



Frequently Asked Questions (FAQs)

Measures for Medicaid Managed Long Term Services and Supports (MLTSS) Plans

January 2019

Background

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research¹ and its partner the National Committee for Quality Assurance, to develop measures for people receiving long term services and supports (LTSS) through managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). These measures provide information about assessment and care planning processes with MLTSS plan members, as well as LTSS use and rebalancing, that can be used by states, managed care plans, and other stakeholders for quality improvement purposes.

This FAQ document provides additional information and addresses common questions about these measures.

General FAQ (pertaining to all 8 MLTSS quality measures)

Q1: *Where can I find the technical specifications and other materials related to these measures?*

A1: The technical specifications and webinar materials for these measures are available on the Managed Care, Managed LTSS (MLTSS) page of Medicaid.gov, <https://www.medicare.gov/medicaid/managed-care/ltss/index.html>:

- Technical specifications: https://www.medicare.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf
- Value set: <https://www.medicare.gov/medicaid/managed-care/downloads/ltss/ltss-value-sets.xlsx>
- Risk Adjustment Tables: <https://www.medicare.gov/medicaid/managed-care/downloads/ltss/ltss-risk-adjustment.xlsx>
- Webinar slides: <https://www.medicare.gov/medicaid/managed-care/downloads/ltss/mltss-assessment-careplan-webinar.pdf>
- Webinar recording: <https://www.youtube.com/watch?v=5h0GVaKc56Q&feature=youtu.be>

¹ Measures developed as part of CMS contract: Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees, HHSM-500-2013-130111, Task Order #HHSM-500-T0004.

- Q2:** *Who should I contact if I have additional questions about these measures?*
- A2:** If you have additional questions about these measures, please submit your question to the technical assistance (TA) mailbox at MLTSSmeasures@cms.hhs.gov for assistance.
- Q3:** *Why were these measures developed?*
- A3:** As more states shift to MLTSS and gain more experience, the need to measure program outcomes and quality has increased. The new quality measures, which were carefully designed for beneficiaries enrolled in MLTSS plans, represent a major step forward in giving CMS, states, MLTSS plans, providers, and consumers the ability to compare the performance of MLTSS programs and plans within and across states. Specifically, CMS wanted to create nationally-standardized measures meeting importance, usability, feasibility, and scientific validity and reliability standards for use across MLTSS plans and State Medicaid programs in order to fill key gaps in MLTSS measure domains while not duplicating other measures that have been developed or are currently under development.
- Q4:** *Is CMS requiring reporting of these measures?*
- A4:** No, CMS does not require states or MLTSS plans to report these measures. However, states may choose to require plans to report any of these measures to the State Medicaid agency.
- Q5:** *An MLTSS plan may document the data elements required for these measures, but the information may be recorded in different locations or abstracted inconsistently from members' records. What can states and plans do to ease the potential burden of data collection and help standardize the data collection process?*
- A5:** Through our discussions with MLTSS plans, we learned that plans—particularly those operating in multiple states—can ease the burden of data collection by mapping their existing assessment and care plan tools to the standardized data elements and terminology in these measures, which would make it easier to abstract data and standardize the data collection process. It is also important for MLTSS plan managers to train staff to document assessment and care plan elements consistently, as well as to train individuals responsible for collecting data on how to interpret each of the elements specified in each measure. Plans can also ease the burden of data collection by ensuring data from multiple sources are consolidated into a central data system.
- Q6:** *Care managers often do not document data elements in the assessment and care plan measures unless the member has "a problem." For example, they may not document that they assessed the member's vision or need for an assistive device if no problem was identified. How can states or plans address this issue?*
- A6:** MLTSS plan managers should provide training on proper documentation practices to care managers and other delegated staff. States and MLTSS plans could consider including data field entry options to remind care managers to record all results of the assessment, even if findings are negative, that is, the member does not have a problem or need assistance or services. For example, states and plans could include a question in the member's record that requires the care manager to document both whether an assessment was performed and whether or not a problem was identified, along with another required field to include the details of the problem if there was a problem identified.
- Q7:** *How should states validate plan-reported measure rates?*
- A7:** If measure rates are reported by MLTSS plans directly to the state, the state should conduct an independent review of a sample of members included in the reported measures, for example, by the External Quality Review Organization (EQRO) or state-employed abstractors.

