NATIONAL QUALITY FORUM

MEASURE WORKSHEET

This document summarizes the evaluation of the measure as it progresses through NQF's Consensus Development Process (CDP). The information submitted by measure developers/stewards is included after the Brief Measure Information, Preliminary Analysis, and Pre-meeting Public and Member Comments sections.

To navigate the links in the worksheet: Click to go to the link. ALT + LEFT ARROW to return

Purple text represents the responses from measure developers.

Red text denotes developer information that has changed since the last measure evaluation review.

Brief Measure Information

NQF #: 3326

Measure Title: Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

Brief Description of Measure: The measure has two rates:

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate): 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 LTSS re-assessment within 30 days of discharge.

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate): The percentage of discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment and care plan update within 30 days of discharge.

Developer Rationale: This measure addresses continuity of care following a discharge from an acute (i.e. hospital) or non-acute (i.e. nursing facility) inpatient setting for Medicaid MLTSS enrollees. The MLTSS enrollee population includes individuals with complex health and social support needs. Given their complex needs, they require high levels of care coordination. 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, which may have changed following an inpatient admission.

The Technical Expert Panel (TEP) convened in 2013 to advise on these measures originally suggested a measure assessing whether the member care plan is updated after a major change in health status or living situation. Since "major change in health status or living situation" could not be feasibly identified from claims or enrollment records, the measure development team and TEP decided to use a care transition from an acute or post-acute facility as a proxy for major change in health status or living situation. The TEP advised that although the desired result is to ensure that the care plan is revised to reflect changes in the individual's situation, goals and preferences and assessment is necessary to determine such changes. Therefore, the measure that was tested looked for both assessment and care plan update conducted face-to-face after discharge for an unplanned hospitalization or from a post-acute care facility.

Through our field test, we determined that requiring both a re-assessment and care plan update within 30 days would not result in meaningful performance rates (i.e., three out of five plans had a 0% performance rate). Follow-up analysis identified that often re-assessment is done without a care plan update (see Appendix: Additional Testing Results).

To balance the need for a measure that is feasible in the current MLTSS environment that would produce non-zero rates and the desire of the TEP to push the field further to do truly comprehensive care plan updates, we decided to break the measure into two rates:

1) LTSS Re-Assessment after Inpatient Discharge Rate, and

2) LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate

The two-rate approach aims to give program administrators and policymakers a much-needed tool to help move the managed long-term services and supports (MLTSS) field from extremely low performance (as demonstrated in our testing) to more comprehensive and standardized documentation of updated care plans after transitions in care. The inclusion of both rates in a single measure signals the importance of this concept.

Numerator Statement: The measure has two rates. The numerators for the two rates are as follows:

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment within 30 days of discharge.

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment and care plan update within 30 days of discharge.

Denominator Statement: 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.

Denominator Exclusions: For Rate 2, enrollees who refuse care planning are excluded.

For both rates:

- Pregnancy-related or other perinatal hospital discharges are excluded.

- Enrollees who refuse re-assessment are excluded.

- Exclude planned hospital admissions from the measure denominator. A hospital stay is considered planned if it meets any of the following criteria:

- Hospital stays with a principal diagnosis of pregnancy or condition originating in the perinatal period are

- A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).

- A principal diagnosis of rehabilitation (Rehabilitation Value Set).

- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set).

- A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Measure Type: Process

Data Source: Claims, Management Data, Other, Paper Medical Records

Level of Analysis: Health Plan

Criteria 1: Importance to Measure and Report

1a. Evidence

1a. Evidence. The evidence requirements for a *structure, process or intermediate outcome* measure is that it is based on a systematic review (SR) and grading of the body of empirical evidence where the specific focus of the evidence matches what is being measured. For measures derived from patient report, evidence also should demonstrate that the target population values the measured process or structure and finds it meaningful.

The developer provides the following evidence for this measure:

- **Systematic Review of the evidence specific to this measure?** ☐ **Yes** ☒ **No**
- **Quality, Quantity and Consistency of evidence provided?** ☐ **Yes** ☒ **No**
- **Evidence graded?** ☐ **Yes** ☒ **No**

Evidence Summary

- The developer provides a logic model describing the steps between the process of completing a comprehensive assessment and care plan and the outcome of improvement in quality of life.
- There is no systematic review assess assessing the impact of re-assessment and care plan update after a discharge from an inpatient (or other type of facility) on outcomes. Developer conducted a targeted literature review to gather evidence in support of this measure:
  - When individuals with multiple chronic conditions or disabilities do not receive transitional care support, they are more likely to receive duplicative medical services, experience medication errors, and have avoidable re-hospitalizations (Coleman & Berenson, 2004; Arbaje et al., 2014)
  - 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 (Rennke et al., 2013)
  - 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 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 (Coleman et al., 2006).
  - Additional randomized trials found that "nurse-led transition care programs" can reduce preventable readmission rates by up to 56 percent (Parry et al., 2003; Parry et al., 2008; Naylor et al., 2003; Naylor et al., 2004; Naylor, 2003).
- Technical Expert Panel (TEP) convened 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. A second TEP was convened in 2015 with a similar composition to inform the continued development and testing of this measure.

Exception to evidence

N/A

Questions for the Committee:

- *What is the relationship of this measure to patient outcomes?*
- *How strong is the evidence for this relationship?*
- *Is the evidence directly applicable to the process of care being measured?*

- *Is there evidence of a systematic assessment of expert opinion beyond those involved in developing the measure?*

Guidance from the Evidence Algorithm

Process measure not based on systematic review (Box3) -> Empirical evidence without SR or grading (Box 7) -> Empirical evidence includes all studies in the body of evidence (Box 8) -> High-moderate quality of evidence (box 9) -> Moderate

Preliminary rating for evidence: ☐ **High** ☒ **Moderate** ☐ **Low** ☐ **Insufficient**

RATIONALE:

1b. Gap in Care/Opportunity for Improvement and 1b. Disparities

1b. Performance Gap**.** The performance gap requirements include demonstrating quality problems and opportunity for improvement.

This measure addresses continuity of care following a discharge from an acute (i.e. hospital) or non-acute (i.e. nursing facility) inpatient setting for Medicaid MLTSS enrollees. The MLTSS enrollee population includes individuals with complex health and social support needs. 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, which may have changed following an inpatient admission.
The Technical Expert Panel (TEP) convened in 2013 to advise on these measures originally suggested a measure assessing whether the member care plan is updated after a major change in health status or living situation. The developer states that "major change in health status or living situation" could not be feasibly identified from claims or enrollment records, therefore care transition from an acute or post-acute facility was used as a proxy for major change in health status or living situation.
Performance data indicates low rates of re-assessment and care plan update post discharge.

Rate	Rate 1 - Re-assessment only, no face-to-face requirement	Rate 2 - Re-assessment and care plan update, no face-to-face requirement
Mean	22.4%	5.2%
Standard Deviation	12.5%	6.0%
Minimum	7.4%	0%
Maximum	40.0%	14.3%

Disparities

- The developer collected information about race and ethnicity during testing, however, due to overall low rates, they did not conduct additional analysis of disparities.
- The developer did not provide any disparities information from the literature regarding the comprehensive assessment addressed in this measure.
- The developer discussed research that identifies racial and ethnic disparities in the need for LTSS. One study from the Congressional Budget found that older black and Hispanic individuals have higher rates of functional impairment than whites (CBO, 2013).

Questions for the Committee:

- *Is there a gap in care that warrants a national performance measure?*
- *Since no disparities information is provided, are you aware of evidence that disparities exist in this area of healthcare?*

Preliminary rating for opportunity for improvement: ☒ **High** ☐ **Moderate** ☐ **Low** ☐ **Insufficient**

RATIONALE:

Committee Pre-evaluation Comments: Criteria 1: Importance to Measure and Report (including 1a, 1b, 1c)

1a. Evidence

Comments

**The evidence demonstrates a need for improved communication between the developers of the Care Plan and PCP but due to the lack of standardization and variation in the tools and the outcome goals that the plans use, it is difficult to assess how submitting an updated care plan will result in an improved outcomes.

**It simply does not seem that empirical data exists to support the logic model provided by the developer that links a comprehensive care plan to improved outcomes and quality of life. The literature findings support the idea of proper care coordination, which I think is agreeable as it relates to a higher quality and cheaper healthcare system. But does the presence of a care plan actually lead to better care coordination? The connection from a care plan to better care coordination is where the lack of empirical data and the literature review both fall short. I personally agree that a co-designed care plan that is revisited post-discharge would improve care coordination and transitions, but there is a lack of empirical evidence to support that fact.

And does revisiting the care plan after an inpatient discharge actually improve outcomes? Some outcomes might include better adherence to the care plan, or improved communication with primary care providers. If the care plan were to be updated a majority of the time after discharge - it be evidence to the fact that post-discharge is an effective point in the care continuum to re-visit a care plan.

But does continuous re-evaluation of a care plan after an inpatient discharge actually improve some of these outcomes? The empirical evidence is limited in supporting this idea.

**According to the review there was evidence to support the measure although there were several related references.

1b. Performance Gap

Comments

**Disparities in Care were not reported. However, the review demonstrated performance gap in care and opportunity for improvement.

**The performance data provided by the developer does show a gap in the regular re-evaluation of and care plan updates post-discharge. There is no disparities data provided, but the performance gap is large overall, so any subsets of the population would be assumed to be low also.

But again, the question is: if a health plan is scoring 100% on re-assessment after discharge does that have a direct impact on adherence to the care plan or physician communication? Or are there other indicators out there for major changes in health status or living situation?

**I question if this measure is a reflection of MLTSS quality or the outcomes of an acute or sub-acute stay. The information provided indicates poor performance with completing care plans post discharge.

Criteria 2: Scientific Acceptability of Measure Properties

2a. Reliability: Specifications **and** Testing
2b. Validity: Testing; Exclusions**;** Risk-Adjustment**;** Meaningful Differences**;** Comparability Missing Data

2c. For composite measures: empirical analysis support composite approach

Reliability

2a1. Specifications requires the measure, as specified, to produce consistent (reliable) and credible (valid) results about the quality of care when implemented. For maintenance measures – no change in emphasis – specifications should be evaluated the same as with new measures.

2a2. Reliability testing demonstrates if the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or that the measure score is precise enough to distinguish differences in performance across providers. For maintenance measures – less emphasis if no new testing data provided.

Validity

2b2. Validity testing should demonstrate the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality. For maintenance measures – less emphasis if no new testing data provided.

2b2-2b6. Potential threats to validity should be assessed/addressed.

Complex measure evaluated by Scientific Methods Panel? ☐ **Yes** ☒ **No**

Evaluators: NQF Staff

Evaluation of Reliability and Validity (and composite construction, if applicable):

Link A

Questions for the Committee regarding reliability:

- *Do you have any concerns that the measure can be consistently implemented (i.e., are measure specifications adequate)?*
- *Is the Committee satisfied with the reliability analysis for this measures, and is a need to discuss and/or vote on reliability?*

Questions for the Committee regarding validity:

- *Do you have any concerns regarding the validity of the measure (e.g., multiple rates, exclusions, risk-adjustment approach, etc.)?*
- *Is the Committee satisfied with the validity analysis for this measures, and is a need to discuss and/or vote on validity?*

Preliminary rating for reliability:	☐ **High**	☒ **Moderate**	☐ **Low**	☐ **Insufficient**
Preliminary rating for validity:	☐ **High**	☒ **Moderate**	☐ **Low**	☐ **Insufficient**

Scientific Acceptability

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion.**

Instructions:

- Please complete this form for each measure you are evaluating.
- Please pay close attention to the skip logic directions.
- If you are unable to check a box, please highlight or shade the box for your response.
- You must answer the "overall rating" item for both Reliability and Validity. Also, be sure to answer the composite measure question at the end of the form if your measure is a composite.
- We have provided TIPS to help you answer the questions.
- We've designed this form to try to minimize the amount of writing that you have to do. That said, **it is critical that you explain your thinking/rationale if you check boxes where we ask for an explanation** (because this is a Word

document, you can just add your explanation below the checkbox). Feel free to add additional explanation, even if an explanation is not requested (but please type this underneath the appropriate checkbox).

