Laura P., Yun Wang, George P. McCabe, Kristofer Jennings, Catherine Eng, and Kenneth E. Covinsky. "Rates of Acute Care Admissions for Frail Older People Living with Met Versus Unmet Activity of Daily Living Needs." *Journal of the American Geriatrics Society*, vol. 53, no. 2, 2006, pp. 339-344.

[9] Gaugler, Joseph E., Sue Duval, Keith A. Anderson, and Robert L. Kane. "Predicting Nursing Home Admission in the U.S.: A Meta-Analysis." *BMC Geriatrics*, vol. 7, no. 1, 2007, pp. 1.

[10] Muramatsu, Naoko, Hongjun Yin, Richard T. Campbell, Ruby L. Hoyem, Martha A. Jacob, and Christopher O. Ross. "Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home- and Community-Based Services Matter?" *The Journals of Gerontology: Social Sciences*, vol. 62, no. 3, 2007, pp. S169-S178.

[11] Guo, Jing, R. Tamara Konetzka, and Willard G. Manning. "The Causal Effects of Home Care Use on Institutional Long-Term Care Utilization and Expenditures." *Health Economics*, vol. 24, no. 1, 2015, pp. 4-17.

[12] Saucier, P. K. (2012). *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Centers for Medicare & Medicaid Services.

almost two dozen states provide LTSS through managed care programs. At its best, managed care offers the promise of delivering improved? community-based coordinated care by integrating medical care, behavioral health care and LTSS across providers and settings. At its worst, it could disrupt longstanding relationships (e.g. if patients' providers are not part of the managed care plan's network) and create additional barriers to obtaining needed care (e.g., through gatekeeping or coverage restrictions). Because the range of potential outcomes from these shifts in care delivery is so broad, it is necessary to systematically monitor the quality of care delivered to people in MLTSS plans and the use of institutional care.

1a.1.

This is a measure of health outcomes: It is a rate of institutional admissions (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) per 1,000 enrollee months among MLTSS beneficiaries age 18 and older. For more information on importance, please see section 1b.

1a.2.—Linkage

1a.2.1 Rationale

Care coordination is a central feature of a high quality health care system, promoting effective communication between patients and their families, caregivers, and healthcare providers; safe care transitions; and the facilitation of linkages between communities and the healthcare system.[13]

With effective care coordination, timely access to high quality community-based LTSS, MLTSS beneficiaries should have fewer institutional admissions, shorter stays in institutions, and spend longer time in community settings.

Decreasing the institutional admission rate among MLTSS beneficiaries represents an increase in timely access to high quality services and effective care coordination provided to individuals receiving LTSS in community settings. A majority of older adults and people with disabilities also prefer to avoid unnecessary admissions to nursing homes and other institutions and remain in home or community settings as long as possible.

[13] National Quality Forum. "NQF-Endorsed Measures for Care Coordination: Phase 3, 2014. Technical Report." December 2, 2014. Available at https://www.qualityforum.org/Publications/2014/12/NQF-Endorsed_Measures_for_Care_Coordination__Phase_3.aspx.

1a.3.—Linkage

1a.3.1. Source of Systematic Review

- Clinical Practice Guideline recommendation – ***complete sections 1a.4, and 1a.7***
- US Preventive Services Task Force Recommendation – ***complete sections 1a.5 and 1a.7***
- Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections 1a.6 and 1a.7***
- ✓ Other – complete section 1a.8

1a.4.—Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation

Not Applicable.

1a.4.2. Specific Guideline

Not Applicable.

1a.4.3. Grade

Not Applicable.

1a.4.4. Grades and Associated Definitions

Not Applicable.

1a.4.5. Methodology Citation

Not Applicable.

1a.4.6. Quantity, Quality, and Consistency

Not Applicable.

1a.5.—United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation

Not Applicable.

1a.5.2. Specific Recommendation

Not Applicable.

1a.5.3. Grade

Not Applicable.

1a.5.4. Grades and Associated Definitions

Not Applicable.

1a.5.5. Methodology Citation

Not Applicable.

1a.6.—Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation

Not Applicable.

1a.6.2. Methodology Citation

Not Applicable.

1a.7.—Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review

Not Applicable.

1a.7.2. Grade

Not Applicable.

1a.7.3. Grades and Associated Definitions

Not Applicable.

1a.7.4. Time Period

Not Applicable.

1a.7.5. Number and Type of Study Designs

Not Applicable.

1a.7.6. Overall Quality of Evidence

Not Applicable.

1a.7.7. Estimates of Benefit

Not Applicable.

1a.7.8. Benefits Over Harms

Not Applicable.

1a.7.9. Provide for Each New Study

Not Applicable.

1a.8.—Other Source of Evidence

1a.8.1. Process Used

The Project Team performed a targeted literature review to identify literature to support the measure concept. For our targeted literature review, we searched academic journal articles published from 2008 to 2015 using MEDLINE, CINAHL, Scopus, and Ageline. We searched the gray literature using a Google custom search, focusing on federal and state agencies and organizations most likely to have relevant sources. In addition to our targeted academic journal article and gray literature searches, we focused on several reports from the National Quality Forum (NQF), including the following resources:

- Phase 1 of the NQF HCBS Committee's work, which defined a conceptual framework for HCBS quality measurement, including a set of broad domains and detailed subdomains of measurement.[14]
- Phase 2 of the NQF HCBS Committee's work, which included an environmental scan of measures, measure concepts, and instruments for HCBS quality measurement.[15]

We also conducted 13 expert interviews to gain diverse insights about the priority areas for measurement and the usefulness and feasibility of the identified measures for Medicaid. The interviews included individuals with expertise related to Medicaid policy and programs, measure development, and patient advocacy.

1a.8.2. Citation

See footnotes included above in Section 1a.8.1.

1b.—Evidence to Support Measure Focus

1b.1. Rationale

The Supreme Court *Olmstead* decision found that unjustified institutionalization of persons with disabilities violates the Americans with Disabilities Act, so states are obligated to

[14] National Quality Forum. "Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Initial Components of the Conceptual Framework." Interim Report. July 15, 2015a. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=79920. Accessed October 2, 2015.

[15] National Quality Forum. "Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Synthesis of Evidence and Environmental Scan." Interim Report. December 15, 2015b.

provide LTSS in the most integrated setting appropriate to the needs of qualified beneficiaries.[16,17]

With effective care coordination and timely access to high quality community-based LTSS, MLTSS beneficiaries should have fewer institutional admissions, a shorter length of stay in institutions, and more time in community settings.

Institutional use is a commonly used measure, and widely-regarded as an important indicator of timely access to quality HCBS, and effective care coordination among:

- Individuals (beneficiaries) – public opinion surveys consistently show the majority of older adults and people with disabilities generally prefer to receive services in community settings, rather than institutions.
- Community service providers – who gauge their progress and success by their ability to reduce or delay long-term institutional admissions among the people they serve.
- Health plans – whose capitation payment rates are designed to reduce the use of institutional services.
- State Medicaid agencies – who have responsibility for supporting beneficiaries in community settings to delay or divert institutional admissions and to transition individuals who are admitted to institutions back to the community as soon as it is safe to do so.

1b.2. Performance Scores

Not applicable.

