Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measures

TECHNICAL ASSISTANCE RESOURCE

January 2025

Calculating the Long-Term Services and Supports Comprehensive Care Plan and Update (CPU-AD) Measure in the 2025 Adult Core Set

Introduction

Long-term services and supports (LTSS) include a broad range of supportive services that people may need when they have difficulty completing self-care tasks as a result of aging, chronic illness, or disability. These services may be provided at home, in the community, or in a facility. The goal of LTSS is to establish a person-driven support system that provides people with choice, control, and access to a full array of quality services that ensure optimal outcomes, such as independence, health, and quality of life. In light of these priorities, CMS added the LTSS Comprehensive Care Plan and Update (CPU-AD) measure to the Adult Core Set starting with 2023 reporting.[1] This measure assesses documentation of a comprehensive LTSS care plan within a specified time frame that includes core and supplemental elements (Table 1). This technical assistance (TA) resource provides a step-by-step guide to calculating the CPU-AD measure. This guide is intended to complement the more detailed Core Set technical specifications for the CPU-AD measure.[2]

Step-by-Step Guide to Calculating the CPU-AD Measure

The CPU-AD measure is based on a health plan measure included in the Healthcare Effectiveness Data Information Set (HEDIS®)[3] that was adapted for state-level reporting in the Adult Core Set.[4] The measure is designed to assess the provision of comprehensive LTSS regardless of (1) who provides the services (such as state Medicaid agencies, managed LTSS [MLTSS] plans, or

Table 1. Overview of the CPU-AD Measure for 2025 Adult Core Set Reporting

Measure steward	National Committee for Quality Assurance (NCQA)
Data collection method	Case management record review
Description	Percentage of beneficiaries receiving LTSS services ages 18 and older who have documentation of a comprehensive LTSS care plan in a specified time frame that includes core elements. The following rates are reported: 1. Care Plan with Core Elements Documented. Beneficiaries who had a comprehensive LTSS care plan with 9 core elements documented within 120 days of enrollment (for new beneficiaries) or during the measurement year (for established beneficiaries). 2. Care Plan with Core and Supplemental Elements Documented. Beneficiaries who had a comprehensive LTSS care plan with 9 core elements and at least 4 supplemental elements documented within 120 days of enrollment (for new beneficiaries) or during the measurement year (for established beneficiaries).
Age	Ages 18 and older as of December 31 of the measurement year.
Continuous enrollment	Enrollment in LTSS services for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For beneficiaries with multiple distinct continuous enrollment periods during the measurement year, look at the care plan completed in the last continuous enrollment period of 150 days or more during the measurement year.
Benefits	Coverage or coordination of home and community- or institution-based LTSS. This includes beneficiaries who are enrolled in the LTSS benefit and require LTSS.
Required exclusions	• Could not be reached for care planning. • Refusal to participate in care planning

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib111522.pdf.

[2] https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf.

[3] HEDIS® is a registered trademark of NCQA.

[4] The term "states" includes the 50 states, the District of Columbia, and the territories.

This technical assistance resource is a product of the Technical Assistance and Analytic Support for the Medicaid and CHIP Quality Measurement and Improvement Program, sponsored by the Center for Medicaid and CHIP Services, and led by Mathematica. This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

community-based organizations [CBOs]) or (2) how the services are paid (managed care or fee-for-service). Some MLTSS plans are responsible solely for LTSS; other plans, such as comprehensive managed care organizations (MCOs), are responsible for both medical care and LTSS. Both types of plans may coordinate LTSS directly or delegate coordination to CBOs.

The measure intends to include Medicaid beneficiaries receiving LTSS services.[5] Beneficiaries who do not require the use of LTSS services should not be included in the measure. For example, if aged, blind, and disabled beneficiaries are automatically enrolled in the LTSS benefit, but they do not require LTSS services, do not include them in the initial population.

The CPU-AD measure is calculated using case management record review. Case management systems are databases of beneficiary information collected through a collaborative process of beneficiary assessment, care planning, care coordination, or monitoring of a beneficiary's functional status and care experience. For 2025 Adult Core Set reporting, states should calculate the measure by examining services delivered in calendar year (CY) 2024. Because the measure evaluates nonmedical services, it is not necessary to review medical records.