Q8: *Can all eight measures be applied to members who receive LTSS benefits but do not receive a medical care benefit (e.g., hospitalizations, primary and specialty physician care, and other outpatient services) through an MLTSS plan?*

A8: Four of the eight measures (LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, LTSS Shared Care Plan with Primary Care Practitioner (PCP), and Screening, Risk Assessment, and Plan of Care to Prevent Future Falls) apply to all members receiving a LTSS benefit through the MLTSS plan regardless of whether the MLTSS plan covers their medical care benefit. The remaining four measures (LTSS Reassessment/Care Plan Update after Inpatient Discharge, LTSS Admission to an Institution from the Community, LTSS Minimizing Institutional Length of Stay, and LTSS Successful Transition after Long-Term Institutional Stay) require members to receive a medical benefit through the MLTSS plan to be eligible for the measures (i.e., the MLTSS plan is the primary payer for the medical care services, such as inpatient hospital stays and post-acute care). These four measures rely on inpatient claims (i.e., hospital and skilled nursing facility) which may not be available to the MLTSS plan if the plan is not the primary payer for the service. Although members whose medical care benefits are not covered through the MLTSS plan are not eligible for the measure, we recommend MLTSS plans track members' admissions or discharges from inpatient facilities where possible.

If MLTSS plans can obtain timely, complete, and accurate inpatient claims data for their members, then a state may choose to deviate from the measure specifications to require MLTSS plans not providing medical benefits report these four measures.

Q9: *Do these measures apply to participants in HCBS 1915(c) waiver programs?*

A9: The measures are intended for any MLTSS plan that covers Medicaid LTSS benefits. Federal regulations pertaining to 1915(c) waivers require person-centered service plans², but states can decide whether or not to require that these measures be reported by MLTSS plans participating in a state program operating under 1915(c) authority, and if they do, can specify which types of plans and eligible members to which the measures apply.

Questions about specific measures

Assessment and care planning measures

Q10: *Which are the assessment and care planning measures?*

A10: The assessment and care planning measures include: LTSS Comprehensive Assessment and Update; LTSS Comprehensive Care Plan and Update; LTSS Shared Care Plan with Primary Care Practitioner (PCP); LTSS Reassessment/Care Plan Update after Inpatient Discharge; and Screening, Risk Assessment, and Plan of Care to Prevent Future Falls: Falls Part 1 (Screening) and Falls Part 2 (Risk Assessment and Plan of Care).

² "In accordance with 42 CFR §441.301 (b)(1)(i), all waiver services must be furnished pursuant to a written service plan that is developed for each waiver participant." (1915c waiver application, Instructions, Technical Guide and Review Criteria, Appendix D-1: Service Plan Development, CMCS, DEHPG, November 2014. Available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf>).

Q11: *Should states require plans to report both the core and supplemental rates for the LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update measures, and LTSS Reassessment/Care Plan Update After Inpatient Discharge measures?*

A11: It is recommended that MLTSS plans report both rates. However, if the state believes there are valid reasons for not reporting both rates, such as costly changes in assessment and care planning forms and IT systems, it might consider phasing in the supplemental rates over time. For instance, in the first year of measure use (e.g., measurement year 2018), the state could require MLTSS plans to report just the core rate, and then require that MLTSS plans report both core and supplemental rates for measurement year 2019 or 2020. Although they are called “supplemental rates,” they are still very important, and should be viewed as “aspirational.” MLTSS plans should strive to cover more assessment and care plan elements over time.