1b.3. Summary of Data Indicating Opportunity

Individuals without adequate community-based supports are at risk for institutionalization, and without targeted interventions to help them transition back to the community, some of these individuals will remain in institutions unnecessarily. Around 5-12 percent of individuals in nursing homes have minimal need for skilled nursing services and could reasonably live in community settings with support services.[18] These individuals are commonly referred to as "low-care" nursing home residents. Evidence suggests that states with less investment in HCBS and higher rates of nursing home use have higher proportions of low-care residents in

[16] https://kaiserfamilyfoundation.files.wordpress.com/2015/12/8617-02-medicaid-and-long-term-services-and-supports-a-primer.pdf

[17] Rosenbaum S. "The Olmstead decision: implications for state health policy." *Health Affairs*, vol. 19, no. 5, 2000, pp. 228-32.

[18] Mor, Vincent, Jacqueline Zinn, Pedro Gozalo, Zhanlian Feng, Orna Intrator, and David C. Grabowski. "Prospects for Transferring Nursing Home Residents to the Community." *Health Affairs*, vol. 26, no. 6, 2007, pp. 1762–1771.

nursing homes.[19,20] The presence of low-care residents in nursing homes reflects a quality gap for LTSS users and indicates an opportunity for improvement.

Further, studies suggest that the provision of community-based services impacts the use of institutional services. Among Medicaid beneficiaries, greater home care use reduced the likelihood of a nursing home stay and reduced the number of days in a nursing home among those who were admitted.[21]

Through testing we will be able to identify the rate of admission to institutions for as sample of MLTSS plans.

1b.4. and 1b.5. Disparities

Not applicable.

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

High resource use, patient/societal consequences of poor quality, other (care coordination).

1c.3. Epidemiologic or Resource Use Data

Institutional settings are costly. The median annual cost of nursing facility care in 2015 was $91,250.[22]

Inadequate access to HCBS and poor care coordination puts patients at higher risk for transitions between settings (such as home, hospital, and nursing facility or other institutions) and for serious health complications resulting from these transitions.

1c.4. Citations

See footnotes included above in Section 1c.3.

1c.5. Patient-Reported Outcome Performance Measure (PRO-PM)

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[19] Mor, Vincent, Jacqueline Zinn, Pedro Gozalo, Zhanlian Feng, Orna Intrator, and David C. Grabowski. "Prospects for Transferring Nursing Home Residents to the Community." *Health Affairs*, vol. 26, no. 6, 2007, pp. 1762–1771.

[20] Arling, Greg, Kathleen A. Abrahamson, Valerie Cooke, Robert L. Kane, and Teresa Lewis. "Facility and Market Factors Affecting Transitions from Nursing Home to Community." *Medical Care*, vol. 49, no. 9, September 2011, pp. 790–796.

[21] Guo, Jing, R. Tamara Konetzka, and Willard G. Manning. "The Causal Effects of Home Care Use on Institutional Long-Term Care Utilization and Expenditures." *Health Economics*, vol. 24, no. 1, 2015, pp. 4-17.

[22] https://kaiserfamilyfoundation.files.wordpress.com/2015/12/8617-02-medicaid-and-long-term-services-and-supports-a-primer.pdf

Not applicable.

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.2. Identify the Specific Dataset

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.3. What are the Dates of the Data Used in Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.4. What Levels of Analysis Were Tested?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.7. Sample Differences, if Applicable

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.2. Method of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.3. Statistical Results from Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.4. Interpretation

Not applicable. Reliability will be determined during the measure testing phase.

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.2. Method of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.3. Statistical Results from Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.4. Interpretation

Not applicable. Validity will be determined during the measure testing phase.

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.2. Statistical Results From Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.3. Interpretation

Not applicable. Exclusions will be determined during the measure testing phase.

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable.

2b4.2. Rationale why Risk Adjustment is not needed

Not applicable.

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable.

2b4.4. Statistical Results

Not applicable.

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable.

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R^2)

Not applicable.

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable.

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable.

2b4.9. Results of Risk Stratification Analysis

Not applicable.

2b4.10. Interpretation

Not applicable.

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable.

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method

Not applicable. Differences will be determined during the measure testing phase.

2b5.2. Statistical Results

Not applicable. Results will be determined during the measure testing phase.

2b5.3. Interpretation

Not applicable. This will be determined during the measure testing phase.

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable. Comparability will be determined during the measure testing phase.

2b6.2. Statistical Results

Not applicable. Comparability will be determined during the measure testing phase.

2b6.3. Interpretation

Not applicable. Comparability will be determined during the measure testing phase.

Feasibility

3a.1. How are the data elements needed to compute measure scores generated

Not applicable. Feasibility will be determined during the measure testing phase.

3b.1. Are the data elements needed for the measure as specified available electronically

Not applicable. Feasibility will be determined during the measure testing phase.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable. This is not an eMeasure.

3c.1. Describe what you have learned or modified as a result of testing

Not applicable. Feasibility will be determined during the measure testing phase.

3c.2. Describe any fees, licensing, or other requirements

Not applicable. No fees, licensing, or other requirements at this phase.

Usability and Use

4.1—Current and Planned Use

Planned use: Public reporting, Quality Improvement with Benchmarking (external benchmarking to multiple organizations), and Quality Improvement (internal to the specific organization).

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients

Not applicable. This is a new measure.

4a.2. If not publicly reported or used for accountability, reasons

Not applicable. This is a new measure.

4a.3. If not, provide a credible plan for implementation

This measure is intended for use by states to monitor and improve the quality of healthcare. Stakeholder input supported this measure for public reporting and quality improvement.

4b.1. Progress on improvement

Not applicable. This is a new measure.

4b.2. If no improvement was demonstrated, what are the reasons

Not applicable. This is a new measure.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. The measure titles and NQF numbers are listed here

There are no NQF-endorsed measures related to admission to an institution among HCBS users.

5.1b. If the measures are not NQF-endorsed, indicate the measure title

A related measure is specified for Medicaid Fee-for-Service (FFS) enrollees called "Admission to an Institution from the Community." This measure is specified at the Medicaid FFS HCBS Program level and will undergo testing in 2016, under the same project as the currently proposed measure (Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees).

5a—Harmonization

5a.1. Are the measure specifications completely harmonized

Yes, this measure harmonizes with the Medicaid FFS Admission to an Institution from the Community measure being tested under the current project.

5a.2. If not completely harmonized, identify the differences rationale, and impact

Not applicable.

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures

There are no competing measures.

Additional Information

Co.1.—Measure Steward Point of Contact

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services, Roxanne Dupert-Frank, Mail Stop: S3-02-01, 7500 Security Boulevard ,Baltimore, MD, Roxanne.Dupert-Frank@cms.hhs.gov. (410) 786-9667

Co.2.—Developer Point of Contact (indicate if same as Measure Steward Point of Contact

Mathematica Policy Research, Debra Lipson, DLipson@Mathematica-Mpr.com, (202) 484-9220

Ad.1. Workgroup/Expert Panel Involved in Measure Development

Development of Assessment and Care Planning Measures for Use in Medicaid Managed Long Term Services and Supports (MLTSS) Programs Technical Expert Panel

Anne Cohen, Health and Disability Policy Consultant, Disability Health Access, LLC

Patti Killingsworth, Assistant Commissioner and Chief of LTSS, Bureau of TennCare

Jennifer Lenz, Executive Director, State and Corporate Services, Health Services Advisory Group

Bonnie Marsh, Executive Director, State and Corporate Services, Health Services Advisory Group

Diane McComb, ANCOR Liaison with State Associations

Margaret A. Nygren, Executive Director and CEO, American Association on Intellectual and Developmental Disabilities

Joseph Ouslander, Professor of Clinical Biomedical Science, Florida Atlantic University

Pamela J. Parker, Manager, Special Needs Purchasing, State of Minnesota Department of Human Services

Cheryl Phillips, Senior VP Public Policy and Advocacy, Leading Age

D.E.B. Potter, Senior Survey Statistician, Agency for Healthcare Research and Quality (AHRQ)

Juliana Preston, Utah Executive Director, HealthInsight

Genie Pritchett, Sr. Vice President Medical Services, Colorado Access

Alice Lind, Aging and Long Term Support Division, Washington State Department of Social and Health Services

Ad.2. Year the Measure Was First Released

Not applicable. This measure is still under development.