Calculating the Eligible Population

Step 1: Identify Beneficiaries Age 18 and Older

Calculate the age for each beneficiary based on the end date of the measurement year and the beneficiary's date of birth. For 2025 Adult Core Set reporting, include beneficiaries if they are 18 years and older as of December 31, 2024. If the date of birth for a beneficiary is missing, do not include the beneficiary in the measure calculation.

Step 2: Calculate Continuous Enrollment

To be eligible for the measure, beneficiaries must be continuously enrolled in LTSS services for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. There is no allowable gap.

For beneficiaries with multiple distinct continuous enrollment periods during the measurement year, look at the care plan completed in the last continuous enrollment period of 150 days or more during the measurement year. To be eligible for the measure, a beneficiary must have received LTSS services during the continuous enrollment period.

Calculating the Denominator

The denominator is based on a systematic sample drawn from the eligible population.

Step 3: Identify the Sample

The minimum required sample size for this measure is 96, which is the denominator for the measure. Use a starting sample size that is larger than the minimum required sample size (that is, an oversample) because case management records must be substituted if a beneficiary is ineligible for the measure. For example, a beneficiary may not be eligible for the measure due to continuous enrollment criteria or the beneficiary meets exclusion criteria for the measure.

If the measure's eligible population is smaller than the minimum required sample size, use the entire eligible population for the sample.

Step 4: Exclude Beneficiaries Who Could Not Be Reached for Care Planning (Required Exclusion)

For each beneficiary who meets the criteria defined in Step 3, identify and exclude beneficiaries who could not be reached for care planning. Use the oversample to replace exclusions. Exclusions may be identified from manual review of case management records or standardized electronic data sources.

[5] States may vary in how they define the LTSS benefit and may include home and community-based services and/or institutional care services.

The criteria differ for new and established beneficiaries:

- **New beneficiaries:** Exclude *new* beneficiaries who could not be contacted to create an LTSS comprehensive care plan within 120 days of enrollment.
- **Established beneficiaries:** Exclude *established* beneficiaries who could not be contacted to create an LTSS comprehensive care plan during the measurement year.

See Table 2 for definitions of new and established beneficiaries.

Table 2. Definitions of new and established beneficiaries

New beneficiary	A beneficiary who was newly enrolled in LTSS services between August 1 of the year prior to the measurement year and July 31 of the measurement year.
Established beneficiary	A beneficiary who was enrolled prior to August 1 of the year prior to the measurement year.

States should use their own process for identifying beneficiaries who cannot be contacted for care planning. There must be documentation in the case management record that at least three attempts were made to contact the beneficiary, the date and mode of each contact (such as telephone call or letter), and that the beneficiary could not be reached. Beneficiaries with a partial care plan may not be classified as "could not be contacted for care plan."

Step 5: Exclude Beneficiaries Who Refused to Participate in Care Planning (Required Exclusion)

For each beneficiary who meets the sampling criteria defined in Step 3 and remains in the denominator after applying the required exclusions in Step 4, identify beneficiaries who refused an LTSS comprehensive care plan. Use the oversample to replace exclusions. Exclusions may be identified from manual review of case management records or standardized electronic data sources.

For such beneficiaries, there must be documentation in the case management record that the beneficiary was contacted and refused the care plan, and the date of the refusal. Beneficiaries with a partial care plan may not be classified as "refused care plan."

Calculating the Numerators

The numerators are defined as the number of beneficiaries who had a care plan with core elements documented (Numerator 1) or who had a care plan with core and supplemental elements documented (Numerator 2). All beneficiaries in the numerators must also be included in the denominator and meet the denominator criteria mentioned earlier. Numerator events may be identified from manual review of case management records or standardized electronic data sources.

Step 6: Identify Beneficiaries in Numerator 1: Care Plan with Core Elements Documented

New beneficiaries: For each beneficiary in the denominator, identify new beneficiaries who had a comprehensive LTSS care plan completed within 120 days of enrollment, with nine core elements documented (see Table 3). If the comprehensive care plan is developed as part of the process to determine eligibility for the LTSS benefit and occurs within 30 days prior to the enrollment start date, it may be counted toward the measure if the care plan meets the rest of the numerator criteria.