- This form is based on Algorithms 2 and 3 in the Measure Evaluation Criteria and Guidance document (see pages 18-24). These algorithms provide guidance to help you rate the Reliability and Validity subcriteria. **We ask that you refer to this document when you are evaluating your measures.**
- Please contact Methods Panel staff if you have questions (methodspanel@qualityforum.org).

Measure Number: 3226

Measure Title: Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge

RELIABILITY

1. Are submitted specifications precise, unambiguous, and complete so that they can be consistently implemented? *NOTE: NQF staff will conduct a separate, more technical, check of eMeasure (eCQM) specifications, value sets, logic, and feasibility, so no need to consider these in your evaluation.*

   TIPS: Consider the following: Are all the data elements clearly defined? Are all appropriate codes included? Is the logic or calculation algorithm clear? Is it likely this measure can be consistently implemented?

   ☒Yes (go to Question #2)

   ☐No (please explain below, and go to Question #2) NOTE that even though ***non-precise specifications should result in an overall LOW rating for reliability***, we still want you to look at the testing results.

2. Was empirical reliability testing (at the data element or measure score level) conducted using statistical tests with the measure as specified?

   TIPS: Check the 2nd "NO" box below if: only descriptive statistics provided; only describes process for data management/cleaning/computer programming; testing does not match measure specifications (i.e. data, eMeasure, level of analysis, patients)

   ☒Yes (go to Question #4)

   ☐No, there is reliability testing information, but *not* using statistical tests and/or not for the measure as specified OR there is no reliability testing (please explain below then go to Question #3)

3. Was **empirical VALIDITY testing** of patient-level data conducted?

   ☐Yes (use your rating from data element validity testing – Question #16- under Validity Section)

   ☐No (please explain below and rate Question #11: OVERALL RELIABILITY as INSUFFICIENT and proceed to the VALIDITY SECTION)

4. Was reliability testing conducted with computed performance measure scores for each measured entity?

   TIPS: Answer no if: only one overall score for all patients in sample used for testing patient-level data

   ☒Yes (go to Question #5)

   ☐No (go to Question #8)

5. Was the method described and appropriate for assessing the proportion of variability due to real differences among measured entities? *NOTE: If multiple methods used, at least one must be appropriate.*

   TIPS: Examples of appropriate methods include signal-to-noise analysis (e.g. Adams/RAND tutorial); random split-half correlation; other accepted method with description of how it assesses reliability of the performance score.

   ☒Yes (go to Question #6) Split-sample reliability using Inter-class correlation coefficient (ICC) was used to determine agreement of reliability of measure performance rates.

☐No (please explain below then go to Question #8)

6. **RATING (score level)** - What is the level of certainty or confidence that the performance measure scores are reliable?

   TIPS: Consider the following: Is the test sample adequate to generalize for widespread implementation?

   Do the results demonstrate sufficient reliability so that differences in performance can be identified?

   ☐High (go to Question #8)

   ☐Moderate (go to Question #8)

   ☒Low (please explain below then go to Question #7)

   Results of reliability of both rates (re-assessment and assessment and care plan) after inpatient discharge showed only fair agreement. Developer suggests result may be caused by low numbers in discharges that were followed by a re-assessment or care plan update.

7. Was other reliability testing reported?

   ☒Yes (go to Question #8)

   ☐No (rate Question #11: OVERALL RELIABILITY as LOW and proceed to the VALIDITY SECTION)

8. Was reliability testing conducted with patient-level data elements that are used to construct the performance measure?

   TIPS: Prior reliability studies of the same data elements may be submitted; if comparing abstraction to "authoritative source/gold standard" see Validity Section Question #15)

   ☒Yes (go to Question #9)

   ☐No (if there is score-level testing, rate Question #11: OVERALL RELIABILITY based on score-level rating from Question #6; otherwise, rate Question #11: OVERALL RELIABILITY as INSUFFICIENT. Then proceed to the VALIDITY SECTION)

9. Was the method described and appropriate for assessing the reliability of ALL critical data elements?

   TIPS: For example: inter-abstractor agreement (ICC, Kappa); other accepted method with description of how it assesses reliability of the data elements

   Answer no if: only assessed percent agreement; did not assess separately for all data elements (at least numerator, denominator, exclusions)

   ☒Yes (go to Question #10) Cohen's kappa statistic to evaluate inter-rater reliability of data elements.

   ☐No (if no, please explain below and rate Question #10 as INSUFFICIENT)

10. **RATING (data element)** – Based on the reliability statistic and scope of testing (number and representativeness of patients and entities), what is the level of certainty or confidence that the data used in the measure are reliable?

    TIPS: Consider the following: Is the test sample adequate to generalize for widespread implementation? Can data elements be collected consistently?

    ☒Moderate (if score-level testing was NOT conducted, rate Question #11: OVERALL RELIABILITY as MODERATE)

    ☐Low (if score-level testing was NOT conducted, rate Question #11: OVERALL RELIABILITY as LOW)

    ☐Insufficient (go to Question #11)

    3 of the 4 data elements had substantial to moderate reliability, however discharge date was only slight.

11. OVERALL RELIABILITY RATING

OVERALL RATING OF RELIABILITY taking into account precision of specifications and all testing results:

☐High (NOTE: Can be HIGH only if score-level testing has been conducted)

☒Moderate (NOTE: Moderate is the highest eligible rating if score-level testing has not been conducted)

☐Low (please explain below) [NOTE: Should rate LOW if you believe specifications are NOT precise, unambiguous, and complete]

☐Insufficient (please explain below) [NOTE: For most measure types, testing at both the score level and the data element level is not required]

VALIDITY

ASSESSMENT OF THREATS TO VALIDITY

1. Were all potential threats to validity that are relevant to the measure empirically assessed?

   TIPS: Threats to validity include: exclusions; need for risk adjustment; Able to identify statistically significant and meaningful differences; multiple sets of specifications; missing data/nonresponse.

   ☒Yes (go to Question #2)

   ☐No (please explain below and go to Question #2) [NOTE that even if ***non-assessment of applicable threats should result in an overall INSUFFICENT rating for validity***, we still want you to look at the testing results]

2. Analysis of potential threats to validity: Any concerns with measure exclusions?

   TIPS: Consider the following: Are the exclusions consistent with the evidence? Are any patients or patient groups inappropriately excluded from the measure? Are the exclusions/exceptions of sufficient frequency and variation across providers to be needed (and outweigh the data collection burden)? If patient preference (e.g., informed decisionmaking) is a basis for exclusion, does it impact performance and if yes, is the measure specified so that the information about patient preference and the effect on the measure is transparent?

   ☐Yes (please explain below then go to Question #3)

   ☒No (go to Question #3)

   ☐Not applicable (i.e., there are no exclusions specified for the measure; go to Question #3)

3. Analysis of potential threats to validity: Risk-adjustment (applies to all outcome, cost, and resource use measures; may also apply to other types of measure)

   ☒Not applicable (e.g., structure or process measure that is not risk-adjusted; go to Question #4)

   a. Is a conceptual rationale for social risk factors included? ☐Yes ☐No

   b. Are social risk factors included in risk model? ☐Yes ☐No

   c. Any concerns regarding the risk-adjustment approach?

   *TIPS: Consider the following: If a justification for **not risk adjusting** is provided, is there any evidence that contradicts the developer's rationale and analysis? If the developer asserts there is **no conceptual basis** for adjusting this measure for social risk factors, do you agree with the rationale? **If risk adjusted**: Are the candidate and final variables included in the risk adjustment model adequately described for the measure to be implemented? Are the candidate and final variables included in the risk adjustment model adequately described for the measure to be implemented? Are all of the risk adjustment variables present at the start of care (if not, do you agree with the rationale)? If social risk factors are not included in the risk-adjustment approach, do you agree with the developer's decision? Is an appropriate risk-adjustment strategy included in the measure (e.g., adequate model discrimination and calibration)? Are all statistical model specifications included, including a "clinical model only" if social risk factors are included in the final model?*

   ☐Yes (please explain below then go to Question #4)

   ☐No (go to Question #4)

4. Analysis of potential threats to validity: Any concerns regarding ability to identify meaningful differences in performance or overall poor performance?

   ☒Yes (please explain below then go to Question #5)

   ☐No (go to Question #5)

   Very poor overall performance observed by developer. However, developer indicates that health plan 01 had rates demonstrating a statistically significant difference from the mean. This finding indicates that the measure as specified does have the potential to identify meaningful differences in performance between health plans.

5. Analysis of potential threats to validity: Any concerns regarding comparability of results if multiple data sources or methods are specified?

   ☐Yes (please explain below then go to Question #6)

   ☐No (go to Question #6)

   ☒Not applicable (go to Question #6)

6. Analysis of potential threats to validity: Any concerns regarding missing data?

   ☐Yes (please explain below then go to Question #7)

   ☒No (go to Question #7)

ASSESSMENT OF MEASURE TESTING

7. Was empirical validity testing conducted using the measure as specified and appropriate statistical test?

   Answer no if: face validity; only refer to clinical evidence; only descriptive statistics; only describe process for data management/cleaning/computer programming; testing does not match measure specifications (i.e. data, eMeasure, level, setting, patients).

   ☐Yes (go to Question #10) [NOTE: If appropriate empirical testing has been conducted, then evaluation of face validity is not necessary. Go to Question #8 **only if** there is insufficient information provided to evaluate data element and score-level testing.]

   ☒No (please explain below then go to Question #8)

8. Was face validity systematically assessed by recognized experts to determine agreement on whether the computed performance measure score from the measure as specified can be used to distinguish good and poor quality?

   TIPS: Answer no if: focused on data element accuracy/availability/feasibility/other topics; the degree of consensus and any areas of disagreement not provided/discussed.

   ☒Yes (go to Question #9)

   ☐No (please explain below and rate Question #17: OVERALL VALIDITY as INSUFFICIENT)

9. **RATING (face validity)** - Do the face validity testing results indicate substantial agreement that the performance measure score from the measure as specified can be used to distinguish quality AND potential threats to validity are not a problem, OR are adequately addressed so results are not biased?

   ☒Yes (if a NEW measure, rate Question #17: OVERALL VALIDITY as MODERATE)

   ☐ Yes (if a MAINTENANCE measure, do you agree with the justification for not conducting empirical testing? If no, rate Question #17: OVERALL VALIDITY as INSUFFICIENT; otherwise, rate Question #17: OVERALL VALIDITY as MODERATE)

   ☐No (please explain below and rate Question #17: OVERALL VALIDITY AS LOW)

Response	Would high performance on this measure indicate that a health plan is providing higher quality care?	In the future, do you think that performance scores on this measure will distinguish between good and poor performance?
Strongly Agree	0	0
Agree	8	8
Disagree	4	4
Strongly Disagree	1	1
No Response	0	0
Total Percent Agree	62%	62%

10. Was validity testing conducted with computed performance measure scores for each measured entity?

    TIPS: Answer no if: one overall score for all patients in sample used for testing patient-level data.

    ☐Yes (go to Question #11)

    ☐No (please explain below and go to Question #13)

11. Was the method described and appropriate for assessing conceptually and theoretically sound hypothesized relationships?

    TIPS: For example: correlation of the performance measure score on this measure and other performance measures; differences in performance scores between groups known to differ on quality; other accepted method with description of how it assesses validity of the performance score

    ☐Yes (go to Question #12)

    ☐No (please explain below, rate Question #12 as INSUFFICIENT and then go to Question #14)

12. **RATING (measure score)** - Based on the measure score results (significance, strength) and scope of testing (number of measured entities and representativeness) and analysis of potential threats, what is the level of certainty or confidence that the performance measure scores are a valid indicator of quality?

    ☐High (go to Question #14)

    ☐Moderate (go to Question #14)

    ☐Low (please explain below then go to Question #13)

    ☐Insufficient

13. Was other validity testing reported?

    ☐Yes (go to Question #14)

    ☐No (please explain below and rate Question #17: OVERALL VALIDITY as LOW)

14. Was validity testing conducted with patient-level data elements?

    TIPS: Prior validity studies of the same data elements may be submitted

    ☐Yes (go to Question #15)

    ☐No (please explain below and rate Question #17: OVERALL VALIDITY as INSUFFICIENT if no score-level testing was conducted, otherwise, rate Question #17: OVERALL VALIDITY based on score-level rating from Question #12)

15. Was the method described and appropriate for assessing the accuracy of ALL critical data elements? *NOTE that data element validation from the literature is acceptable.*

TIPS: For example: Data validity/accuracy as compared to authoritative source- sensitivity, specificity, PPV, NPV; other accepted method with description of how it assesses validity of the data elements.