Ad.3. Month and Year of Most Recent Revision

Not applicable. This measure is still under development.

Ad.4. What is your frequency for review/update of this measure?

Not applicable. This measure is still under development.

Ad.5. When is your next scheduled review/update for this measure?

Not applicable. This measure is still under development.

Ad.6. Copyright Statement

Not applicable. This measure is still under development.

Ad.7. Disclaimers

Not applicable. This measure is still under development.

Ad.8. Additional Information/Comments

Not applicable.

Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations (Managed Long Term Services and Supports Plans - MLTSS)
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on July 22, 2016.

Measure Name

Successful transition after short-term institutional stay among Managed Long Term Services and Support (MLTSS) enrollees.

Descriptive Information

Measure Name (Measure Title De.2.)

Successful transition after short-term institutional stay among Managed Long Term Services and Support (MLTSS) enrollees.

Measure Type De.1.

Outcome

Brief Description of Measure De.3.

The percentage of MLTSS enrollee institution admissions (nursing facility [NF] or Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID]) that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission.

If Paired or Grouped De.4.

None

Subject/Topic Areas De.5.

This measure is for a new topic area: community integration - long-term services and supports (LTSS).

This new topic area is focused on improving community integration for Medicaid beneficiaries receiving community-based LTSS, also referred to as home and community-based services (HCBS).[1]

Crosscutting Areas De 6.

Care Coordination: Care Coordination

Measure Specifications

Measure-specific Web Page S.1.

Not applicable. This measure is still under development.

If This Is an eMeasure S.2a.

Not applicable. This is not an eMeasure.

[1] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/community-integration-ltss/ci-ltss.html

Data Dictionary, Code Table, or Value Sets S.2b.
Not applicable. This measure is still under development.

For Endorsement Maintenance S.3.
Not applicable. This measurement is still under development.

Numerator Statement S.4.
Admissions that resulted in a short-term institutional (NF and ICF/IID) stay (100 days or less) and discharge to the community for 30 consecutive days.

Numerator statements may change as this measure is still under development.

Time Period for Data S.5.
The proposed data period is: Denominator – 11 months; Numerator – 12 months

However, the optimal data period will be determined during the measure testing phase.

Numerator Details S.6.
The number of short-term (100 days or less) institutional facility stays among MLTSS enrollees age 18 and older that result in successful transition to a community residence for 30 consecutive days. Discharges that result in hospitalization or re-admission to the institution within 30 days of discharge from the institution do not meet the numerator criteria.

Community residence: Any residence that is not a Medicaid- or Medicare- certified nursing facility or ICF for Individuals with Intellectual or Developmental Disabilities (IDD).

> *Note: Individuals who were admitted to the nursing facility from the hospital setting and who lived in the community prior to the hospital admission are considered residing in the community.*

Institutional facility: Medicaid- or Medicare- certified nursing facilities provide skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as “custodial care”) or Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Numerator details may change as this measure is still under development.

Denominator Statement S.7.MLTSS enrollees age 18 and older who were admitted to or residing in an institution (nursing facility or ICF/IID) for less than or equal to 100 consecutive days.

Denominator statement may change as this measure is still under development.

Target Population Category S.8.

Populations at Risk: Populations at Risk
Populations at Risk: Dual-eligible beneficiaries
Populations at Risk: Individuals with multiple chronic conditions
Senior Care

Denominator Details S.9.

New admissions to a nursing facility or ICF/IID between September 1 of the year prior to the measurement year and July 31 of the measurement year among MLTSS enrollees age 18 and older.

Minimum length of enrollment in the MLTSS plan will be considered in the testing period. A beneficiary can be counted more than once in the denominator if the individual had more than one admission to a nursing facility or ICF/IID during the measurement year.

Value set codes constituting nursing facilities and ICF/IIDs will be revised over the course of testing.

Table NFU.A. Codes to Identify Nursing Facilities

UB -04 Type of Bill	Place of Service Codes	UB-04 Revenue Codes
021x, 022x, 023x, 028x	31, 32, 33	019x, 055x

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10.

Institutional admissions that are transfers from another institution, admissions from the hospital that originated from an institution, and admissions that result in death in the institution.

Denominator exclusion details may change as this measure is still under development.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11.

See section S.10 for all relevant exclusion details. Denominator exclusion details may change as this measure is still under development.

Stratification Details/Variables S.12.

Potential strata include:
1. Age: 18 – 64 vs. 65 and older
2. Type of institution: NF or ICF/IID
3. Dual-eligible vs. Medicaid-only beneficiary

The need for stratification will be evaluated during the measure testing phase.

Risk Adjustment Type S.13.

The need and methods for risk-adjustment will be evaluated during the measure testing phase.

Statistical Risk Model and Variables S.14.
The need and methods for risk-adjustment will be evaluated during the measure testing phase.

Detailed Risk Model Specifications S.15.
The need and methods for risk-adjustment will be evaluated during the measure testing phase.

Type of Score S.16.
Rate/proportion

Interpretation of Score S.17.
Better quality is indicated by a higher rate.

Calculation Algorithm/Measure Logic S.18.
Denominator

Steps to Identify Institution Admissions from the Community (Refer to Figure 1)

1) Identify all admissions to institutional facilities (NF and ICF/IID facilities) in the measurement year.

- Refer to Table NFU.A. for codes to identify institutional facilities. MLTSS plans may alternatively use a State or MLTSS specific residence classification system that indicates beneficiary residence in a nursing facility or ICF/IID.
  Note: The denominator for this measure is based on number of admissions. A beneficiary could be counted more than once in the denominator if the individual had more than one admission to an institution in the measurement year.

2) Exclude admissions that are transfers from another institution.

3) Exclude admissions from the hospital that originated from an institution.

4) Exclude admissions that result in death in the institution (not shown in figure).

5) All resulting admissions directly from the community and from the hospital that originated in the community are considered qualified admissions.

6) Classify admissions as NF or ICF/IID.

Numerator

Steps to Calculate Length of Stay (LOS) for Qualified Admissions (Refer to Figure 2)

1) Identify all qualified admissions (see Denominator criteria).

2) Look for location of the first discharge in the measurement year.

- If the beneficiary is discharged to the community, calculate LOS as the date of institution discharge minus the index admission date.
- If there is no discharge, calculate LOS as the date of the last day of the measurement year minus index admission date.
- If the beneficiary is discharged to the hospital, look for the hospital discharge and location of discharge.
    - If the beneficiary is discharged from the hospital to the community, calculate LOS as the date of institution discharge minus the qualified admission date.
    - If the beneficiary is discharged from the hospital to the institution, repeat step 2.
- If the beneficiary is discharged to a different institution (i.e. a transfer), repeat step 2.

3) Classify LOS as short term or long term: When counting the duration of each stay within a measurement period, 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.

- Short-term stay: A beneficiary had a short-term stay if the LOS is less than or equal to 100 days.
- Long-term stay: A beneficiary had a long-term stay if the LOS is greater than or equal to 101 days.

4) Classify institution as NF or ICF/IID.