Established beneficiaries: For each beneficiary in the denominator, identify established beneficiaries who had a comprehensive LTSS care plan completed during the measurement year, with nine core elements documented (see Table 3). The care plan must be discussed during a face-to-face, telephone, or video conference encounter between the care manager and the beneficiary. The care plan is not required to be created in the beneficiary's home. Assessment of the beneficiary and development of the care plan may be done during the same encounter or during different encounters.

Note that beneficiaries without a care plan, or with an incomplete care plan, may not be excluded.

Table 3. Core Elements of Care Plan (All elements must be documented in the care plan)

1. At least one individualized beneficiary goal.
2. A plan of care to meet the beneficiary's medical needs.
3. A plan of care to meet the beneficiary's functional needs; for example, support for activities of daily living limitations or instrumental activity of daily living limitations.
4. A plan of care to meet the beneficiary's needs due to cognitive impairment.
5. A list of all LTSS services and supports the beneficiary receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings, including the number and frequency.
6. A plan for the care manager to follow up and communicate with the beneficiary.
7. A plan to ensure that the beneficiary's needs are met in an emergency.
8. Family/friend caregivers who were involved in development of the care plan, and their contact information.
9. Beneficiary or beneficiary representative agreement to or appeal of the completed care plan.

Step 7: Identify Beneficiaries in Numerator 2: Care Plan with Core and Supplemental Elements Documented

New beneficiaries: For each beneficiary in the denominator, identify new beneficiaries who had a comprehensive LTSS care plan completed within 120 days of enrollment, with nine core elements documented (see Table 3) *and* at least four supplemental elements documented (see Table 4). If the comprehensive care plan is developed as part of the process to determine eligibility for the LTSS benefit and occurs within 30 days prior to the enrollment start date, it may be counted toward the measure if the care plan meets the rest of the numerator criteria.

Established beneficiaries: For each beneficiary in the denominator, identify established beneficiaries who had a comprehensive LTSS care plan created during the measurement year, with nine core elements documents (see Table 3) *and* at least four supplemental elements documented (see Table 4). The care plan must be discussed during a face-to-face, telephone, or video conference encounter between the care manager and the beneficiary. The care plan is not required to be created in the beneficiary's home. Assessment and development of the care plan may be done during the same encounter or during different encounters.

Table 4. Supplemental Elements of Care Plan (At least four elements must be documented in the care plan)

1. A plan of care to meet the beneficiary's mental health needs.
2. A plan of care to meet the beneficiary's social or community integration needs.
3. The duration of all LTSS the beneficiary receives or is expected to receive in the next month, in the home (paid or unpaid) or in other settings, or the date when services will be reassessed.
4. Contact information for the beneficiary's LTSS providers.
5. A plan to assess the beneficiary's progress toward meeting established goals, including a time frame for reassessment and follow-up.
6. Barriers to meeting defined goals.
7. The beneficiary's first point of contact.
8. Contact information for a beneficiary's primary care practitioner (PCP), or a plan for connecting the beneficiary to a PCP if the beneficiary does not currently have one.

Calculating and Reporting the CPU-AD Rates

For the purpose of Adult Core Set reporting, states should calculate and report two rates based on the two numerators and the denominator:

1. Percentage of beneficiaries with a care plan with core elements documented (= [Numerator 1 / Denominator] * 100).
2. Percentage of beneficiaries with a care plan with core and supplemental elements documented (= [Numerator 2 / Denominator] * 100).

In addition, states should report the number of exclusions identified in steps 4 and 5 by type: "Could Not Be Reached for Care Planning" and "Refusal to Participate in Care Planning."

Technical Assistance Resources for Calculating the CPU-AD Measure

The following resources are available to help states calculate the CPU-AD measure for Adult Core Set reporting:

- The technical specifications for the CPU-AD measure are in the 2025 Adult Core Set Resource Manual, available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf. Note that use of the Core Set technical specifications is subject to a license agreement solely for the purpose of Core Set reporting.
- Adult Core Set reporting resources are available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set-reporting-resources/index.html.
- More information about the Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

For More Information

For technical assistance related to calculating and reporting the CPU-AD measure or other questions about measures in the Child, Adult, and Health Home Core Sets, contact the TA mailbox at **MACQualityTA@cms.hhs.gov**.