Answer No if: only assessed percent agreement; did not assess separately for all data elements (at least numerator, denominator, exclusions)

☐Yes (go to Question #16)

☐No (please explain below and rate Question #16 as INSUFFICIENT)

16. **RATING (data element)** - Based on the data element testing results (significance, strength) and scope of testing (number and representativeness of patients and entities) and analysis of potential threats, what is the level of certainty or confidence that the data used in the measure are valid?

☐Moderate (if score-level testing was NOT conducted, rate Question #17: OVERALL VALIDITY as MODERATE)

☐Low (please explain below) (if score-level testing was NOT conducted, rate Question #17: OVERALL VALIDITY as LOW)

☐Insufficient (go to Question #17)

17. OVERALL VALIDITY RATING

OVERALL RATING OF VALIDITY taking into account the results and scope of all testing and analysis of potential threats.

☐High (NOTE: Can be HIGH only if score-level testing has been conducted)

☒Moderate (NOTE: Moderate is the highest eligible rating if score-level testing has NOT been conducted)

☐Low (please explain below) [NOTE: Should rate LOW if you believe that there are threats to validity and/or threats to validity were not assessed]

☐Insufficient (if insufficient, please explain below) [NOTE: For most measure types, testing at both the score level and the data element level is not required] [NOTE: If rating is INSUFFICIENT for all empirical testing, then go back to Question #8 and evaluate any face validity that was conducted, then reconsider this overall rating.]

Empirical validity provided was inconclusive (neither validated, nor invalidated the measure). Rating was based on face validity results (which are lower than desired -- most likely due to the extremely low performance rate of the plans in the testing sample).

FOR COMPOSITE MEASURES ONLY: Empirical analyses to support composite construction

What is the level of certainty or confidence that the empirical analysis demonstrates that the component measures add value to the composite and that the aggregation and weighting rules are consistent with the quality construct?

TIPS: Consider the following: Do the component measures fit the quality construct? Are the objectives of parsimony and simplicity achieved while supporting the quality construct?

☐High

☐Moderate

☐Low (please explain below)

☐Insufficient (please explain below)

Committee Pre-evaluation Comments: Criteria 2: Scientific Acceptability of Measure Properties (including all 2a, 2b, and 2c)

2a1. Reliability- Specifications

Comments

**Likelihood of measure being consistently implemented is low. Without standardized data or tools there is no way to evaluate the impact on the desired outcomes.
**It seems that all data elements are clearly defined here. I am a bit confused as to why the discharge date is only slightly reliable when considering the key data elements. Why would this slump in reliability exist? Seems like a pretty important element to have reliable.

2a2. Reliability- Testing

Comments

**meaningful differences about quality not accessed.
**It seems that reliability drops when tested at the measure rates.

2b1. Validity—Testing

2b4-7. Threats to Validity

2b4. Meaningful Differences

Comments

**Missing data and variation in data sources constitute a moderate threat.
**The TEP that was utilized for validity testing even expressed a decrease in agreement when asked about "high performance on this measure indicating a health plan is providing higher quality care."

2b2-3. Other Threats to Validity

2b2. Exclusions

2b3. Risk Adjustment

Comments

**N/A

**Considering the intent of the measure, the exclusions seem appropriate and there is no need for risk adjustment since this is a process measure. Agree that the denominator should be based off discharges and not enrollees.

**This measure is not risk adjusted.

Criterion 3. Feasibility

3. Feasibility is the extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.
The developer provided the following information:

- This measure is primarily collected from health plan and case management records, many of which are electronic.
    - Some data elements are in defined fields in electronic sources
    - The data elements needed for this measure are not standardized (i.e. may be in free text rather than structured fields).
- The developer noted that as the LTSS fields move forward, more of the data elements used in the measure will become structured fields.
- No fees or licensing are currently required.
- This is a multi-rate measure.

Questions for the Committee:

- *Are the required data elements routinely generated and used during care delivery?*
- *Does the Committee agree that measurement in this area will drive standardization?*
- *Does the Committee believe the use of multi-rate for this measure is the best approach?*

Preliminary rating for feasibility: ☐ **High** ☐ **Moderate** ☒ **Low** ☐ **Insufficient**

RATIONALE: Non standardized data elements, many of which are in free text fields.

Committee Pre-evaluation Comments: Criteria 3: Feasibility

3. Feasibility

Comments

**Low feasibility in the absence of standardized tools

**Due to the unstandardized fields in the electronic health plan and case management records, it may be difficult to extrapolate what is needed. But I agree with the developer that health plans and case management records should start to have structured fields for care plans in the future. I stand at a low-moderate primary rating for feasibility.

**There are questions about the methodology which is used across MLTSS including reporting and data collection methodologies.

Criterion 4: Usability and Use

4a. Use (4a1. Accountability and Transparency; 4a2. Feedback on measure)

4a. Use evaluate the extent to which audiences (e.g., consumers, purchasers, providers, policymakers) use or could use performance results for both accountability and performance improvement activities.

4a.1. Accountability and Transparency**.** Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

Current uses of the measure

Publicly reported? ☐ **Yes** ☒ **No**

Current use in an accountability program? ☐ **Yes** ☒ **No** ☐ **UNCLEAR**

OR

Planned use in an accountability program? ☐ **Yes** ☒ **No**

Accountability program details

- This is a new measure and is not currently in use.
- This measure is intended for use by states and health plans to monitor and improve quality of care provided for the Medicaid MLTSS enrollee population.
- This measure is included in the National MLTSS Health Plan Association recommended LTSS performance measure set model.

4a.2. Feedback on the measure by those being measured or others. Three criteria demonstrate feedback: 1) those being measured have been given performance results or data, as well as assistance with interpreting the measure results and data; 2) those being measured and other users have been given an opportunity to provide feedback on the measure performance or implementation; 3) this feedback has been considered when changes are incorporated into the measure

Feedback on the measure by those being measured

N/A

Additional Feedback:

N/A

Questions for the Committee*:*

- *How can the performance results be used to further the goal of high-quality, efficient healthcare?*

Preliminary rating for Use: ☒ **Pass** ☐ **No Pass**

RATIONALE:

4b. Usability (4a1. Improvement; 4a2. Benefits of measure)

4b. Usability evaluate the extent to which audiences (e.g., consumers, purchasers, providers, policymakers) use or could use performance results for both accountability and performance improvement activities.
4b.1 Improvement. Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated.

Improvement results

N/A

4b2. Benefits vs. harms. Benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

Unexpected findings (positive or negative) during implementation

N/A - This measure has not been implemented yet. There were no unexpected findings identified during testing of this measure.

Potential harms

N/A

Additional Feedback

None

***Questions for the Committee**:*

- *How can the performance results be used to further the goal of high-quality, efficient healthcare?*
- *Do the benefits of the measure outweigh any potential unintended consequences?*

Preliminary rating for Usability and use: ☐ **High** ☒ **Moderate** ☐ **Low** ☐ **Insufficient**

RATIONALE:

Committee Pre-evaluation Comments: Criteria 4: Usability and Use

4a1. Use- Accountability and Transparency

Comments

**Not currently publicly reported.
**There measure is not currently in use. The biggest unintended benefit in my mind would be another taxation on the health system's bandwidth if it is not providing any benefit (e.g. if care plans are not actually being updated regularly at this point in the care continuum).
I see no plan for implementation beyond the feasibility rational provided.
**There are plans to report this publicly but it is unclear the relevance to the public from my view.

Criterion 5: Related and Competing Measures

Related or competing measures

Related measures include:

- 3319 LTSS Comprehensive Assessment and Update
- 3324 LTSS Comprehensive Care Plan and Update
- 3325 LTSS Shared Care Plan with Primary Care Practitioner

Harmonization

N/A

Committee Pre-evaluation Comments: Criterion 5: Related and Competing Measures

N/A

Public and Member Comments

Comments and Member Support/Non-Support Submitted as of: January 18, 2018

Comments:

Morgan Buchko, Meridian Health Plan

From the LTSS reassessment care elements, it seems like this means an LTSS reassessment is performing a new CA. If it is a new CA/HRA entirely, that would be a large lift to complete a new one after every discharge, even considering the exlcusions. There are two rates for this measure: LTSS reassessment after discharge and LTSS reassessment and care plan update after discharge. We are seeking clarification on when a member would fall only into the first rate. If we are completing a new assessment with them, we would update the care plan. The second rate requires the plan of care to have 7 core elements which would be a manual investigation to ensure they are completed in the POC for us or new logic built. Additionally, with the lack of EDT feeds directly from facilities, we anticipate that would be a barrier to completign the 30 day timeframe

- **Zero NQF members have submitted a support/non-support choice.**

Developer Submission

Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 3326

Corresponding Measures:

De.2. Measure Title: Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge

Co.1.1. Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

De.3. Brief Description of Measure: The measure has two rates:

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate): 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 LTSS re-assessment within 30 days of discharge.

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate): The percentage of discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment and care plan update within 30 days of discharge.

1b.1. Developer Rationale: This measure addresses continuity of care following a discharge from an acute (i.e. hospital) or non-acute (i.e. nursing facility) inpatient setting for Medicaid MLTSS enrollees. The MLTSS enrollee population includes individuals with complex health and social support needs. Given their complex needs, they require high levels of care coordination. 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, which may have changed following an inpatient admission.

The Technical Expert Panel (TEP) convened in 2013 to advise on these measures originally suggested a measure assessing whether the member care plan is updated after a major change in health status or living situation. Since "major change in health status or living situation" could not be feasibly identified from claims or enrollment records, the measure development team and TEP decided to use a care transition from an acute or post-acute facility as a proxy for major change in health status or living situation. The TEP advised that although the desired result is to ensure that the care plan is revised to reflect changes in the individual's situation, goals and preferences and assessment is necessary to determine such changes. Therefore, the measure that was tested looked for both assessment and care plan update conducted face-to-face after discharge for an unplanned hospitalization or from a post-acute care facility.

Through our field test, we determined that requiring both a re-assessment and care plan update within 30 days would not result in meaningful performance rates (i.e., three out of five plans had a 0% performance rate). Follow-up analysis identified that often re-assessment is done without a care plan update (see Appendix: Additional Testing Results).

To balance the need for a measure that is feasible in the current MLTSS environment that would produce non-zero rates and the desire of the TEP to push the field further to do truly comprehensive care plan updates, we decided to break the measure into two rates:

1) LTSS Re-Assessment after Inpatient Discharge Rate, and

2) LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate

The two-rate approach aims to give program administrators and policymakers a much-needed tool to help move the managed long-term services and supports (MLTSS) field from extremely low performance (as demonstrated in our

testing) to more comprehensive and standardized documentation of updated care plans after transitions in care. The inclusion of both rates in a single measure signals the importance of this concept.

S.4. Numerator Statement: The measure has two rates. The numerators for the two rates are as follows:

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment within 30 days of discharge.

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment and care plan update within 30 days of discharge.

S.6. Denominator Statement: 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.

S.8. Denominator Exclusions: For Rate 2, enrollees who refuse care planning are excluded.

For both rates:

- Pregnancy-related or other perinatal hospital discharges are excluded.

- Enrollees who refuse re-assessment are excluded.

- Exclude planned hospital admissions from the measure denominator. A hospital stay is considered planned if it meets any of the following criteria:

- Hospital stays with a principal diagnosis of pregnancy or condition originating in the perinatal period are

- A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).

- A principal diagnosis of rehabilitation (Rehabilitation Value Set).

- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set).

- A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

De.1. Measure Type: Process

S.17. Data Source: Claims, Management Data, Other, Paper Medical Records

S.20. Level of Analysis: Health Plan

IF Endorsement Maintenance – Original Endorsement Date: Most Recent Endorsement Date:

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? This measure is not currently paired or grouped.

1. Evidence and Performance Gap – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

LTSS_ReAssess_CarePlan_Update_Evidence_Attachment.docx

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission? Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

1a Evidence (subcriterion 1a)

Measure Number (*if previously endorsed*)**:** TBD

Measure Title: LTSS Re-Assessment/Care Plan Update After Inpatient Discharge

IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here: N/A

Date of Submission: 11/7/2017

Instructions

- *Complete 1a.1 and 1a.2 for all measures. If instrument-based measure, complete 1a.3.*
- *Complete **EITHER 1a.2, 1a.3 or 1a.4** as applicable for the type of measure and evidence.*
- *For composite performance measures:*
  - *A separate evidence form is required for each component measure unless several components were studied together.*
  - *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*
- All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed.
- If you are unable to check a box, please highlight or shade the box for your response.
- Contact NQF staff regarding questions. Check for resources at Submitting Standards webpage.

Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF's evaluation criteria.

1a. Evidence to Support the Measure Focus

The measure focus is evidence-based, demonstrated as follows:

- Outcome: [3] Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias.
- Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [4] that the measured intermediate clinical outcome leads to a desired health outcome.
- Process: [5] a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [4] that the measured process leads to a desired health outcome.
- Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [4] that the measured structure leads to a desired health outcome.

- Efficiency: [6] evidence not required for the resource use component.
- For measures derived from patient reports, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful.
- Process measures incorporating Appropriate Use Criteria: See NQF's guidance for evidence for measures, in general; guidance for measures specifically based on clinical practice guidelines apply as well.

Notes

3. Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.

4. The preferred systems for grading the evidence are the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) guidelines and/or modified GRADE.

5. Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.

6. Measures of efficiency combine the concepts of resource use and quality (see NQF's Measurement Framework: Evaluating Efficiency Across Episodes of Care; AQA Principles of Efficiency Measures).

1a.1.This is a measure of: (*should be consistent with type of measure entered in De.1*)

Outcome

☐ Outcome:

☐Patient-reported outcome (PRO):

PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors. (*A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)*

☐ Intermediate clinical outcome (*e.g., lab value*):

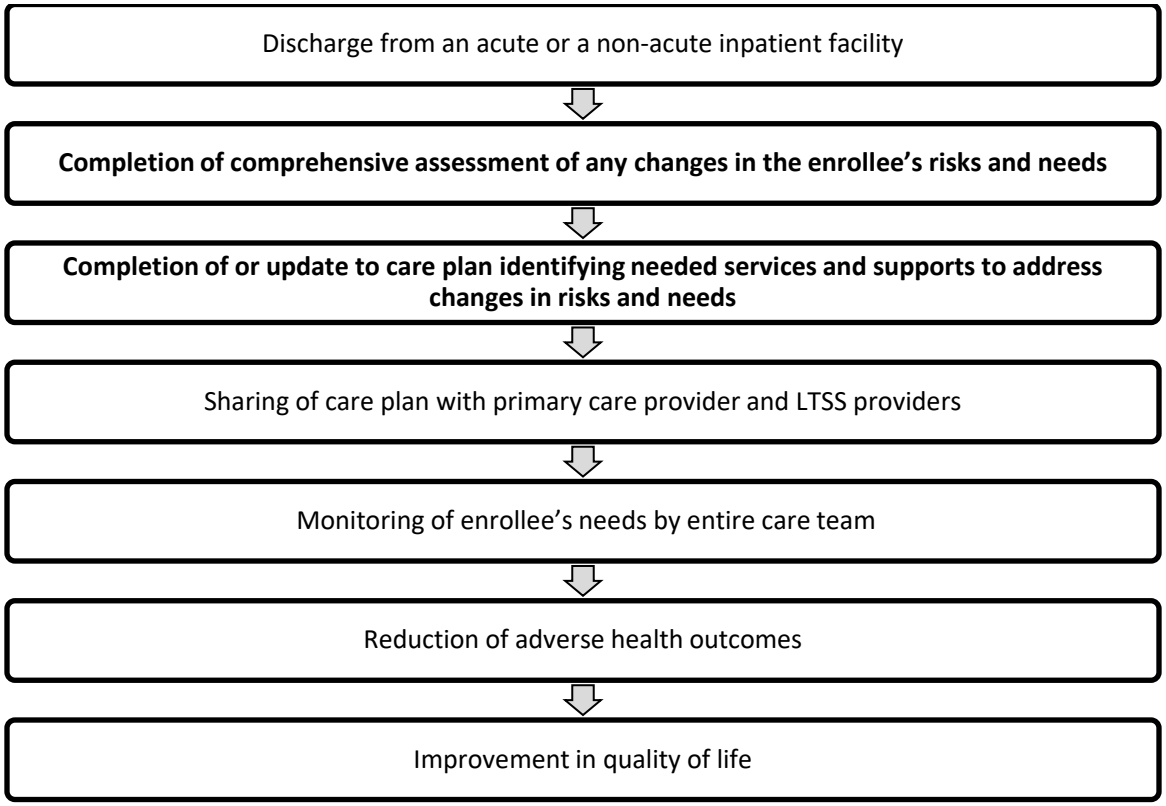
☒ Process: The rate of discharges from acute and non-acute inpatient facilities for MLTSS enrollees age 18 and older that were followed by a reassessment within 30 days.

☐ Appropriate use measure:

☐ Structure:

☐ Composite:

1a.2 LOGIC MODEL Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient's health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.



1a.3 Value and Meaningfulness: IF this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

Not applicable

****RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) ****

1a.2 FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.

Not applicable. Not an outcome measure.

1a.3. SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for INTERMEDIATE OUTCOME, PROCESS, OR STRUCTURE PERFORMANCE MEASURES, INCLUDING THOSE THAT ARE INSTRUMENT-BASED) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.

What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)

☐Clinical Practice Guideline recommendation (with evidence review)

☐US Preventive Services Task Force Recommendation

☐Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)

☐Other

Not applicable. Evidence is not based on a systematic review

Source of Systematic Review: • Title • Author • Date • Citation, including page number • URL	
Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR.	
Grade assigned to the **evidence** associated with the recommendation with the definition of the grade	
Provide all other grades and definitions from the evidence grading system	
Grade assigned to the **recommendation** with definition of the grade	
Provide all other grades and definitions from the recommendation grading system	
Body of evidence: • Quantity – how many studies? • Quality – what type of studies?	
Estimates of benefit and consistency across studies	
What harms were identified?	
Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR?	

1a.4 OTHER SOURCE OF EVIDENCE

If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.

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.

1a.4.1 Briefly SYNTHESIZE the evidence that supports the measure. A list of references without a summary is not acceptable.

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 (MACPAC, 2016; KFF, 2015). Given their complex needs, they often receive care from multiple providers and settings (Ujvari et al., 2015). MLTSS enrollees are also more likely to be Medicare-Medicaid enrollees, whose benefits are not aligned (MACPAC, 2014; Saucier & Burwell, 2015). 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 (Ujvari et al., 2015; Toles et al., 2012; Naylor et al., 2009; Saucier & Burwell, 2015; Freedman & Spillman, 2014; Allen et al., 2014; Komisar et al., 2005; Sands et al., 2006; Gaugler et al., 2007).

To adequately meet their needs, MLTSS enrollees require high levels of care coordination (Saucier & Burwell, 2015). 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 indicate the services and supports to be provided, and sharing care plans to inform care team members about the individual's needs, preferences, care goals, and services to be coordinated (Rich et al., 2012). 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 (Ujvari et al., 2015; CMS, 2013).

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 discharge from an inpatient or other type of facility on outcomes. However, there is extensive evidence to support the importance to care quality of interventions that assess or re-assess patient care needs and development of a new or updated care plan following a transition of care from hospital to home.

When individuals with multiple chronic conditions or disabilities do not receive transitional care support, they are more likely to receive duplicative medical services, experience medication errors, and have avoidable re-hospitalizations (Coleman & Berenson, 2004; Arbaje et al., 2014). Discharge from an inpatient facility can be followed by multiple care setting transitions in a short period of time, for example to a rehabilitation facility, a nursing facility, and potentially a hospital readmission. 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 (Rennke et al., 2013).

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 (Coleman et al., 2006). 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 (Epstein, 2009; Phillips et al., 2004). 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 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 (Coleman et al., 2006). Additional randomized trials found that "nurse-led transition care programs" can reduce preventable readmission rates by up to 56 percent (Parry et al., 2003; Parry et al., 2008; Naylor et al., 2003; Naylor et al., 2004; Naylor, 2003).

A number of care transition models have been developed and implemented in the past decade, such as the Transitional Care Model (Naylor et al., 2003), Care Transitions Program (Coleman et al., 2006), Project RED (Berkowitz et al., 2013), and Project BOOST (Hansen et al., 2013), in an effort to avoid or reduce adverse outcomes. Research is ongoing to identify the exact components of these transitional care models that best improve outcomes for at-risk populations (PCORI, 2015).

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 (Alliance for Home Health Quality and Innovation, 2014). In order to avoid or reduce the risk of readmission to an acute facility, or to a nursing home or other institution, and to ensure continuity of care, it is critical that LTSS providers: 1) know a enrollee is being discharged, 2) proactively assess or reassess any changes in the enrollee's physical, mental, and social health needs, and 3) develop or update 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 and people with disabilities, one-in-four are not discharged directly from the hospital to home but receive care in another acute or non-acute care facility (MACPAC, 2015). The rate of post-acute care use is likely to be higher among Medicaid MLTSS enrollees, including those who are dually eligible, because LTSS enrollees often have more functional limitations than the overall population of Medicare beneficiaries. For example, in 2012, 31 percent of dual eligible enrollees had 3 or more limitations in activities of daily living, three times the rate (10 percent) of non-dual Medicare beneficiaries (MedPAC and MACPAC, 2017).

Transitions from nursing facilities 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 (Naylor & Keating, 2008). 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 (Howell et al., 2007). 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.

1a.4.2 What process was used to identify the evidence?

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 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 2013 TEP was comprised of individuals representing multiple perspectives from the MLTSS community including consumers, practitioners, health plans, the federal government, and state governments. Under the current contract in 2016, we convened a new TEP (21 members) with a similar composition to inform the continued development and testing of this measure.

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).

1a.4.3. Provide the citation(s) for the evidence.

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.

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.

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.

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.

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.

CMS. 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.

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.

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1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure *(e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)*

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

This measure addresses continuity of care following a discharge from an acute (i.e. hospital) or non-acute (i.e. nursing facility) inpatient setting for Medicaid MLTSS enrollees. The MLTSS enrollee population includes individuals with complex health and social support needs. Given their complex needs, they require high levels of care coordination. 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, which may have changed following an inpatient admission.

The Technical Expert Panel (TEP) convened in 2013 to advise on these measures originally suggested a measure assessing whether the member care plan is updated after a major change in health status or living situation. Since "major change in health status or living situation" could not be feasibly identified from claims or enrollment records, the measure development team and TEP decided to use a care transition from an acute or post-acute facility as a proxy for

major change in health status or living situation. The TEP advised that although the desired result is to ensure that the care plan is revised to reflect changes in the individual's situation, goals and preferences and assessment is necessary to determine such changes. Therefore, the measure that was tested looked for both assessment and care plan update conducted face-to-face after discharge for an unplanned hospitalization or from a post-acute care facility.

Through our field test, we determined that requiring both a re-assessment and care plan update within 30 days would not result in meaningful performance rates (i.e., three out of five plans had a 0% performance rate). Follow-up analysis identified that often re-assessment is done without a care plan update (see Appendix: Additional Testing Results).

To balance the need for a measure that is feasible in the current MLTSS environment that would produce non-zero rates and the desire of the TEP to push the field further to do truly comprehensive care plan updates, we decided to break the measure into two rates:

1) LTSS Re-Assessment after Inpatient Discharge Rate, and

2) LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate

The two-rate approach aims to give program administrators and policymakers a much-needed tool to help move the managed long-term services and supports (MLTSS) field from extremely low performance (as demonstrated in our testing) to more comprehensive and standardized documentation of updated care plans after transitions in care. The inclusion of both rates in a single measure signals the importance of this concept.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

These data are from five MLTSS health plans that participated in testing these measures with enrollees representing at least two or more of the major LTSS sub-populations, which include frail elderly, older adults age 65 and over, people under age 65 with physical disabilities, people with developmental or intellectual disabilities, and people with serious mental illness). All five participating plans covered Medicare benefits as well as Medicaid LTSS and had at least one of the following types of contracts: Medicare-Medicaid Plan (MMP) (integrated care), Dual-Special Needs Plan (D-SNP), or Fully Integrated Dual Eligible (FIDE) SNP. For purposes of testing, the eligible population included MLTSS members who were age 18 and older as of January 1, 2015 and enrolled on or prior to August 31, 2015, allowing for at least 120 days of enrollment during the measurement year of CY 2015.