Q12: *Do I need value sets to calculate any of the five assessment and care planning measures? If so, where can I find the value sets?*

A12: Value sets are the complete set of procedure and diagnostic codes used to identify a service or condition included in a measure. One of the assessment and care planning measures—LTSS Reassessment/Care Plan Update After Inpatient Discharge—uses value sets to identify potentially planned hospitalizations. Please see question 48 below for more information regarding using value sets for the three institutional rebalancing and utilization measures.

The value sets are available at this link: <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/ltss-value-sets.xlsx>. Please see Table 2 in the “LTSS Value Sets to Codes” tab. Table 1 in the “LTSS Measures to Value Sets” tab shows each value set needed for each measure.

Q13: *Can I use the same sample for Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measure as the LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, LTSS Shared Care Plan with Primary Care Practitioner, and LTSS Reassessment/Care Plan Update after Inpatient Discharge measures?*

A13: Yes, the same sample can be used for Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measure as the LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, and LTSS Shared Care Plan with Primary Care Practitioner measures.

LTSS Comprehensive Assessment and Update

Q14: *Does the assessment have to take place in the home?*

A14: Yes, for the LTSS Comprehensive Assessment and Update measure, the assessment is required to take place in the member’s home as a face-to-face discussion unless certain exceptions are met. These exceptions include circumstances where the member was offered an in-home assessment and refused the in-home assessment (either refused to allow the care manager into the home or requested a telephone assessment instead of an in-home assessment), the member is residing in an acute or post-acute care facility (hospital, skilled nursing facility, other post-acute care facility) during the assessment time period, or the state policy, regulation, or other state guidance excludes the member from a requirement for in-home assessment.

Q15: *What if a member refuses an assessment?*

A15: There must be documentation of the refusal, which would result in exclusion from the measure. The rate of exclusion due to a member refusing to participate should also be reported along with the measure performance rate.

Q16: *What if a member could not be reached?*

A16: There must be documentation that at least three attempts were made to reach the member, and they could not be reached, which would result in exclusion from the measure. The rate of exclusion due to inability to reach a member should also be reported along with the measure performance rate.

LTSS Comprehensive Care Plan and Update

Q17: *Does the completion of a comprehensive care plan have to take place in the home?*

A17: No, for the LTSS Comprehensive Care Plan and Update measure, the care plan does not have to take place in the member's home. However, it must be done face-to-face unless certain exceptions are met. These exceptions include circumstances where the member was offered a face-to-face discussion and refused (either refused a face-to-face encounter or requested a telephone discussion instead of a face-to-face discussion), or the state policy, regulation, or other state guidance excludes the member from a requirement for face-to-face discussion of a care plan.

Q18: *What if there are multiple care plans documented during the measurement period?*

A18: Use the most recently updated care plan.

Q19: *What if a member refuses a care plan?*

A19: There must be documentation of the refusal, which would result in exclusion from the measure. The rate of exclusion due to a member refusing to participate should be reported along with the measure performance rate.

Q20: *How should a member's refusal to sign a plan be documented?*

A20: To meet the LTSS Comprehensive Care Plan and Update measure numerator, the care plan must be signed by the member, unless the care plan is under appeal in the specified timeframe, and there is documentation that the care plan was in appeal. There is an exclusion for members who refuse to take part in care planning. This exclusion is reported with the measure rate, so the overall measure rate can be interpreted correctly. For example, a plan that is not successful at engaging members in care planning, indicated by a high exclusion rate, would suggest the overall rate on the measure should be interpreted with caution.

Q21: *What if a member could not be reached?*

A21: There must be documentation that at least three attempts were made to reach the member, and they could not be reached. The rate of exclusion due to inability to reach a member should also be reported along with the measure performance rate.