<u>Steps to Identify Successful Discharges from Short-Term Admissions</u>

1) Identify all short-term stays among qualified admissions.

2) Identify if the beneficiary was hospitalized, admitted to an institution, or died in the 30 days after discharge from the qualified admission and drop those admissions from numerator.

<u>Steps to Calculate Reporting Rates:</u>

1) Calculate the discharge rate by dividing the denominator (institution admissions) by the numerator (successful discharges to the community after short-term stay) separately by age group and institution type. Rates should be reported as:

- NF Discharge 18-64: Successful discharges to the community after a short term stay/qualified admissions to the NF for MLTSS enrollees age 18-64
- NF Discharge 65+: Successful discharges to the community after a short term stay/qualified admissions to the NF for MLTSS enrollees age 65+
- NF Discharge Total: Successful discharges to the community after a short term stay/qualified admissions to the NF for all MLTSS enrollees
- ICF/IID Discharge 18-64: Successful discharges to the community after a short term stay/qualified admissions to the ICF/IID for MLTSS enrollees 18-64

- ICF/IID Discharge 65+: Successful discharges to the community after a short term stay/qualified admissions to the ICF/IID for MLTSS enrollees 65+
- ICF/IID Discharge Total: Successful discharges to the community after a short term stay/qualified admissions to the ICF/IID for all MLTSS enrollees

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.

Figure 1: Steps to Identify Qualified Index Admissions

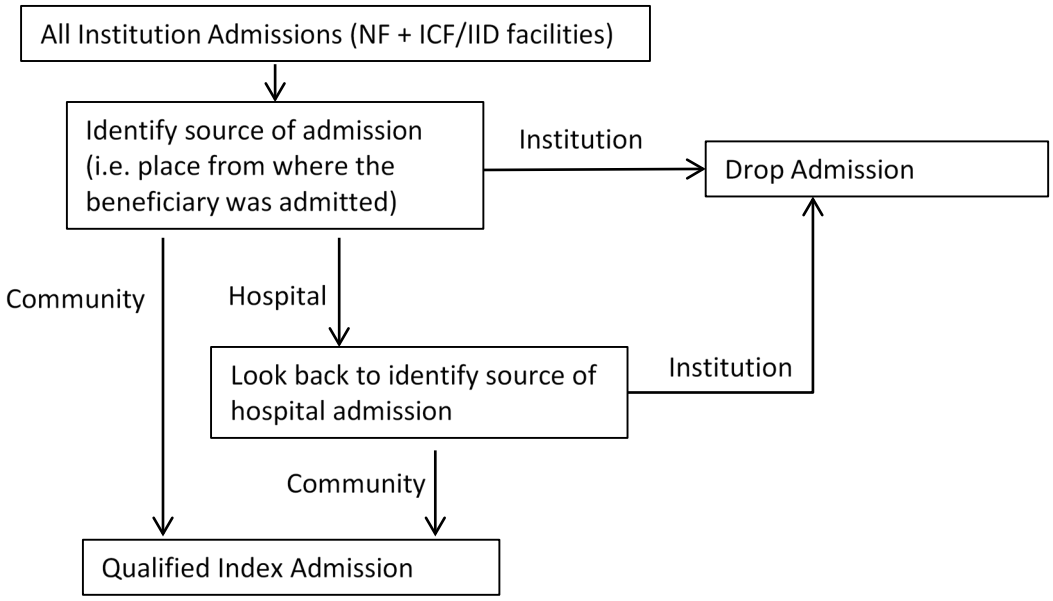
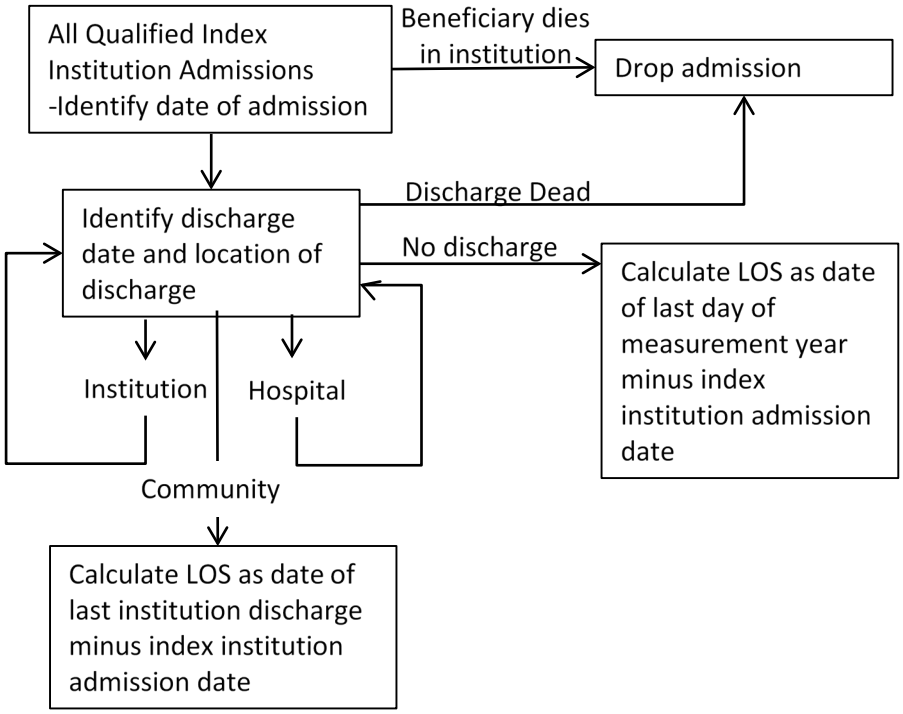


Figure 2 Calculating Length of Stay (LOS)



Sampling S.20.
Not applicable.

Survey/Patient-Reported Data S.21.
Not applicable.

Missing Data S.22.
The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23.
Administrative Claims

Data Source or Collection Instrument S.24.
Both the numerator and denominator for this measure are based on administrative claims data.

Data Source or Collection Instrument (Reference) S.25.
No instrument provided.

Level of Analysis S.26.
Health Plan

Integrated Delivery System

The level of analysis may change as this measure is still under development.

Care Setting S.27.

Post-acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility
Other: ICF/IID
Other: Community Settings

Composite Performance Measure S.28.

Not applicable.

Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations (Managed Long Term Services and Supports Plans – MLTSS)
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on July 22, 2016.

Measure Name

Successful transition after long-term institutional stay among Managed Long Term Services and Support (MLTSS) enrollees.

Descriptive Information

Measure Name (Measure Title De.2.)

Successful transition after long-term institutional stay among Managed Long Term Services and Support (MLTSS) enrollees.

Measure Type De.1.

Outcome

Brief Description of Measure De.3.

The percentage of MLTSS enrollees who are long-term residents (101 days or more) of institutions (nursing facility [NF] or Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID]) who are successfully discharged to the community (community residence for 30 or more days).

If Paired or Grouped De.4.

None

Subject/Topic Areas De.5.

This measure is for a new topic area: community integration - long-term services and supports (LTSS).

This new topic area is focused on improving community integration for Medicaid beneficiaries receiving community-based LTSS, also referred to as home and community-based services (HCBS).[1]

Crosscutting Areas De 6.

Care Coordination: Care Coordination

Measure Specifications

Measure-specific Web Page S.1.

Not applicable. This measure is still under development.

If This Is an eMeasure S.2a.

Not applicable. This is not an eMeasure.

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[1] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/community-integration-ltss/ci-ltss.html

Data Dictionary, Code Table, or Value Sets S.2b.
Not applicable. This measure is still under development.