The data shown below demonstrating the proportion of beneficiaries with re-assessment only after discharge and the proportion beneficiaries who receive an assessment and care plan update after discharge, aligns with feedback from alpha testing, which indicates that care coordinators only conduct a care plan update if the nature of the discharge warrants it.

Rate 1. Re-assessment only, no face-to-face requirement

Mean: 22.4 %

Standard Deviation: 12.5%

Minimum: 7.4%

Maximum: 40.0%

Rate 2. Re-assessment and care plan update, no face-to-face requirement

Mean: 5.2%

Standard Deviation: 6.0%

Minimum: 0%

Maximum: 14.3%

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

Not applicable.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Not applicable. We collected information about race and ethnicity during testing. However, due to the overall low rates, we did not

believe additional analysis of disparities would provide meaningful information.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

We could not find any research on disparities in performing 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.

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 (CBO, 2013).

We collected information about race and ethnicity during testing. However, due to the overall low rates, we did not believe additional analysis of disparities would provide meaningful information.

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

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area *(check all the areas that apply):*

De.6. Non-Condition Specific*(check all the areas that apply):*

De.7. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

S.1. Measure-specific Web Page *(Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)*

Measure specifications have been drafted, and are anticipated to be publicly posted on CMS's MLTSS website in early 2018. However, currently there is no link.

S.2a. <u>If this is an eMeasure</u>, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure **Attachment:**

S.2b. Data Dictionary, Code Table, or Value Sets *(and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)*

Attachment **Attachment:** LTSS_ReAssess_CarePlan_Exclusions_Value_Set.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure **Attachment:**

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. <u>For maintenance of endorsement:</u> Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. <u>For maintenance of endorsement,</u> please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

S.4. Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.*

<u>IF an OUTCOME MEASURE</u>, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The measure has two rates. The numerators for the two rates are as follows:

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment within 30 days of discharge.

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment and care plan update within 30 days of discharge.

S.5. Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

<u>IF an OUTCOME MEASURE,</u> describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The numerator details for the two rates are as follows.

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment within 30 days of discharge.

LTSS Re-Assessment: The LTSS re-assessment must include a discussion with the enrollee using a structured or semi-structured tool that assesses the status of, and any changes to, the enrollee's health status and needs. The LTSS re-assessment must document current enrollee status on nine (9) core elements. The date of the LTSS re-assessment must be documented.

LTSS Re-Assessment Core Elements:

1. Limitations in activities of daily living (ADLs): Any difficulty in performing ADLs without assistance (i.e., walking, toileting, bathing, dressing, eating, and transferring) must be documented. Ability to perform all six ADLs must be documented.

2. Acute and chronic health conditions

3. List of current medications (The medication list may include medication names only)

4. Cognitive function assessed using a standardized validated tool (e.g., AD8 = Eight-item Informant Interview to Differentiate Aging and Dementia; AWV = Annual Wellness Visit; GPCOG = General Practitioner Assessment of Cognition; HRA = Health Risk Assessment; MIS = Memory Impairment Screen; MMSE = Mini Mental Status Exam; MoCA = Montreal Cognitive Assessment; SLUMS = St. Louis University Mental Status Exam; Short IQCODE = Short Informant Questionnaire on Cognitive Decline in the Elderly)(e.g., concentration, memory, problem solving abilities)

5. Mental health status (e.g., Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening,and PRIME MD-PHQ2, Generalized Anxiety Disorder 7-Item Scale (GAD7)mood, affect, anxiety)

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

7. Living arrangement: Documentation of whether member lives in a nursing facility, institution, assisted living, general community or other setting (e.g., home, nursing facility, assisted living).

8. Family and Friend Caregiver Availability: Documentation 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). The availability of a friend or a family caregiver (paid or unpaid) to provide caregiving support in the future must be documented along with the contact information for said caregivers. If there is no friend or family caregiver, the lack of informal caregiver availability must be documented to meet this element.

9. Current providers including primary care practitioner

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate) Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment (described above) AND care plan update within 30 days of discharge (described below).

LTSS Care Plan Update: The LTSS care plan is 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. There must be documentation that the care plan update after discharge was completed with input from the enrollee during a discussion between the individual responsible for creating the care plan (care manager) and enrollee. The LTSS re-assessment and care plan update after discharge may be done during the same encounter or during different encounters. A care plan update may be called a service plan update in certain Medicaid MLTSS plans. Per its definition, the LTSS care plan update must include:

- Documentation on whether family or friend caregiver(s) were involved in the development of the care plan, and the contact information for said caregiver(s). If there is no friend or family caregiver involved in care-planning, the lack of informal caregiver availability must be documented to meet this element.

- Documentation of enrollee (or power of attorney) agreement to comprehensive care plan, or appeal of care plan. Documentation of agreement includes: verbal agreement from the enrollee, or power of attorney (POA), received by phone or in person OR written agreement from the enrollee, or POA, received by mail (e.g., a signature). Documentation that a care plan was discussed or reviewed is not sufficient to meet this measure. The documentation must indicate that the enrollee (or POA) agreed to the care plan or the care plan is being appealed.

The care plan update after discharge must include documentation of seven (7) core elements:

LTSS Care Plan Update Core Elements

1. Care planned to meet enrollee medical needs. Documentation must include either plan for addressing need or documentation of no need.

2. Care planned to meet enrollee functional needs. Documentation must include either plan for addressing need or documentation of no need.

3. Care planned to meet enrollee needs due to cognitive impairment or documentation of no cognitive impairment. Example of care to meet cognitive impairment needs includes support for behavioral difficulties, caregiver support or education to address cognitive impairment, or support for keeping individual cognitive engaged in activities. Documentation must include either plan for addressing need related to cognition (or cognitive impairment/dementia) or documentation of no need.

4. List of all LTSS services and supports the enrollee receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings (e.g., adult day health center, nursing facility), including amount (e.g., hours, days) and frequency (e.g., every day, once a week). Documentation of no LTSS services is sufficient to meet the numerator criteria.

5. At least one enrollee (and family as appropriate) individualized goal (medical or non-medical goals).

6. A plan for follow-up and communication with the care manager (i.e., documentation of follow-up and communication schedule with care manager)

7. 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 at the MLTSS plan or contracted provider to contact in case of an emergency.

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

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.

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.) IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*

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 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 30 days after the qualifying discharge.
- Who have either of the following benefits: 1) long-term services and supports: home and community based or 2) long-term services and supports: institutional care AND 3) medical care: inpatient care.

The time frame for the denominator allows for 30 days to conduct the LTSS 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.

The MLTSS plan may use its own method to identify discharges from acute or non-Acute inpatient facilities.

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

For Rate 2, enrollees who refuse care planning are excluded.

For both rates:

- Pregnancy-related or other perinatal hospital discharges are excluded.

- Enrollees who refuse re-assessment are excluded.

- Exclude planned hospital admissions from the measure denominator. A hospital stay is considered planned if it meets any of the following criteria:

- Hospital stays with a principal diagnosis of pregnancy or condition originating in the perinatal period are

- A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).

- A principal diagnosis of rehabilitation (Rehabilitation Value Set).

- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set).

- A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

For Rate 2, enrollees who refuse care planning are excluded.

For both rates:

- Pregnancy-related or other perinatal hospital discharges are excluded.

- Enrollees who refuse re-assessment are excluded.

- Exclude planned hospital admissions from the measure denominator. A hospital stay is considered planned if it meets any of the following criteria:

- Hospital stays with a principal diagnosis of pregnancy or condition originating in the perinatal period are

- A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).

- A principal diagnosis of rehabilitation (Rehabilitation Value Set).

- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set).

- A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

See attachment: LTSS ReAssess CarePlan Exclusions Value Sets.

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*

Not Applicable, no stratification.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (*Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)*

Step 1a. Determine the eligible population of qualifying discharges.

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

Step 1c. Exclude discharges for planned admissions and pregnancy-related or other perinatal hospital stays. Exclude discharges where the enrollee refused LTSS re-assessment.

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate):

Step 1d. From the remaining qualifying discharges, identify through documentation in the medical or care management record if the enrollee had a LTSS re-assessment within 30 days of the qualifying discharge date.

Step 1e. Divide the number of discharges in Step 1d by the number of discharges in Step 1c to calculate the rate.

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate):

Step 2a. From discharges identified in Step 1d, exclude discharges where the enrollee refused care planning.

Step 2b. Identify through documentation in the medical or care management record if the enrollee had a LTSS re-assessment and care plan update within 30 days of discharge.

Step 2c. Divide the number of discharges in Step 2b by the remaining number of discharges in Step 2a to calculate the rate.

S.15. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

MLTSS plans should identify a systematic sample of 411 discharges for enrollees who meet the eligible population criteria.

S.16. Survey/Patient-reported data *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*

Specify calculation of response rates to be reported with performance measure results.

Not applicable.

S.17. Data Source *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
If other, please describe in S.18.

Claims, Management Data, Other, Paper Medical Records

S.18. Data Source or Collection Instrument *(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*
IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Other: Case Management Records. Records are reviewed to determine if re-assessment or care plan update were completed within the required time frame.

S.19. Data Source or Collection Instrument *(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*

No data collection instrument provided

S.20. Level of Analysis *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*

Health Plan

S.21. Care Setting *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*

Home Care, Other

If other: Long-term non-acute care, home- and community-based services, health plan case management

S.22. COMPOSITE Performance Measure - Additional Specifications *(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)*

2. Validity – See attached Measure Testing Submission Form

LTSS_ReAssess_CarePlan_Update_Testing_Attachment_Nov28.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

Measure Testing (subcriteria 2a2, 2b1-2b6)

Measure Number (*if previously endorsed*)**:** TBD
Measure Title: LTSS Re-Assessment/Care Plan Update After Inpatient Discharge
Date of Submission: 11/7/2017

Type of Measure:

☐ **Outcome (*including PRO-PM*)**	☐ **Composite –** *STOP – use composite testing form*
☐ Intermediate Clinical Outcome	☐ Cost/resource
☒ Process *(including Appropriate Use)*	☐ Efficiency
☐ Structure	

Instructions

- Measures must be tested for all the data sources and levels of analyses that are specified. ***If there is more than one set of data specifications or more than one level of analysis, contact NQF staff*** about how to present all the testing information in one form.
- **For all measures, sections 1, 2a2, 2b1, 2b2, and 2b4 must be completed.**
- **For outcome and resource use measures**, section **2b3** also must be completed.
- If specified for **multiple data sources/sets of specificaitons** (e.g., claims and EHRs), section **2b5** also must be completed.
- Respond to all questions as instructed with answers immediately following the question. All information on testing to demonstrate meeting the subcriteria for reliability (2a2) and validity (2b1-2b6) must be in this form. An appendix for *supplemental* materials may be submitted, but there is no guarantee it will be reviewed.
- If you are unable to check a box, please highlight or shade the box for your response.

- Maximum of 25 pages (*incuding questions/instructions;* minimum font size 11 pt; do not change margins). ***Contact NQF staff if more pages are needed.***
- Contact NQF staff regarding questions. Check for resources at Submitting Standards webpage.
- For information on the most updated guidance on how to address social risk factors variables and testing in this form refer to the release notes for version 7.1 of the Measure Testing Attachment.

Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the testing results for this measure meet NQF's evaluation criteria for testing.

2a2. Reliability testing [10] demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or that the measure score is precise. For **instrument-based measures** (including PRO-PMs) **and composite performance measures**, reliability should be demonstrated for the computed performance score.

2b1. Validity testing [11] demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality. For **instrument-based measures (including PRO-PMs) and composite performance measures**, validity should be demonstrated for the computed performance score.

2b2. Exclusions are supported by the clinical evidence and are of sufficient frequency to warrant inclusion in the specifications of the measure; [12]

AND

If patient preference (e.g., informed decisionmaking) is a basis for exclusion, there must be evidence that the exclusion impacts performance on the measure; in such cases, the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately). [13]

2b3. For outcome measures and other measures when indicated (e.g., resource use):

- **an evidence-based risk-adjustment strategy** (e.g., risk models, risk stratification) is specified; is based on patient factors (including clinical and social risk factors) that influence the measured outcome and are present at start of care; [14,15] and has demonstrated adequate discrimination and calibration

OR

- rationale/data support no risk adjustment/ stratification.