Q22: *What if a member either does not have a caregiver involved or does not want their caregiver involved? What if a member's caregiver declines to participate in care planning?*

A22: In these circumstances, MLTSS plan records should clearly document that no caregiver was involved to satisfy the measure criteria. For example, there are situations where it may not be appropriate to engage the caregiver, including cases in which the member refused to involve the caregiver, or the invited caregiver declined to participate. Reasons for lack of caregiver involvement are not required; documentation that a caregiver was not involved is sufficient.

- Q23:** *Does the LTSS Comprehensive Care Plan and Update measure account for how well MLTSS plans are addressing member goals identified in the care plan?*
- A23:** As a process measure, it is not designed to address the outcome of care planning, in other words, whether the services authorized by MLTSS plans and specified in the care plan are sufficient to meet members' goals. One way to evaluate this outcome is through person-reported outcome measures reported through a survey or another method that asks individuals about their perspective on their care. Other measures and indicators, including those derived from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) HCBS Experience of Care Survey and the National Core Indicators Aging and Disability (NCI-AD) Survey, can be used to help inform whether the services provided are sufficient to help individuals meet their goals.
- Q24:** *If no deficit is identified for one of the core elements required for the care plan (e.g. functional needs), what should the care plan contain?*
- A24:** For certain elements of the care plan, documentation of no deficit is sufficient to receive credit for the elements (e.g., functional needs, medical needs, cognitive impairment needs). Other elements in the core and supplemental rates of the LTSS Comprehensive Care Plan and Update measure require documentation regardless of whether a deficit is identified (e.g., individualized member goal, plan for follow-up and communication, plan for emergency). Refer to the details in the measure specification to identify where documentation of no deficit is sufficient to meet the element definition.

LTSS Shared Care Plan with Primary Care Practitioner (PCP)

- Q25:** *Does a MLTSS member need to have a documented care plan to be eligible for this measure?*
- A25:** Yes, the denominator for this measure includes all MLTSS members with a care plan meeting the criteria outlined in the LTSS Comprehensive Care Plan and Update measure core rate.
- Q26:** *Who is considered a primary care practitioner (PCP) for the purpose of calculating this measure?*
- A26:** A primary care practitioner (PCP) is a physician, non-physician (e.g., nurse practitioner, physician assistant), or group of providers who offers primary care medical services. However, a care plan can be shared with a medical care practitioner other than the PCP if the practitioner is identified by the member as the primary point of contact for their medical care. Therefore, any medical care practitioner identified by the member as the primary point of contact for their medical care is considered their PCP for the purpose of calculating the measure.
- Q27:** *Why is the care plan shared just with the PCP or other documented medical care practitioner identified by the member?*
- A27:** The care plan is shared with the PCP to promote coordination of medical and LTSS services.
- Q28:** *What are some acceptable ways to share the care plan with the PCP? What if the participant refuses to share it?*
- A28:** The measure specifications allow sharing the care plan by mail, fax, secure email or mutual access to an electronic portal or Electronic Health Record. Members who refuse to have their care plan shared are excluded from the measure denominator, but there must be documentation in the record that the member refused to allow the care plan to be shared (notation of verbal refusal is sufficient). The rate of exclusion due to a member refusing to share their care plan with the PCP should also be reported along with the measure performance rate.

- Q29:** *Does the full care plan need to be shared with the PCP to meet the numerator criteria for this measure?*
- A29:** No. MLTSS plans are not required to share the full care plan with the PCP or other documented medical care practitioner. MLTSS plans may choose which parts of the care plan are most relevant to the practitioner.
- Q30:** *Is the provider's signature on the shared care plan required?*
- A30:** No, this measure only looks to see that a care plan was sent to a PCP by the MLTSS plan. No signature from the PCP is necessary to count towards the numerator of this measure.
- Q31:** *Do plans need to get a release of information (ROI) from the member to share the care plan with the PCP?*
- A31:** There is no need for a release of information. If a member gives the plan the contact information for their PCP, the plan is allowed to share information with that PCP. Plans or other providers of LTSS should try to coordinate LTSS services with medical services, even if they are not the primary payer for medical services for the member. Plans that do not know the member's PCP can/should ask the member to identify their PCP and request their contact information. The measure is intended to determine whether plans made an effort to try to connect with the medical care provider. There is an exclusion in this measure for members who refuse to have their care plan shared with the PCP, so if the member refuses, this should be documented and such members are excluded from the measure rate.