For Endorsement Maintenance S.3.
Not applicable. This measurement is still under development.

Numerator Statement S.4.
The number of long term (101 days or more) institutional stays (nursing facility or ICF/IID) among MLTSS enrollees age 18 and older that result in successful transition to the community (community residence for 30 or more days).

Numerator statements may change as this measure is still under development.

Time Period for Data S.5.
The proposed data period is: 2 years

However, the optimal data period will be determined during the measure testing phase.

Numerator Details S.6.

MLTSS enrollees discharged during the measurement period from an institutional facility (NF or ICF/IID) to a community residence who reside in the community with no death, institution readmissions or hospital admissions within 30 days following the day of discharge.

Community residence: Any residence that is not a Medicaid- or Medicare- certified nursing facility or ICF for Individuals with Intellectual or Developmental Disabilities (IDD).

> *Note: Individuals who were admitted to the nursing facility from the hospital setting and who lived in the community prior to the hospital admission are considered residing in the community.*

Institutional facility: Medicaid- or Medicare- certified nursing facilities provide skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as “custodial care”) or Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Numerator details may change as this measure is still under development.

Denominator Statement S.7.
MLTSS enrollees age 18 and older residing in a nursing facility or ICF/IID for greater than or equal to 101 consecutive days.

Denominator statement may change as this measure is still under development.

Target Population Category S.8.

Populations at Risk: Populations at Risk
Populations at Risk: Dual-eligible beneficiaries
Populations at Risk: Individuals with multiple chronic conditions
Senior Care

Denominator Details S.9.

All MLTSS enrollees residing in an institution (NF or ICF/IID) for 101 days or more between September 19 of the year prior to the start of the 2-year measurement period and September 19 of the last year of the 2-year measurement period among MLTSS enrollees age 18 and older.

Note: The residence does not need to be in the same institution for 101 days or more. Enrollees who were transferred between facilities are still included if the total consecutive time in one or more institutional facilities was 101 days or more.

An enrollee can be counted more than once in the denominator if the individual had more than one long-term stay in a nursing facility or ICF/IID during the measurement year.

Minimum length of enrollment in the MTLSS plan will be considered in the testing period. An enrollee can be counted more than once in the denominator if the individual had more than one admission to a nursing facility or ICF/IID during the measurement year.

Value set codes constituting nursing facilities and ICF/IIDs will be revised over the course of testing.

Table NFU.A. Codes to Identify Nursing Facilities

UB -04 Type of Bill	Place of Service Codes	UB-04 Revenue Codes
021x, 022x, 023x, 028x	31, 32, 33	019x, 055x

Denominator details may change as this measure is still under development.

Denominator Exclusions (NQF Includes “Exceptions” in the “Exclusion” Field) S.10.

Denominator exclusion details may change as this measure is still under development.

Denominator Exclusion Details (NQF Includes “Exceptions” in the “Exclusion” Field) S.11.

Denominator exclusion details may change as this measure is still under development.

Stratification Details/Variables S.12.

Potential strata include:
1. Age: 18 – 64 vs. 65 and older
2. Type of institution: NF or ICF/IID
3. Dual-eligible vs. Medicaid-only beneficiary

The need for stratification will be evaluated during the measure testing phase.

Risk Adjustment Type S.13.

The need and methods for risk-adjustment will be evaluated during the measure testing phase.

Statistical Risk Model and Variables S.14.

The need and methods for risk-adjustment will be evaluated during the measure testing phase.

Detailed Risk Model Specifications S.15.

The need and methods for risk-adjustment will be evaluated during the measure testing phase.

Type of Score S.16.

Rate/proportion

Interpretation of Score S.17.

Better quality is indicated by a higher rate.

Calculation Algorithm/Measure Logic S.18.

Denominator

Steps to Identify Long-Term Institution Residents *(Refer to Figure 1)*

1) Identify all enrollees residing in an institution (NF and ICF/IID facilities) at the beginning of the measurement period. Look back 101 days from the first day of the measurement period to determine if the enrollee has been continuously residing in the institution. Enrollees who were transferred between facilities are still included if the total consecutive time in one or more institutional facilities was 101 days or more.
2) Identify all admissions to institutional facilities (NF and ICF/IID facilities) in the measurement period.
    - Refer to Table 1 for codes to identify institutional facilities. MLTSS plans may alternatively use a State or MLTSS specific residence classification system that indicates beneficiary residence in a nursing facility or ICF/IID.

      Note: The denominator for this measure is based on number of admissions. An enrollee could be counted more than once in the denominator if the individual had more than one admission to an institution followed by a discharge to the community during the measurement period.
3) Look for location of the first discharge in the measurement period.

- If the enrollee is discharged to the community, calculate length of stay (LOS) as the date of institution discharge minus the index admission date.
- If there is no discharge, calculate LOS as the date of the last day of the measurement period minus the index admission date.
- If the enrollee is discharged to the hospital, look for the hospital discharge and location of discharge.
    i. If the enrollee is discharged from the hospital to the community, calculate LOS as the date of institution discharge minus the qualified admission date.
    ii. If the enrollee is discharged from the hospital to the institution, repeat step 2.
- If the enrollee is discharged to a different institution (i.e. a transfer), repeat step 2.

4) Classify LOS as short term or long term.
    - *Short-term stay:* An enrollee had a short-term stay if the LOS is less than or equal to 100 days.
    - *Long-term stay*: An enrollee had a long-term stay if the LOS is greater than or equal to 101 days.
5) Exclude all short-term stays.
6) Sum the admissions from step 1 (residing the institution prior to the start of the measurement period) and step 5 (admitted to the institution with a long-term stay in the measurement period).
7) Classify admission as NF or ICF/IID institution.

Numerator

<u>Steps to Identify Successful Discharge to the Community (See Figure 2)</u>

1) Identify all long-term stays among qualified admissions
2) Look for location of the first discharge in the measurement year
    - If there is no discharge, remove from the numerator.
    - If the enrollee is discharged to a different institution (i.e. a transfer), repeat step 2 to find the first discharge to the community.
    - If the enrollee is discharged to the hospital, look for the hospital discharge and location of discharge.

i. If the enrollee is discharged from the hospital to the institution, repeat step 2

ii. If the enrollee is discharged from the hospital to the community move to step 3.

- If the enrollee is discharged to the community, move to step 3.

1) Identify if the enrollee was hospitalized or admitted to an institution in the 30 days after discharge from the qualified admission and drop those admissions from numerator.

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.