2b4. Data analysis of computed measure scores demonstrates that methods for scoring and analysis of the specified measure allow for **identification of statistically significant and practically/clinically meaningful** 16 **differences in performance**;

OR

there is evidence of overall less-than-optimal performance.

2b5. If multiple data sources/methods are specified, there is demonstration they produce comparable results.

2b6. Analyses identify the extent and distribution of **missing data** (or nonresponse) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and nonresponders) and how the specified handling of missing data minimizes bias.

Notes

10. Reliability testing applies to both the data elements and computed measure score. Examples of reliability testing for data elements include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing of the measure score addresses precision of measurement (e.g., signal-to-noise).

11. Validity testing applies to both the data elements and computed measure score. Validity testing of data elements typically analyzes agreement with another authoritative source of the same information. Examples of validity testing of the measure score include, but are not limited to: testing hypotheses that the measures scores indicate quality of care,

e.g., measure scores are different for groups known to have differences in quality assessed by another valid quality measure or method; correlation of measure scores with another valid indicator of quality for the specific topic; or relationship to conceptually related measures (e.g., scores on process measures to scores on outcome measures). Face validity of the measure score as a quality indicator may be adequate if accomplished through a systematic and transparent process, by identified experts, and explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality. The degree of consensus and any areas of disagreement must be provided/discussed.

12. Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, variability of exclusions across providers, and sensitivity analyses with and without the exclusion.

13. Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.

14. Risk factors that influence outcomes should not be specified as exclusions.

15. With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74 percent v. 75 percent) is clinically meaningful; or whether a statistically significant difference of $25 in cost for an episode of care (e.g., $5,000 v. $5,025) is practically meaningful. Measures with overall less-than-optimal performance may not demonstrate much variability across providers.

1. DATA/SAMPLE USED FOR ALL TESTING OF THIS MEASURE

Often the same data are used for all aspects of measure testing. In an effort to eliminate duplication, the first five questions apply to all measure testing. If there are differences by aspect of testing,(e.g., reliability vs. validity) be sure to indicate the specific differences in question 1.7.

1.1. What type of data was used for testing? (*Check all the sources of data identified in the measure specifications and data used for testing the measure. Testing must be provided for all the sources of data specified and intended for measure implementation.* ***If different data sources are used for the numerator and denominator, indicate N [numerator] or D [denominator] after the checkbox.***)

Measure Specified to Use Data From: (*must be consistent with data sources entered in S.17*)	Measure Tested with Data From:
☒ abstracted from paper record	☒ abstracted from paper record
☒ claims	☒ claims
☐ registry	☐ registry
☐ abstracted from electronic health record	☐ abstracted from electronic health record
☐ eMeasure (HQMF) implemented in EHRs	☐ eMeasure (HQMF) implemented in EHRs
☒ other: abstracted from case management records	☒ other: abstracted from case management records

1.2. If an existing dataset was used, identify the specific dataset (*the dataset used for testing must be consistent with the measure specifications for target population and healthcare entities being measured; e.g., Medicare Part A claims, Medicaid claims, other commercial insurance, nursing home MDS, home health OASIS, clinical registry*).

Not Applicable.

1.3. What are the dates of the data used in testing? September 1, 2014 to December 31, 2015.

1.4. What levels of analysis were tested? (*testing must be provided for all the levels specified and intended for measure implementation, e.g., individual clinician, hospital, health plan*)

Measure Specified to Measure Performance of: (*must be consistent with levels entered in item S.20*)	Measure Tested at Level of:
☐ individual clinician	☐ individual clinician
☐ group/practice	☐ group/practice
☐ hospital/facility/agency	☐ hospital/facility/agency
☒ health plan	☒ health plan
☐ other:	☐ other:

1.5. How many and which measured entities were included in the testing and analysis (by level of analysis and data source)? (*identify the number and descriptive characteristics of measured entities included in the analysis (e.g., size, location, type); if a sample was used, describe how entities were selected for inclusion in the sample*)

Five MLTSS plans representing both large national plans and small local plans from five states, located in geographically diverse regions of the country were included in the testing and analysis. All five participating health plans enrolled two or more of the major LTSS sub-populations, which include frail older adults age 65 and over, people under age 65 with physical disabilities, people with developmental or intellectual disabilities, and people with serious mental illness. All five participating plans covered Medicare benefits as well as Medicaid LTSS and had at least one of the following types of contracts: Medicare-Medicaid Plan (MMP), Dual Eligible Special Needs Plan (D-SNP), or Fully Integrated Dually Eligible Special Needs Plan (FIDE SNP).

1.6. How many and which patients were included in the testing and analysis (by level of analysis and data source)? (*identify the number and descriptive characteristics of patients included in the analysis (e.g., age, sex, race, diagnosis); if a sample was used, describe how patients were selected for inclusion in the sample*)

Each of the five plans identified a random sample of 150 enrollees from an eligible population of MLTSS members age 18 and older as of January 1, 2015. Forty-six enrollees were removed from the sample for inconsistent information, and the total sample included in the testing and analysis contained 715 enrollees. The total number of inpatient admissions of enrollees was 354. Of the 354 inpatient admissions and discharges, 35 discharges were excluded from the sample as they were for planned admissions. The remaining sample of 319 discharges were for unplanned or unknown reasons. Table 1 summarizes the enrollees' characteristics for the sample. Table 2 summarizes their place of residence, type of plan, whether they were new or established enrollees, and presence of chronic conditions or activities of daily living (ADL) limitations.

Table 1. Analytic Sample Demographic Information

Characteristics	**Percentage of enrollees in the testing sample (n=715)**
Sex	
Female	68.5
Male	31.0
Missing	0.4
Age	
Under 18	0.7
18-40	6.9
41-64	33.3
65 and older	59.0
Missing	0.1

Characteristics	Percentage of enrollees in the testing sample (n=715)
Race	
White	37.9
Black/African American	27.0
Asian	3.5
American Indian/Alaskan Native	0.3
Multi-race	0.1
Hawaiian/Pacific Islander	0.1
Unknown	19.2
Other	11.2
Ethnicity	
Non-Hispanic	55.9
Hispanic	17.3
Unknown	22.0
Primary language	
English	66.7
Spanish	10.4
Missing	17.1
Other	5.9

Source: Mathematica analysis of MLTSS enrollees from five health plans. Information from 46 enrollees was excluded due to data quality issues.

Table 2. Analytic Sample LTSS information

Characteristic	Percentage of enrollees in the testing sample (n=715)
Place of residence	
Home or community residence	77.6
Nursing facility	14.3
Assisted living facility	1.1
Other institution	0.7
Missing	6.3
MLTSS program	
Integrated plan (MMP, D-SNP, FIDE-SNP)	68.3
Non-integrated	31.6
Missing	0.1
Type of enrollee	
New	48.6
Established	51.3
Missing	0.1
Chronic conditions present by end of measurement year	
Arthritis	42.8
Asthma	13.2

Characteristic	Percentage of enrollees in the testing sample (n=715)
Cancer	8.0
Cardiac conditions (e.g., CAD, arrhythmia)	42.1
Dementia	17.5
Depression	34.3
Diabetes	35.4
Gastrointestinal (GI) disorders (e.g., IBD, cirrhosis)	26.0
Chronic Heart Failure	16.9
HIV	1.5
Neurological Disorders	20.7
Other Pulmonary Conditions (e.g., COPD)	24.2
Psychotic Disorder	11.9
Renal Disease	13.4
Stroke	16.1
ADL Limitations present by end of measurement year	
Walking	69.5
Toileting	57.2
Bathing	61.5
Eating	26.9
Transferring	61.0
Dressing	59.0

Source: Mathematica analysis of MLTSS enrollees from five health plans. Information from 46 enrollees was excluded due to data quality issues. The total number of inpatient admissions of enrollees age 18 or older for unplanned or unknown reasons included in the sample was 319.

1.7. If there are differences in the data or sample used for different aspects of testing (e.g., reliability, validity, exclusions, risk adjustment), identify how the data or sample are different for each aspect of testing reported below.

No difference in the sample size was used for testing.

1.8 What were the social risk factors that were available and analyzed? For example, patient-reported data (e.g., income, education, language), proxy variables when social risk data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate) which do not have to be a proxy for patient-level data.

No patient-level social risk factors were analyzed. All patients in the sample were Medicaid-eligible.

2a2. RELIABILITY TESTING

***Note**: If accuracy/correctness (validity) of data elements was empirically tested, separate reliability testing of data elements is not required – in 2a2.1 check critical data elements; in 2a2.2 enter "see section 2b2 for validity testing of data elements"; and skip 2a2.3 and 2a2.4.*

2a2.1. What level of reliability testing was conducted? (*may be one or both levels*)

☒ **Critical data elements used in the measure** (*e.g., inter-abstractor reliability; data element reliability must address ALL critical data elements*)

☒ **Performance measure score** (e.g., *signal-to-noise analysis*)

2a2.2. For each level checked above, describe the method of reliability testing and what it tests (*describe the steps—do not just name a method; what type of error does it test; what statistical analysis was used*)

Data presented here is on the final measure specifications. Additional detail on assessment domains and data elements documents can be found in the Appendix: Additional Testing Data.

Reliability of Data Elements

We calculated reliability of the critical data elements used in the measure with Cohen's kappa statistic to evaluate inter-rater reliability. Four participating health plans contributed thirty paired assessments and one plan contributed twenty-four paired assessments for analysis by two independent assessors. In total, the records of 144 MLTSS health plan enrollees were used for this analysis.

When comparing observations made by two individuals, Cohen's kappa statistic, or $\hat{\kappa}$ (ranging from 0 to 1) measures the percentage of agreement between individuals. If the observed agreement is greater than or equal to chance agreement, then $\hat{\kappa} \geq 0$, with $\hat{\kappa} = 1$ signifying perfect agreement. If the observed agreement is less than or equal to chance agreement, then $\hat{\kappa} \leq 0$ (Fleiss, Levin and Paik, 2003). We calculated the $\hat{\kappa}$ statistic reflecting the amount of agreement among key data elements as:

$$\widehat{\mathrm{K}} = \frac{\rho_a - \rho_e}{1 - \rho_e}$$

Where ρe is the expected percent chance agreement and ρa is the observed agreement.

Reliability of Measure Rates

To examine the reliability of measure performance rates, we evaluated split-sample reliability using the Inter-class correlation coefficient (ICC) to determine agreement. Enrollees were randomly assigned to each of the two groups, and rates were calculated separately for each group and then compared at the health plan-level.

When evaluating the reliability of rates or proportions, the inter-class correlation coefficient, $\hat{\rho}$, summarizes the estimated agreement among observations. The inter-class correlation coefficient (ICC) is the ratio of the subject variance to the total variance (the subject variance plus the error variance). Higher values of $\hat{\rho}$ indicate that the subject variance exceeds the error variance by a wide margin (Gwet, 2014). We calculated the $\hat{\rho}$ statistic reflecting the amount of agreement among measure results as:

$$\hat{\rho} = \frac{\sigma_s^2}{\sigma_s^2 - \sigma_e^2}$$

where $\sigma s2$ is the subject variance, and $\sigma e2$ is the error variance.

2a2.3. For each level of testing checked above, what were the statistical results from reliability testing? (e.*g., percent agreement and kappa for the critical data elements; distribution of reliability statistics from a signal-to-noise analysis*)

Reliability of Data Elements

Seven of the nine potential data elements (four measure specific elements and five additional elements related to dates, settings, and contact information) met the threshold for moderate or higher reliability ($\hat{\kappa} \geq 0.4$), as shown in Table 3. Data elements with the highest reliability were type of facility that the patient was discharged from, type of stay and if an assessment took place, ($\hat{\kappa}$=0.6364, 0.6258 and 0.4561). The data element with the lowest reliability was discharge date at $\hat{\kappa}$=0.240.

Table 3. Reliability of key data elements

Measure (elements)	Data element	Kappa statistic	Interpretation
General	Date of Birth	0.8426	Almost Perfect
(5)	Sex	0.8788	Almost Perfect
	Place of Residence	0.4706	Moderate
	Date of First Enrollment	0.7108	Substantial
	Date of First Disenrollment	-0.5052	Less than Chance Agreement
LTSS Re-Assessment and Care Plan Update After Inpatient Discharge* (4)	Discharged from acute/non-acute inpatient facility	0.6364	Substantial
	Discharge date	0.0240	Slight
	Type of stay	0.6258	Substantial
	Assessment occurred after discharge	0.4561	Moderate

Source: Mathematica analysis of paired data from 144 MLTSS enrollees, representing five health plans.