LTSS Reassessment/Care Plan Update after Inpatient Discharge

- Q32:** *Does this measure include discharges for planned hospital admissions?*
- A32:** No; discharges for planned hospital admissions are excluded from the measure denominator. You can identify planned discharges using the value sets available at <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/ltss-value-sets.xlsx>.
- Q33:** *Does the re-assessment and care plan update need to include the core elements specified in the LTSS Comprehensive Assessment and Update and LTSS Comprehensive Care Plan and Update measures and be done face-to-face?*
- A33:** Yes, both the re-assessment and the care plan must include each of the nine specified core elements. The re-assessment and care plan must be done face-to-face unless there is documentation that the member refused a face-to-face encounter.
- Q34:** *Why does this measure exclude members who do not receive medical benefits through their MLTSS plan?*
- A34:** The denominator for the Reassessment/Care Plan Update after Inpatient Discharge measure is identified through administrative claims for inpatient discharges. Managed care plans that are not the primary payer for inpatient care, which is usually covered under a medical benefit, do not routinely have reliable access to administrative claims for inpatient stays to identify individuals who are eligible to be counted in the measure denominator. Therefore, the eligible population for this measure is restricted to individuals who receive both medical and LTSS benefits through the managed care plan providing MLTSS.

Q35: *What if my state wishes to require MLTSS plans that are not providing medical care to report this measure?*

A35: If MLTSS plans can obtain timely, complete, and accurate inpatient claims data for their members, then a state may choose to deviate from the measure specifications to require MLTSS plans not providing medical benefits report this measure. For example, because the timely transfer of information between hospitals and MLTSS plans is key to ensuring smooth transfers between settings of care, MLTSS plans may have access to hospital discharge data through state or regional health information exchanges. In some cases, MLTSS plans are working closely with hospitals to share timely information about admissions and discharges. In addition, some states have the data and capacity to construct this measure for MLTSS plans using Medicare claims data for Medicare-Medicaid dual eligible beneficiaries (for more information about state access to Medicare claims data, see <http://www.statedataresourcecenter.com/medicare-data-available.html>).

Q36: *If, after discharge from an inpatient facility, the member has not had a change in condition or needs, is a new comprehensive assessment and care plan required?*

A36: A reassessment with the member after they have been discharged from an inpatient facility is required to determine whether a member has had a change (or no change) in their LTSS needs. Even if the reassessment conducted post-discharge finds no change in a member's LTSS needs, the second rate for this measure (Reassessment and Care Plan Update after Inpatient Discharge), MLTSS plan care managers should conduct a care plan update and document that they considered each of the nine core elements of the care plan, and determined that the plan of care for each element remains the same; documentation of "no changes" in the care plan as a whole does not meet the numerator criteria.

Screening, Risk Assessment, and Plan of Care to Prevent Future Falls: Falls Part 1 (Screening) and Falls Part 2 (Risk Assessment and Plan of Care)

Falls Part 1: Screening

Q37: *What is the difference between a screening (Part 1) and a risk assessment (Part 2) for the purposes of calculating this measure?*

A37: A falls screening is an evaluation of whether an MLTSS plan member has experienced a history of falls and/or problems with balance or gait. A falls risk assessment includes a balance/gait assessment AND one other assessment component, and should only be performed for members with a documented history of falls (at least two falls or one fall with injury in the past year).

Q38: *Is a specific screening tool required for this measure?*

A38: No, a specific screening tool is not required for this measure. However, potential screening tools may include the Morse Fall Scale and timed Get-Up-And-Go test.