Figure 1: Calculating Length of Stay (LOS)

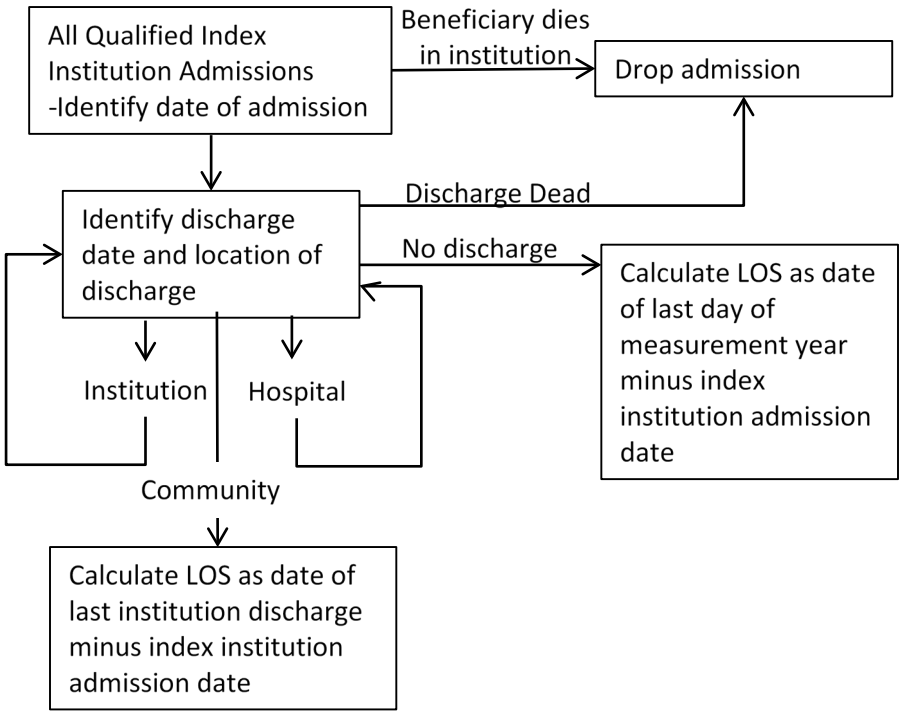
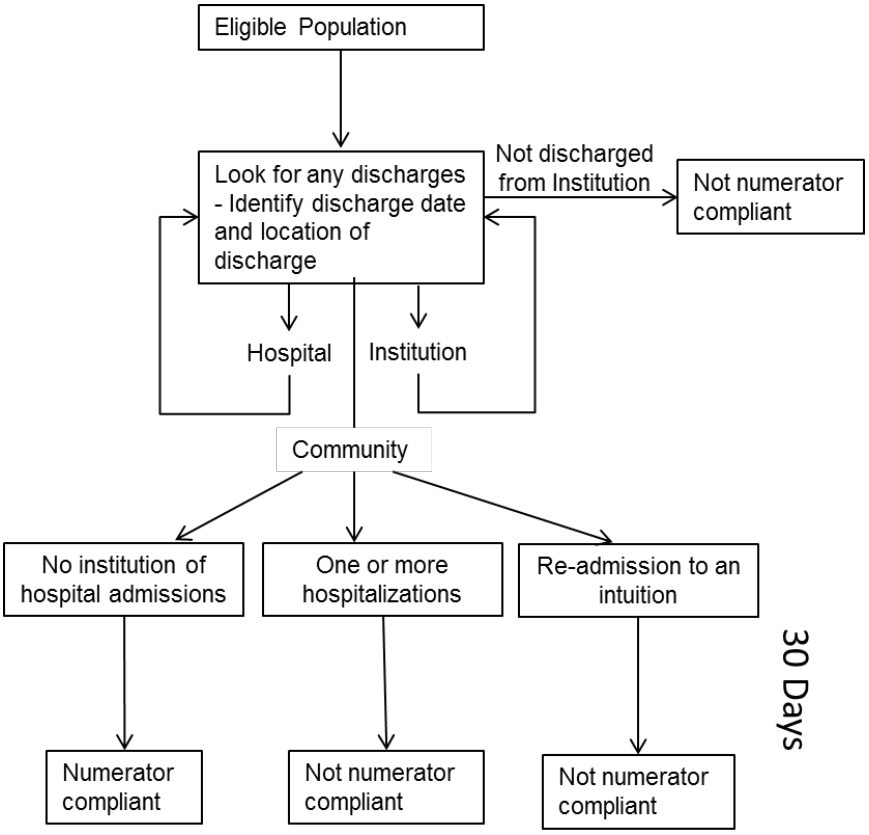


Figure 2: Steps to Identify Successful Discharge to the Community from Long-Term Institution Admissions



Sampling S.20.
Not applicable.

Survey/Patient-Reported Data S.21.
Not applicable.

Missing Data S.22.
The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23.
Administrative Claims

Data Source or Collection Instrument S.24.
Both the numerator and denominator for this measure are based on administrative claims data.

Data Source or Collection Instrument (Reference) S.25.
No instrument provided.

Level of Analysis S.26.
Health Plan
Integrated Delivery System

The level of analysis may change as this measure is still under development.

Care Setting S.27.
Post-acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility
Other: ICF/IID
Other: Community Settings

Composite Performance Measure S.28.
Not applicable.

Measure Justification Form

Project Title

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations (Managed Long Term Services and Supports Plans – MLTSS)
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date

Information included is current on July 22, 2016.

Measure Name

Successful transition after short-term institutional stay among Managed Long Term Services and Support (MLTSS) enrollees

Successful transition after long-term institutional stay among Managed Long Term Services and Support (MLTSS) enrollees

Type of Measure

Outcome

Importance

1a—Opportunity for Improvement

The majority of older adults and people with disabilities generally prefer to receive services in community settings, rather than institutions, and states have an obligation under the Supreme Court *Olmstead* decision to provide LTSS in the most integrated setting appropriate to the needs of qualified beneficiaries.[1,2]

With adequate transition planning and high-quality community-based LTSS, individuals can successfully transition to community settings from an institution.

Evidence from the Money Follows the Person Demonstration program shows that individuals can successfully transition to community settings from institutions, even after long-stays in an institution.[3]

Among individuals who had been receiving HCBS prior to their admission, it is often easier to re-establish some of those services after a short interruption than having to create an entirely new care plan with new providers many months or years later. In addition, housing options typically diminish the longer an individual remains in an institution, making it more difficult for institutional residents to be discharged, so it is critical to focus on discharge

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[1] https://kaiserfamilyfoundation.files.wordpress.com/2015/12/8617-02-medicaid-and-long-term-services-and-supports-a-primer.pdf

[2] Rosenbaum S. "The Olmstead decision: implications for state health policy." *Health Affairs*, vol. 19, no. 5, 2000, pp. 228-32.

[3] Irvin, Carol V., Noelle Denny-Brown, Alex Bohl, John Schurrer, Andrea Wysocki, Rebecca Coughlin, and Susan R. Williams. "Money Follows the Person 2014 Annual Evaluation Report." Mathematica Policy Research, Cambridge, MA. December 18, 2015.

planning early in the institutional stay when the person may be able to return to the same home or apartment. Evidence suggests that states with less investment in HCBS and higher rates of nursing home use have higher proportions of "low-care" residents (i.e., individuals who do not require skilled nursing services and could reasonably be living in community settings with support) and lower rates of discharge to the community.[4,5] Low-care nursing home residents are particularly good candidates for discharge to the community, and the prevalence of low-care residents in institutions indicates an opportunity for improvement.[6]

State Medicaid agencies are moving their LTSS beneficiaries into managed care plans, either stand-alone Managed LTSS plans, or comprehensive managed care plans that provide both LTSS and medical care. According to Truven, the number of people receiving LTSS in managed care settings grew from 105,000 to 389,000 from 2004 to 2012.7 As of 2015, almost two dozen states provide LTSS through managed care programs. At its best, managed care offers the promise of delivering community-based coordinated care by integrating medical care, behavioral health care and LTSS across providers and settings. At its worst, it could disrupt longstanding relationships (e.g. if patients' providers are not part of the managed care plan's network) and create additional barriers to obtaining needed care (e.g., through gatekeeping or coverage restrictions). Because the range of potential outcomes from these shifts in care delivery is so broad, it is necessary to systematically monitor the quality of care delivered to people in MLTSS plans and their ability to return individuals from the institutional setting to the community.

1a.1.

These are measures of health outcomes:

1) The percentage of institution admissions (nursing facility [NF] or Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID]) that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission .

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[4] Mor, Vincent, Jacqueline Zinn, Pedro Gozalo, Zhanlian Feng, Orna Intrator, and David C. Grabowski. "Prospects for Transferring Nursing Home Residents to the Community." *Health Affairs*, vol. 26, no. 6, 2007, pp. 1762–1771.

[5] Arling, Greg, Kathleen A. Abrahamson, Valerie Cooke, Robert L. Kane, and Teresa Lewis. "Facility and Market Factors Affecting Transitions from Nursing Home to Community." *Medical Care*, vol. 49, no. 9, September 2011, pp. 790–796.

[6] Ross, Jessica, Sam Simon, Carol Irvin, and Dean Miller. "Institutional Level of Care Among Money Follows the Person Participants." Mathematica Policy Research, Cambridge, MA. The National Evaluation of the Money Follows the Person Demonstration Grant Program, Reports from the Field, Number 10, October 2012.

[7] Saucier, P. K. (2012). *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Centers for Medicare & Medicaid Services

2) The percentage of long-term (101 days or more) institution residents (NF or ICF/IID) who are successfully discharged to the community (community residence for 30 or more days).

1a.2.—Linkage

1a.2.1 Rationale

Care coordination is a central feature of a high quality health care system, promoting effective communication between patients and their families, caregivers, and healthcare providers; safe care transitions; and the facilitation of linkages between communities and the healthcare system.[8]

With effective care coordination and transition planning and timely access to high quality community-based LTSS, MLTSS enrollees who require institutional care but prefer to be in home or community settings should be able to successfully transition from institutions back to the community. Increasing the percentage of institutional stays that result in successful discharge to the community represents an increase in the quality of care coordination, transition planning, and availability of community-based services and supports.

1a.3.—Linkage

1a.3.1. Source of Systematic Review

- Clinical Practice Guideline recommendation – ***complete sections 1a.4, and 1a.7***
- US Preventive Services Task Force Recommendation – ***complete sections 1a.5 and 1a.7***
- Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections 1a.6 and 1a.7***
- ✓ Other – complete section 1a.8

1a.4.—Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation

Not Applicable.

1a.4.2. Specific Guideline

Not Applicable.

[8] National Quality Forum. "NQF-Endorsed Measures for Care Coordination: Phase 3, 2014. Technical Report." December 2, 2014. Available at https://www.qualityforum.org/Publications/2014/12/NQF-Endorsed_Measures_for_Care_Coordination__Phase_3.aspx.

1a.4.3. Grade

Not Applicable.

1a.4.4. Grades and Associated Definitions

Not Applicable.

1a.4.5. Methodology Citation

Not Applicable.

1a.4.6. Quantity, Quality, and Consistency

Not Applicable.

1a.5.—United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation

Not Applicable.

1a.5.2. Specific Recommendation

Not Applicable.

1a.5.3. Grade

Not Applicable.

1a.5.4. Grades and Associated Definitions

Not Applicable.

1a.5.5. Methodology Citation

Not Applicable.

1a.6.—Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation

Not Applicable.

1a.6.2. Methodology Citation

Not Applicable.

1a.7.—Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review

Not Applicable.

1a.7.2. Grade

Not Applicable.

1a.7.3. Grades and Associated Definitions

Not Applicable.

1a.7.4. Time Period

Not Applicable.

1a.7.5. Number and Type of Study Designs

Not Applicable.

1a.7.6. Overall Quality of Evidence

Not Applicable.

1a.7.7. Estimates of Benefit

Not Applicable.

1a.7.8. Benefits Over Harms

Not Applicable.

1a.7.9. Provide for Each New Study

Not Applicable.

1a.8.—Other Source of Evidence

1a.8.1. Process Used

The Project Team performed a targeted literature review to identify literature to support the measure concepts. For our targeted literature review, we searched academic journal articles published from 2008 to 2015 using MEDLINE, CINAHL, Scopus, and Ageline. We searched the gray literature using a Google custom search, focusing on federal and state agencies and organizations most likely to have relevant sources. In addition to our targeted academic journal article and gray literature searches, we focused on several reports from the National Quality Forum (NQF), including the following resources:

- Phase 1 of the NQF HCBS Committee's work, which defined a conceptual framework for HCBS quality measurement, including a set of broad domains and detailed subdomains of measurement.[9]
- Phase 2 of the NQF HCBS Committee's work, which included an environmental scan of measures, measure concepts, and instruments for HCBS quality measurement.[10]

We also conducted 13 expert interviews to gain diverse insights about the priority areas for measurement and the usefulness and feasibility of the identified measures for Medicaid. The interviews included individuals with expertise related to Medicaid policy and programs, measure development, and patient advocacy.

1a.8.2. Citation

See footnotes included above in Section 1a.8.1.

1b.—Evidence to Support Measure Focus

1b.1. Rationale

The majority of older adults and people with disabilities generally prefer to receive services in community settings, rather than institutions. The Supreme Court *Olmstead* decision found that unjustified institutionalization of persons with disabilities violates the Americans with Disabilities Act, so states have an obligation to provide LTSS in the most integrated setting appropriate to the needs of qualified beneficiaries.[11,12]

Many states have implemented transition programs to assist beneficiaries in moving from institutions to home and community settings, but there is variation in successful discharge rates. We were unable to find published evidence of MLTSS plan programs to move individuals from the institutional settings to the community. However, evidence from the Money Follows the Person Demonstration program indicates that individuals can

[9] National Quality Forum. "Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Initial Components of the Conceptual Framework." Interim Report. July 15, 2015a. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=79920. Accessed October 2, 2015.

[10] National Quality Forum. "Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Synthesis of Evidence and Environmental Scan." Interim Report. December 15, 2015b.

[11] https://kaiserfamilyfoundation.files.wordpress.com/2015/12/8617-02-medicaid-and-long-term-services-and-supports-a-primer.pdf

[12] Rosenbaum S. "The Olmstead decision: implications for state health policy." *Health Affairs*, vol. 19, no. 5, 2000, pp. 228-32.

successfully transition to community settings from institutions, even after long-stays in an institution.[13]

1b.2. Performance Scores

Not applicable.

1b.3. Summary of Data Indicating Opportunity

Around 5-12 percent of individuals in nursing homes have minimal need for skilled nursing services and could reasonably live in community settings with support services.[14] These individuals are commonly referred to as "low-care" nursing home residents. The prevalence of low-care residents in nursing homes reflects a quality gap for LTSS users and indicates an opportunity for improving discharge rates among short-stay residents.

There is variation in reinstitutionalization rates after discharge from an institution across states and MLTSS plans, but evidence from the Money Follows the Person Demonstration program shows that improvements can be made in successful transitions, even after long-stays in an institution.[15]

1b.4. and 1b.5. Disparities

Not applicable.

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

High resource use, patient/societal consequences of poor quality, other (care coordination)

1c.3. Epidemiologic or Resource Use Data

Institutional settings are costly. The median annual cost of nursing facility care in 2015 was $91,250.[16]

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[13] Irvin, Carol V., Noelle Denny-Brown, Alex Bohl, John Schurrer, Andrea Wysocki, Rebecca Coughlin, and Susan R. Williams. "Money Follows the Person 2014 Annual Evaluation Report." Mathematica Policy Research, Cambridge, MA. December 18, 2015.

[14] Mor, Vincent, Jacqueline Zinn, Pedro Gozalo, Zhanlian Feng, Orna Intrator, and David C. Grabowski. "Prospects for Transferring Nursing Home Residents to the Community." *Health Affairs*, vol. 26, no. 6, 2007, pp. 1762–1771.