Notes: Interpretation of Kappa statistic used the following standards: < 0 – Less than chance agreement; 0 – 0.2 Slight agreement; 0.21 – 0.39 Fair agreement; 0.4 – 0.59 Moderate agreement; 0.6 – 0.79 Substantial agreement; 0.8 – 0.99 Almost Perfect agreement; 1 Perfect agreement. (Landis and Koch, 1977)

*The remainder of the LTSS Re-Assessment and Care Plan Update After Inpatient Discharge measure's elements (i.e., update to care plan) were assessed too infrequently among the 144 paired assessments (<30) to allow for IRR analysis.

Reliability of Measure Rates

ICCs for Rate 1 and Rate 2 are within the range for fair agreement (0.4 to 0.59).

Table 4. Reliability of recommended measure rates

Measure	ICC statistic	Interpretation
LTSS Re-Assessment and Care Plan Update After Inpatient Discharge		
Rate 1: Assessment Updated after Discharge, without Consideration for Location	0.3831	Fair
Rate 2: : Assessment and Care Plan Updated after Discharge, without Consideration for Location	0.2326	Fair

Source: Mathematica analysis of data from 715 MLTSS enrollees, representing five health plans.

Notes: Interpretation of ICC used the following standards: < 0 – Less than chance agreement; 0 – 0.2 Slight agreement; 0.21 – 0.39 Fair agreement; 0.4 – 0.59 Moderate agreement; 0.6 – 0.79 Substantial agreement; 0.8 – 0.99 Almost Perfect agreement; 1 Perfect agreement. (Landis and Koch, 1977)

2a2.4 What is your interpretation of the results in terms of demonstrating reliability? (i.*e., what do the results mean and what are the norms for the test conducted?*)

There was a mix in the inter-rater reliability of data elements. While the data elements had high reliability, discharge date had low reliability.

The results for reliability of the LTSS Re-Assessment/Care Plan Update After Inpatient Discharge measure rate showed only fair agreement. This result may be caused by the relatively low numbers of discharges that were followed by a re-assessment or care plan update.

2b1. VALIDITY TESTING

2b1.1. What level of validity testing was conducted? (*may be one or both levels*)

☐ **Critical data elements** (*data element validity must address ALL critical data elements*)

☐ **Performance measure score**

☒ **Empirical validity testing**

☒ **Systematic assessment of face validity of performance measure score as an indicator** of quality or resource use (*i.e., is an accurate reflection of performance on quality or resource use and can distinguish good from poor performance*) **NOTE**: Empirical validity testing is expected at time of maintenance review; if not possible, justification is required.

2b1.2. For each level of testing checked above, describe the method of validity testing and what it tests (*describe the steps—do not just name a method; what was tested, e.g., accuracy of data elements compared to authoritative source, relationship to another measure as expected; what statistical analysis was used)*

Empiric Validity of Performance Measure Score

Empiric validity was assessed by analyzing the convergent validity (whether the measure results correlate with other theoretically related quality measure results) of this measure. Comparison with established health plan quality measures was not possible due to the lack of publicly available standardized measures for the MLTSS population. Therefore we analyzed correlation between this measure and the four measures being tested for the MLTSS population in this project:

- LTSS Comprehensive Assessment and Update
- LTSS Comprehensive Care Plan and Update Measure
- LTSS Shared Care Plan with Primary Care Practitioner
- Falls: Screening, Risk-Assessment and Plan of Care to Prevent Future Falls

We examined the correlation of different versions of the five MLTSS measures with each other using the Spearman Rank Correlations. As with this assessment measure, we tested several variations of each of the other MLTSS measures. Although we analyzed validity among all versions of the five measures for ease of review we present results for only the most promising versions of the measures in Table 3 (reliability of key data elements).

Systematic Assessment of Face Validity

By surveying several panels of stakeholders, we were able to assess face validity, which indicates whether the measure accurately represents the concept being measured and achieves the purpose for which it is intended (i.e., to measure the percent of beneficiaries being assessed and the quality of the assessments conducted).

In November 2017, 13 members of the 2017 Technical Expert Panel (see Ad.1 for member list) voted on the face validity of the measure via a web survey. The TEP voted on whether they “strongly agree”, “agree”, “disagree”, or “strongly disagree” with the following survey items:

1. Denominator is appropriate given the intent of the measure
2. Numerator Rate 1 is appropriate given the intent of the measure
3. Numerator Rate 2 is appropriate given the intent of the measure
4. Exclusion 1 is appropriate given the intent of the measure
5. Exclusion 2 is appropriate given the intent of the measure

6. Would high performance on this measure indicate that a health plan is providing higher quality care?
7. In the future, do you think that performance scores on this measure will distinguish between good and poor performance?

TEP members had the opportunity to provide written comments on all the survey items above, as well as an additional open response question:

8. Do you have any recommendations that would help strengthen the ReAssessment/Care Plan Update after Inpatient Discharge measure?

See Appendix 1 for summaries of the written comments for each survey item. While the majority of TEP members agreed with the measure, the comments included in the summaries are largely from those who disagreed or suggested revisions to the measure.

Additional Face Validity Feedback

Under a previous CMS contract (Contract No. HHSM-500-2010-00026I/HHSM-500-T0011), a multistakeholder technical expert panel (TEP) of 20 individuals representing home and community based services organizations, disability service organizations, organizations providing services for aging populations, state Medicaid and quality organizations, and consumer advocacy groups was convened to provide input on the MLTSS measure development and testing processes (see Ad.1 for TEP member list – 2013 TEP). Under the current contract, we convened a new TEP with a similar size and composition to inform the continued development and testing of this measure (see Ad.1 for TEP member list – 2017 TEP). Six members of the 2017 TEP also participated in a workgroup that provided in-depth feedback on the MLTSS measures specifically (2017 MLTSS Workgroup).

We also received feedback from a three-week public comment period hosted on CMS's online public comment system. The public comment period was open and broadcast to all interested parties.

2b1.3. What were the statistical results from validity testing? (*e.g., correlation; t-test*)

Empiric Validity of Performance Measure Score

Among the recommended measure rates, very few positive, significant relationships were observed. The Spearman Rank Correlation coefficient, $\hat{\rho}$, showed a significant, strong positive relationship between the two rates in *LTSS Re-Assessment and Care Plan Update After Inpatient Discharge* and the three rates in *Falls: Screening, Risk-Assessment and Plan of Care to Prevent Future Falls*.

The remaining relationships were negative, which is likely due to the high prevalence of zero rates across the measures.

Table 5. Correlation of recommended measure rates

Measures	MLTSS-1, Rate 1	MLTSS-1, Rate 2	MLTSS-2, Rate 1	MLTSS-2, Rate 2	MLTSS-3	MLTSS-4, Rate 1	MLTSS-4, Rate 2	MLTSS-5 Screening	MLTSS-5 Assess	MLTSS-5 Care Plan
MLTSS-4, Rate 1: Assessment Updated after Discharge, w/o consideration for Location	-0.2368	-0.2368	-0.2868	-0.2868	-0.4472	--	0.4104	0.3000	0.4588	NA
MLTSS-4, Rate 2: Assessment & Care Plan Updated after Discharge, w/o consideration for Location	-0.0513	-0.0513	-0.2236	-0.2236	-0.4472	0.4104	--	0.9747**	0.8944*	NA

Source: Mathematica analysis of data from 715 MLTSS enrollees, representing five health plans.

*Significant association, at $p < 0.05$

**Significant association, at $p < 0.01$

MLTSS-1 = LTSS Comprehensive Assessment and Update

Rate 1 = Assessment with 9 core elements documented

Rate 2 = Assessment with at least 12 supplemental elements documented

MLTSS-2 = LTSS Comprehensive Care Plan and Update

Rate 1 = Care plan with 7 core elements documented

Rate 2 = Care plan with at least 4 supplemental elements documented

MLTSS-3 = LTSS Shared Care Plan with Primary Care Practitioner

Rate = Care plan transmitted to provider within 30 days of the plan's development or update

MLTSS-4 = LTSS Re-Assessment and Care Plan Update after Inpatient Discharge

Rate 1 = Re-assessment and care plan update, no face to face requirement

Rate 2 = Re-assessment only, no face to face requirement

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

Rate 1 = Screened for falls risk

Rate 2 = Falls risk assessment

Rate 3 = Falls risk plan of care

Systematic Assessment of Face Validity

Table 6 contains the voting results from the survey. Overall, the majority of TEP members supported the denominator, numerators, and exclusions for the Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge measure. The majority of TEP members also agreed that the measure is reflective of quality and had the potential to distinguish performance.

Table 6

Response	Denominator is appropriate given the intent of the measure	Numerator Rate 1 is appropriate given the intent of the measure	Numerator Rate 2 is appropriate given the intent of the measure	Exclusion 1 is appropriate given the intent of the measure	Exclusion 2 is appropriate given the intent of the measure	Would high performance on this measure indicate that a health plan is providing higher quality care?	In the future, do you think that performance scores on this measure will distinguish between good and poor performance?
Strongly Agree	1	1	1	1	3	0	0
Agree	12	8	9	10	7	8	8
Disagree	0	4	3	2	0	4	4
Strongly Disagree	0	0	0	0	0	1	1
No Response	0	0	0	0	3	0	0
Total Percent Agree	100%	69%	78%	85%	78%	62%	62%

Additional Face Validity Feedback

Feedback from the public comment period was generally supportive of the measure. Several comments stressed the importance of harmonizing the measures with existing measures and tools. Numerous comments offered ways that the measure specifications could be furthered clarified, including denominator and numerator criteria, timing, construction of required elements, setting of the assessment and exclusion criteria. A few comments asked us to explore the importance of the measure and the burden for health plans to report during testing.

2b1.4. What is your interpretation of the results in terms of demonstrating validity? (i.*e., what do the results mean and what are the norms for the test conducted?*)

Empiric Validity of Performance Measure Score

As documentation of the core elements improves among plans over time, the other rates are in turn likely to become more meaningful and useful. Specifically, LTSS Re-Assessment and Care Plan Update After Inpatient Discharge Rate 2, which reports the percentage of enrollees with re-assessment and care plan update, with no face-to-face requirement, appears the most useful as a second "aspirational" measure. Health plan performance is lower for Rate 2 relative to Rate 1 (focused on just assessment), but still yields non-zero rates for three of the five health plans. Participants in the TEP, the workgroup and public commenters all supported moving forward with this measure.

Because all of the MLTSS measures under development are expected to reflect the quality of care provided to MLTSS enrollees, ideally we would expect to see significant, strong positive relationships correlations. However, given the overall sub-optimal and incongruent results among health plans, these results are not surprising. For example, this measure has a strong positive relationship with the Falls: Screening, Risk-Assessment and Plan of Care to Prevent Future

Falls measure, but a significant, strong negative relationship with the *LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, and LTSS Shared Care Plan with Primary Care Practitioner* measures, reflecting the fact that for one measure three health plans have zero rates, while for the other measure, the other two measures have zero rates. As reporting improves the internal validity of the measures should also improve accordingly.

Systematic Assessment of Face Validity

While the voting results suggest that this is a valid measure, TEP members noted that the presence of an updated care plan without available network providers to provide services may still result in re-admission and assessment is not the only driver of improvement. The measurement team agrees that future measure goals should include indicators that high quality care was provided, but establishing standard practices for assessments and care plans must take place first. This measure is a first step and is not meant to be used alone to determine quality; rather, it is one piece of critical care delivery in determining whether individuals needs and preferences are being assessed and addressed in care plans - including non-medical needs.

Additional Face Validity Feedback

Stakeholder input suggests that this measure is valid for assessing the need for long term services and supports for plan enrollees. The findings from the TEPs, workgroup, and public comment suggest that modifications made to the measure specification produced valid results.

2b2. EXCLUSIONS ANALYSIS

NA ☐ no exclusions— *skip to section* 2b3

Thirty-five admissions were planned, and excluded from the sample of 354 admissions.