Q39: *Should the rate of required exclusions be reported with this measure's Part 1 performance rate?*

A39: The measure excludes plan members who are not ambulatory from the measure rate, but it is not necessary to report the number of members excluded with the measure's performance rate.

Falls Part 2: Risk Assessment and Plan of Care

Q40: *Do the data elements comprising the falls risk assessment need to be documented as part of a comprehensive assessment?*

A40: No. Although a comprehensive assessment may include falls risk assessment elements, this measure does not require the risk assessment elements to be documented as part of a

comprehensive assessment. For this measure, a falls risk assessment is considered complete if the member record includes any documentation of a balance/gait assessment, and documentation of assessment of postural blood pressure, vision, home fall hazards, and/or medications.

Q41: *Do the components of the risk assessment need to be completed during a single encounter?*

A41: No, the components can be completed during separate encounters, provided they are documented in the member record as having been performed between August 1 of the year prior to the measurement year and December 31 of the measurement year.

Q42: *Is a standardized tool required for assessment of balance/gait?*

A42: No, a standardized tool is not required, although documentation of use of a standardized tool (e.g., Get Up & Go, Berg, Tinetti) would meet the balance/gait assessment component of the measure.

Q43: *Can the same standardized tool be used to conduct screening (Part 1) and risk assessment (Part 2)?*

A43: Yes, the same tool may be used to conduct the screening and risk assessment for this measure.

Q44: *Do the data elements comprising the plan of care to prevent future falls need to be documented as part of a comprehensive care plan?*

A44: No. Although a comprehensive care plan may include the elements comprising a plan of care to prevent future falls, the measure does not require the plan of care elements to be documented as part of a comprehensive care plan. For this measure, a plan of care is considered complete if the member record includes any documentation of exercise therapy or referral to exercise between August 1 of the year prior to the measurement year and December 31 of the measurement year.

Q45: *Should the rate of required exclusions be reported with this measure's Part 2 performance rate?*

A45: Yes, the rate of exclusion for members who refused an assessment and/or a plan of care needs to be reported with the measure's performance rate.

Q46: *Can the same sample for Part 2 of this measure be used for other measures?*

A46: No, the sample for Part 2 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measure is different from the systematic sample used for the LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, LTSS Shared Care Plan with Primary Care Practitioner, and Part 1 of the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measures. Members included in the sample for Part 2 of this measure must have a documented history of falls (at least two falls or one fall with injury in the past year), including documentation of plan member self-reported history of falls.

Institutional rebalancing and utilization measures

Q47: *Which measures assess institutional rebalancing and utilization measures?*

A47: The following measures assess institutional rebalancing and utilization: LTSS Admission to an Institution from the Community, LTSS Minimizing Institutional Length of Stay, and LTSS Successful Transition after Long-Term Institutional Stay.

Q48: *Do I need to use value sets to calculate these measures? If so, where can I find the value sets?*

A48: Yes. Value sets are the complete set of procedure and codes used to identify a service or condition included in a measure. All three of the rebalancing measures—LTSS Admission to an Institution from the Community, LTSS Minimizing Institutional Length of Stay, and LTSS Successful

Transition after Long-Term Institutional Stay—use the “Institutional Facility” value set. The value set is available at this link: <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/ltss-value-sets.xlsx>. See Table 2 in the “LTSS Value Sets to Codes” tab. Table 1 in the “LTSS Measures to Value Sets” tab shows each value set needed for each measure.

Q49: *Should unpaid or denied claims be included in calculating the institutional utilization and rebalancing measures?*

A49: No, include paid claims only (days denied for any reason should not be included) for all three of the rebalancing measures—LTSS Admission to an Institution from the Community, LTSS Minimizing Institutional Length of Stay, and LTSS Successful Transition after Long-Term Institutional Stay.