[15] Irvin, Carol V., Noelle Denny-Brown, Alex Bohl, John Schurrer, Andrea Wysocki, Rebecca Coughlin, and Susan R. Williams. "Money Follows the Person 2014 Annual Evaluation Report." Mathematica Policy Research, Cambridge, MA. December 18, 2015.

[16] https://kaiserfamilyfoundation.files.wordpress.com/2015/12/8617-02-medicaid-and-long-term-services-and-supports-a-primer.pdf

Poor care coordination puts patients at risk for transitions between settings (such as home, hospital, and nursing facility or other institutions) and for serious health complications resulting from these transitions.

1c.4. Citations

See footnotes included above in Section 1c.3.

1c.5. Patient-Reported Outcome Performance Measure (PRO-PM)

Not applicable.

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.2. Identify the Specific Dataset

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.3. What are the Dates of the Data Used in Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.4. What Levels of Analysis Were Tested?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.7. Sample Differences, if Applicable

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.2. Method of Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.3. Statistical Results from Reliability Testing

Not applicable. Reliability will be determined during the measure testing phase.

2a2.4. Interpretation

Not applicable. Reliability will be determined during the measure testing phase.

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.2. Method of Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.3. Statistical Results from Validity Testing

Not applicable. Validity will be determined during the measure testing phase.

2b2.4. Interpretation

Not applicable. Validity will be determined during the measure testing phase.

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.2. Statistical Results From Testing Exclusions

Not applicable. Exclusions will be determined during the measure testing phase.

2b3.3. Interpretation

Not applicable. Exclusions will be determined during the measure testing phase.

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable.

2b4.2. Rationale why Risk Adjustment is not needed

Not applicable.

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable.

2b4.4. Statistical Results

Not applicable.

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable.

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R2)

Not applicable.

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable.

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable.

2b4.9. Results of Risk stratification Analysis

Not applicable.

2b4.10. Interpretation

Not applicable.

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable.

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method

Not applicable. Differences will be determined during the measure testing phase.

2b5.2. Statistical Results

Not applicable. Results will be determined during the measure testing phase.

2b5.3. Interpretation

Not applicable. This will be determined during the measure testing phase.

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable. Comparability will be determined during the measure testing phase.

2b6.2. Statistical Results

Not applicable. Comparability will be determined during the measure testing phase.

2b6.3. Interpretation

Not applicable

Feasibility

3a.1. How are the data elements needed to compute measure scores generated

Not applicable. Feasibility will be determined during the measure testing phase.

3b.1. Are the data elements needed for the measure as specified available electronically

Not applicable. Feasibility will be determined during the measure testing phase.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable. This is not an eMeasure.

3c.1. Describe what you have learned or modified as a result of testing

Not applicable. Feasibility will be determined during the measure testing phase.

3c.2. Describe any fees, licensing, or other requirements

Not applicable. No fees, licensing, or other requirements at this phase.

Usability and Use

4.1—Current and Planned Use

Planned use: Public reporting, Regulatory and Accreditation Programs, Quality Improvement with Benchmarking (external benchmarking to multiple organizations), and Quality Improvement (Internal to the specific organization).

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients

Not applicable. These are new measures.

4a.2. If not publicly reported or used for accountability, reasons

Not applicable. These are new measures.

4a.3. If not, provide a credible plan for implementation

These measures are intended for use by states to monitor and improve the quality of healthcare. Stakeholder input supported these measures for public reporting and quality improvement.

4b.1. Progress on improvement

Not applicable. These are new measures.

4b.2. If no improvement was demonstrated, what are the reasons

Not applicable. These are new measures.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. The measure titles and NQF numbers are listed here

There are no NQF-endorsed measures related successful discharge from an institution.

5.1b. If the measures are not NQF-endorsed, indicate the measure title

Two related measures are proposed for development for Medicaid Fee-For-Service (FFS) enrollees called “Successful transition after short-term institutional stay among Medicaid FFS HCBS users” and “Successful transition after long-term institutional stay among Medicaid FFS HCBS users.” These measures are specified at the Medicaid FFS HCBS program level and may undergo testing under the same project as the currently proposed measure (Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees).

Additional related measures include the following:

- CMS Nursing Home Compare: Percentage of short-stay residents who were successfully discharged to the community
- CMS Nursing Home Compare: Skilled Nursing Facility (SNF) 30-Day All-Cause Readmission Measure (NQF #2510)

- Money Follows the Person (MFP) Reinstitutionalization: Percentage of MFP participants who transitioned to the community after an institutional admission talked at least 90 days.
- Medicare-Medicaid Plan (MMP): Nursing Facility Diversion

5a—Harmonization

5a.1. Are the measure specifications completely harmonized

The measures align but are not completely harmonized with the two proposed Medicaid FFS successful discharge measures proposed for development under the current project.

5a.2. If not completely harmonized, identify the differences rationale, and impact

If the Medicaid FFS successful discharge measures are selected for further development, we will work to harmonize the measures to the greatest extent possible.

We will also carefully review the specifications for the existing CMS Nursing Home Compare, MFP, and MMP measures and assess opportunities to harmonize.

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures

There are no competing measures.

Co.1.—Measure Steward Point of Contact

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services, Roxanne Dupert-Frank, Mail Stop: S3-02-01, 7500 Security Boulevard ,Baltimore, MD, Roxanne.Dupert-Frank@cms.hhs.gov. (410) 786-9667

Co.2.—Developer Point of Contact (indicate if same as Measure Steward Point of Contact

Mathematica Policy Research, Debra Lipson, DLipson@Mathematica-Mpr.com, (202) 484-9220

Ad.1. Workgroup/Expert Panel Involved in Measure Development

Development of Assessment and Care Planning Measures for Use in Medicaid Managed Long Term Services and Supports (MLTSS) Programs Technical Expert Panel, 2013.

Anne Cohen, Health and Disability Policy Consultant, Disability Health Access, LLC

Patti Killingsworth, Assistant Commissioner and Chief of LTSS, Bureau of TennCare

Jennifer Lenz, Executive Director, State and Corporate Services, Health Services Advisory Group

Bonnie Marsh, Executive Director, State and Corporate Services, Health Services Advisory Group

Diane McComb, ANCOR Liaison with State Associations

Margaret A. Nygren, Executive Director and CEO, American Association on Intellectual and Developmental Disabilities

Joseph Ouslander, Professor of Clinical Biomedical Science, Florida Atlantic University

Pamela J. Parker, Manager, Special Needs Purchasing, State of Minnesota Department of Human Services

Cheryl Phillips, Senior VP Public Policy and Advocacy, Leading Age

D.E.B. Potter, Senior Survey Statistician, Agency for Healthcare Research and Quality (AHRQ)

Juliana Preston, Utah Executive Director, HealthInsight

Genie Pritchett, Sr. Vice President Medical Services, Colorado Access

Alice Lind, Aging and Long Term Support Division, Washington State Department of Social and Health Services

Ad.2. Year the Measure Was First Released

Not applicable. These measures are still under development.

Ad.3. Month and Year of Most Recent Revision

Not applicable. These measures are still under development.

Ad.4. What is your frequency for review/update of this measure?

Not applicable. These measures are still under development.

Ad.5. When is your next scheduled review/update for this measure?

Not applicable. These measures are still under development.

Ad.6. Copyright Statement

Not applicable. These measures are still under development.

Ad.7. Disclaimers

Not applicable. These measures are still under development.

Ad.8. Additional Information/Comments

Not applicable.