2b2.1. Describe the method of testing exclusions and what it tests (*describe the steps—do not just name a method; what was tested, e.g., whether exclusions affect overall performance scores; what statistical analysis was used*)

N/A

2b2.2. What were the statistical results from testing exclusions? (*include overall number and percentage of individuals excluded, frequency distribution of exclusions across measured entities, and impact on performance measure scores*)

N/A

2b2.3. What is your interpretation of the results in terms of demonstrating that exclusions are needed to prevent unfair distortion of performance results? (*i.e., the value outweighs the burden of increased data collection and analysis. Note: **If patient preference is an exclusion**, the measure must be specified so that the effect on the performance score is transparent, e.g., scores with and without exclusion*)

N/A

2b3. RISK ADJUSTMENT/STRATIFICATION FOR OUTCOME OR RESOURCE USE MEASURES

If not an intermediate or health outcome, or PRO-PM, or resource use measure, skip to section 2b4.

2b3.1. What method of controlling for differences in case mix is used?

☒ No risk adjustment or stratification

☐ Statistical risk model with _risk factors

☐ Stratification by _risk categories

☐ Other,

2b3.1.1 If using a statistical risk model, provide detailed risk model specifications, including the risk model method, risk factors, coefficients, equations, codes with descriptors, and definitions.

N/A

2b3.2. If an outcome or resource use component measure is not risk adjusted or stratified, provide rationale and analyses to demonstrate that controlling for differences in patient characteristics (case mix) is not needed to achieve fair comparisons across measured entities.

N/A

2b3.3a. Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or social risk factors) used in the statistical risk model or for stratification by risk (*e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of p<0.10; correlation of x or higher; patient factors should be present at the start of care*) **Also discuss any "ordering" of risk factor inclusion**; for example, are social risk factors added after all clinical factors?

N/A

2b3.3b. How was the conceptual model of how social risk impacts this outcome developed? Please check all that apply:

☐ **Published literature**

☐ **Internal data analysis**

☐ **Other (please describe)**

2b3.4a. What were the statistical results of the analyses used to select risk factors?

N/A

2b3.4b. Describe the analyses and interpretation resulting in the decision to select social risk factors *(e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects.)* **Also describe the impact of adjusting for social risk (or not) on providers at high or low extremes of risk.**

N/A

2b3.5. Describe the method of testing/analysis used to develop and validate the adequacy of the statistical model or stratification approach (*describe the steps—do not just name a method; what statistical analysis was used*)

N/A

Provide the statistical results from testing the approach to controlling for differences in patient characteristics (case mix) below.

If stratified, skip to 2b3.9

2b3.6. Statistical Risk Model Discrimination Statistics (*e.g., c-statistic, R-squared*)**:**

N/A

2b3.7. Statistical Risk Model Calibration Statistics (*e.g., Hosmer-Lemeshow statistic*):

N/A

2b3.8. Statistical Risk Model Calibration – Risk decile plots or calibration curves:

N/A

2b3.9. Results of Risk Stratification Analysis:

N/A

2b3.10. What is your interpretation of the results in terms of demonstrating adequacy of controlling for differences in patient characteristics (case mix)? (i.*e., what do the results mean and what are the norms for the test conducted*)

N/A

2b3.11. Optional Additional Testing for Risk Adjustment (*not required, but would provide additional support of adequacy of risk model, e.g., testing of risk model in another data set; sensitivity analysis for missing data; other methods that were assessed*)

N/A

2b4. IDENTIFICATION OF STATISTICALLY SIGNIFICANT & MEANINGFUL DIFFERENCES IN PERFORMANCE

2b4.1. Describe the method for determining if statistically significant and clinically/practically meaningful differences in performance measure scores among the measured entities can be identified (*describe the steps—do not just name a method; what statistical analysis was used? Do not just repeat the information provided related to performance gap in 1b)*

To evaluate whether the measures demonstrated statistically significant variation in performance across health plans and/or showed sub-optimal performance (suggesting room for improvement), we calculated the sample mean, minimum and maximum values, and standard deviations for the five health plans-level results. We utilized two-tailed T-tests to evaluate whether each health plan's results differed significantly from the sample mean.

2b4.2. What were the statistical results from testing the ability to identify statistically significant and/or clinically/practically meaningful differences in performance measure scores across measured entities? (e.g., *number and percentage of entities with scores that were statistically significantly different from mean or some benchmark, different from expected; how was meaningful difference defined*)

MLTSS plan performance on the two measure rates are presented in Table 6. Health plans 04 and 05 demonstrated rates that differed significantly from the mean at the .05 level.

Table 6. Performance rates by health plan with significant differences noted

Health Plan	Rate 1: Re-assessment only, no face-to-face requirement	Rate 2: Re-assessment and care plan update, no face-to-face requirement
HP 01	20.5	0.0
HP 02	15.4	7.7
HP 03	7.4	0.0
HP 04	40.0*	3.9
HP 05	28.6	14.3*
Minimum	7.4	0.0
Mean	22.4	5.2
Maximum	40.0	14.3
Standard deviation	12.5	6.0

Source: Mathematica analysis of enrollee data from 5 MLTSS plans.
Note: Health plan identifiers "HP 01" through "HP-05" are used to protect the confidentiality of health plans participating in beta testing.
NA = Not applicable (no enrollees had all the 9 core elements documented)
* Significantly different from the mean at the .05 level, two-tailed test

2b4.3. What is your interpretation of the results in terms of demonstrating the ability to identify statistically significant and/or clinically/practically meaningful differences in performance across measured entities? (i*.e., what do the results mean in terms of statistical and meaningful differences?*)

Between the two measure rates, we can observe a range in performance across the five health plans. Additionally, health plans 04 and 05 had rates that demonstrated a statistically significant difference from the mean. These findings indicate that the measure as specified does have the potential to identify meaningful differences in performance between health plans.

2b5. COMPARABILITY OF PERFORMANCE SCORES WHEN MORE THAN ONE SET OF SPECIFICATIONS

If only one set of specifications, this section can be skipped.

Note: *This item is directed to measures that are risk-adjusted (with or without social risk factors)* ***OR*** *to measures with more than one set of specifications/instructions (e.g., one set of specifications for how to identify and compute the measure from medical record abstraction and a different set of specifications for claims or eMeasures). It does not apply to measures that use more than one source of data in one set of specifications/instructions (e.g., claims data to identify the denominator and medical record abstraction for the numerator).* ***Comparability is not required when comparing performance scores with and without social risk factors in the risk adjustment model. However, if comparability is not demonstrated for measures with more than one set of specifications/instructions, the different specifications (e.g., for medical records vs. claims) should be submitted as separate measures.***

2b5.1. Describe the method of testing conducted to compare performance scores for the same entities across the different data sources/specifications (*describe the steps—do not just name a method; what statistical analysis was used*)

Not applicable. There is only one set of specifications for this measure.

2b5.2. What were the statistical results from testing comparability of performance scores for the same entities when using different data sources/specifications? (*e.g., correlation, rank order*)

N/A

2b5.3. What is your interpretation of the results in terms of the differences in performance measure scores for the same entities across the different data sources/specifications? (i.*e., what do the results mean and what are the norms for the test conducted*)

N/A

2b6. MISSING DATA ANALYSIS AND MINIMIZING BIAS

2b6.1. Describe the method of testing conducted to identify the extent and distribution of missing data (or nonresponse) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and nonresponders) and how the specified handling of missing data minimizes bias (*describe the steps—do not just name a method; what statistical analysis was used*)

The primary focus of this measure is an assessment of missing data – i.e., whether MLTSS enrollees show documentation of re-assessment and care plan updates after inpatient discharge. When required elements are missing, the enrollee is considered not to have met the numerator requirements. Therefore, the measure results themselves reflect the extent and distribution of missing data overall and by plan. The extent of missing data for key data elements is described in further detail in the Additional Testing Results Appendix.

2b6.2. What is the overall frequency of missing data, the distribution of missing data across providers, and the results from testing related to missing data? (*e.g., results of sensitivity analysis of the effect of various rules for missing data/nonresponse; if no empirical sensitivity analysis, identify the approaches for handling missing data that were considered and pros and cons of each*)

Please see details in the Additional Testing Results Appendix.

2b6.3. What is your interpretation of the results in terms of demonstrating that performance results are not biased due to systematic missing data (or differences between responders and nonresponders) and how the specified handling of missing data minimizes bias**?** (i.*e., what do the results mean in terms of supporting the selected approach for missing data and what are the norms for the test conducted; if no empirical analysis, provide rationale for the selected approach for missing data*)

The low rates for this measure reflect the lack of standardization regarding practices for conducting re-assessments and updating care plans after inpatient discharges among MLTSS enrollees. This measure assesses the percentage of

discharges from inpatient facilities for Medicaid MLTSS enrollees that result in a re-assessment or care plan update within 30 days, and in doing so, should help address this lack of standardization.

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*) Update this field for **maintenance of endorsement**.

Some data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

This measure is primarily collected from health plan and case management records, many of which are electronic. However, the data elements needed for this measure are not currently standardized (i.e., data elements may be in free text instead of structured fields). As the LTSS field moves forward, we anticipate the data elements needed to calculate this measure will become structured allowing for an eMeasure in the future.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

Not applicable.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified *(e.g., value/code set, risk model, programming code, algorithm)*.

The LTSS ReAssess Care Plan Exclusions Value Sets can be used to identify discharges for planned acute care hospital admissions, and includes CPT codes, which are proprietary. CMS has an existing license agreement with the AMA, covering the use of these codes, as follows:

Current Procedural Terminology (CPT) codes © 2017 American Medical Association. All rights reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained therein. Applicable FARS/DFARS restrictions apply to government use.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting Quality Improvement (Internal to the specific organization)	

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Not applicable.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (*e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?*)

Not applicable; the measure is under initial endorsement review and is not currently used in an accountability program. A measure
implementation plan will be developed by, or in conjunction with, CMS.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)

This measure is intended for use by states and health plans to monitor and improve the quality of care provided for the Medicaid MLTSS enrollee population. States and health plans may choose to begin implementing the measures based on their programmatic needs.

In May 2017, the National MLTSS Health Plan Association recommended a set of model LTSS performance measures and network adequacy standards in an effort to assist states in complying with the 2016 final rule on managed care in Medicaid and Children's Health Insurance (CHIP). The LTSS Re-Assessment and Care Plan Update After Inpatient Discharge measure is included in the set of recommended measures that assesses person-centered planning and coordination.

http://mltss.org/wp-content/uploads/2017/05/MLTSS-Association-Quality-Framework-Domains-and-Measures-042117.pdf

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

Not applicable.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Not applicable.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

Not applicable.

4a2.2.2. Summarize the feedback obtained from those being measured.

Not applicable.

4a2.2.3. Summarize the feedback obtained from other users

Not applicable.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Not applicable.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

This measure is being considered for initial endorsement. Adoption of this performance measure has the potential to improve the quality of care for Medicaid enrollees who are receiving long-term services and supports. 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. In order to avoid or reduce the risk of readmission to an acute facility, or to a nursing home or other institution, and to ensure continuity of care, it is

critical that LTSS providers: 1) know a enrollee is being discharged, 2) proactively assess or reassess any changes in the enrollee's physical, mental, and social health needs, and 3) develop or update 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.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

Not applicable. This measure has not been implemented yet. There were no unexpected findings identified during testing of this measure.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

Not applicable. This measure has not been implemented yet. There were no unexpected findings identified during testing of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment Attachment: LTSS_ReAssess_CarePlan_Update_Additional_Testing_Results_Nov28.docx

Contact Information

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Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

2017 Technical Expert Panel

Carol Raphael, Manatt Health Solutions (Chair)

Ann Hwang, MD, Community Catalyst

Ari Houser, PhD, AARP Public Policy Institute

Dennis Heaphy, MPH, Disability Policy Consortium

Joe Caldwell, PhD, National Council on Aging

Lauren Murray, BA, National Partnership for Women and Families

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Quality Measure Development (QMD) – Medicare-Medicaid (Dual) and Medicaid-Only Enrollees MLTSS Workgroup, January 2017

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The 2017 TEP and Workgroup reviewed feedback obtained during public comment, as well as alpha and beta testing results, and advised on the refinements of the technical specifications. The 2013 TEP advised on the development of the initial measure concept and preliminary specifications.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released:

Ad.3 Month and Year of most recent revision:

Ad.4 What is your frequency for review/update of this measure? Not applicable.

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

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Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: Please include Jessica Ross (jross@mathematica-mpr.com) on any communications about these measures, as well as Roxanne Dupert-Frank and Henry Ireys. Thank you.