LTSS Admission to an Institution from the Community

Q50: *Are there exclusions for this measure’s eligible population (denominator)?*

A50: No. However, when identifying the measure’s denominator from the eligible population, there are a few cases in which you should not include member months. For example, do not include months when the plan member was residing in an institutional facility for the entire month (i.e. there were no days in the month spent residing in the community). If a member died, do not include the month during which the member died and any subsequent months of enrollment in the measure’s denominator.

Q51: *Are there exclusions for this measure’s numerator?*

A51: When calculating the measure’s numerator (number of admissions to an institution), do not include admissions that are direct transfers from another institution, admissions from the hospital that originated from an institution, or admissions for individuals who do not meet the continuous enrollment criteria. If the member’s admission resulted in death in the institution or death within 1 day of discharge from the institution, do not include the admission in the numerator.

Q52: *Can the community residence include assisted living?*

A52: Yes, people admitted to an institution who were residing in the community prior to their admission may include those residing in assisted living, adult foster care, or another setting that is not defined as an institution.

Q53: *Is this measure risk-adjusted?*

A53: Yes, this measure is risk-adjusted, using risk stratification by age. Results are reported separately for four age groups (18-64, 65-74, 75-84, 85 and older) for each of the length of stay classifications (short-term stay, medium-term stay, and long-term stay).

LTSS Minimizing Institutional Length of Stay and LTSS Successful Transition after Long-Term Institutional Stay

Q54: *Should I include discharges resulting in readmission to the institution in the numerator?*

A54: No, discharges that result in readmission to the institution within 60 days of discharge from the institution do not meet the numerator criteria.

- Q55:** *When counting the duration of a member's stay for the numerator calculation, should I include the day of discharge?*
- A55:** Do not count the day of discharge unless the member's admission and discharge occurred on the same day. If the admission and discharge occurred on the same day, the number of days in the stay is equal to 1.
- Q56:** *If there is no discharge, how should I calculate the length of stay for the numerator?*
- A56:** If there is no discharge, calculate the length of stay as the date of the last day of the measurement year minus the institutional facility admission date.
- Q57:** *Are these measures risk-adjusted?*
- A57:** Yes, the LTSS Minimizing Institutional Length of Stay and LTSS Successful Transition after Long-Term Institutional Stay measures are risk-adjusted based on the members' dual eligibility status, age and gender, diagnoses from the institutional facility admission, and number of hospital stays and months of enrollment in the classification period. The risk adjustment weights needed for these measures are in the risk adjustment tables available at <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/ltss-risk-adjustment.xlsx>.
- Q58:** *Should a member's admission be included in the denominator if it was a direct transfer from another institution?*
- A58:** No, do not include these admissions in the LTSS Successful Transition after Long-Term Institutional Stay measure denominator.
- Q59:** *Would an admission to an institutional facility following a discharge from another facility two days prior be considered a direct transfer?*
- A59:** No, these would be two distinct institutional stays; do not remove this admission from the denominator.
- Q60:** *How should I account for a member's death when calculating the measure's numerator and denominator?*
- A60:** If the member died in the institution or within one day of discharge from the institution, do not include their admission in the denominator. Members who died one day after discharge are excluded because of the high number of deaths the day after discharge observed while testing this measure; such members are unlikely to have been discharged alive. If the member died between day 2 and day 60 during the 60 days following discharge from the long-term institutional stay, do not include their discharge in the numerator.

Information regarding HEDIS measures resources:

- Specifications for the HEDIS versions of the LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, LTSS Shared Care Plan with Primary Care Practitioner, and LTSS Reassessment/Care Plan Update after Inpatient Discharge measures are available here: <http://store.ncqa.org/index.php/catalog/product/view/id/3419/s/hedis-2019-technical-specifications-for-ltss-organizations-epub/>
- Contact NCQA with questions about HEDIS measures at: <https://my.ncqa.org/>