Medicaid Long-Term Care
Performance Measure Specifications Manual
For July 1, 2018 Reporting

The following areas have been updated:

Required Record Documentation

- New specifications have been added for the eligible population for Numerators One and Five.
- Added a note that exclusions should be made prior to identifying the eligible population.
- New exclusions have been added for Numerators One and Five and for Numerator Six.
- Added additional information about acceptable assessments for enrollees who transitioned to a skilled nursing facility during the measurement year to the specifications for Numerator One.
- Changed the first year of reporting for Numerator Six from July 1, 2018 to July 1, 2019.

Timeliness of Service

- Changed collection method to administrative or hybrid
- Added additional information to the eligible population
- Added additional clarification that this only measures services on the enrollee's Plan of Care.

HEDIS/Agency-Defined measures

Care for Older Adults (CFA)

Description: The percentage of adults 18 years and older who had each of the following during the measurement year:

- Advance Care Planning
- Medication Review
- Functional Status assessment

Three age bands and a total should be reported for each component:

- 18 to 60 years as of December 31 of the measurement year
- 61 to 65 years as of December 31 of the measurement year
- 66 years and older as of December 31 of the measurement year
- Total

Definitions: See the definitions for this measure in the current edition of the HEDIS Technical Specifications for Health Plans, published by the National Committee for Quality Assurance, with the following exception.

- Throughout the specifications for this measure, "medical record" may also be interpreted as "case record" or "case file" in the context of the long-term care plans.

Eligible Population: See the eligible population description for this measure in the current edition of the HEDIS Technical Specifications for Health Plans, with the following exception.

- The eligible population for this measure includes those 18 years and older as of December 31 of the measurement year.

Exclusions: Exclude dual eligible members from the denominator for the Medication Review component.

Administrative Specification: See the administrative specification details in the current edition of the HEDIS Technical Specifications for Health Plans, with the following exceptions.

- For the Medication Review and Functional Status assessment components of this measure, the denominator should be those members of the eligible population who received home and community based services (HCBS) for at least one month of the measurement year.
- For the Medication Review component, the review must have been conducted by a licensed nurse or a pharmacist in consultation with the enrollee's physician during the measurement year.

Hybrid Specification: See the hybrid specification details in the current edition of the HEDIS Technical Specifications for Health Plans, with the following exceptions.

- **Denominator:** For the Medication Review and Functional Status assessment components of this measure, the denominator should be a systematic sample of those members of the eligible population who received home and community based services (HCBS) for at least one month of the measurement year.

- **Numerators: Advance care planning – Medical Record:** For long-term care plans, "Documentation of an advance care planning **discussion** with the provider" includes documentation of an advance care planning discussion with the plan's case manager and/or care coordinator for the enrollee.

- **Numerators: Medication Review – Medical Record:** Documentation must include evidence of a medication review by a licensed nurse or a pharmacist in consultation with the enrollee's physician.

Additional Notes related to the Medication Review component:

- The medication list may include prescriptions, over-the-counter (OTC) medications, and herbal or supplemental therapies.
- The review of the medications (including all prescriptions and OTC medications) may be conducted by a licensed nurse or a pharmacist in consultation with the enrollee's physician. A call to the enrollee's primary care physician (PCP) followed by either an email or fax detailing the enrollee's medication list and request for confirmation that the listed medications are appropriate to manage the enrollee's conditions as determined through periodic laboratory testing. <u>The enrollee's PCP, or a physician assistant (PA) or an advanced registered nurse practitioner (ARNP) under the supervision of the enrollee's PCP must be contacted. Hospice physicians cannot perform this review.</u>

Agency-Defined Measures

Required Record Documentation (RRD)

Description: LTC health plans are required to ensure that enrollees have specific documentation maintained in their records. This measure assesses whether the following documents have been maintained in the record as required: 701B redetermination; Plan of Care signed by the enrollee (or representative) and sent to the Primary Care Physician; Freedom of Choice form; Plan of Care – LTC Service Authorizations; and Plan of Care – Availability and Amount of Family/Informal Support Systems.

Age/Gender: No age limitations.

Data Collection Method: Hybrid. A systematic sample drawn from the eligible population following the Healthcare Effectiveness Data and Information Set (HEDIS) Guidelines for Calculations and Sampling.

Eligible Population – Numerators Two, Three, Four, and Six: Enrollees receiving services during the measurement year.

- For Numerator Six, this excludes enrollees residing in ALFs, AFCHs, and nursing facilities.

Eligible Population – Numerators One and Five: Enrollees receiving home and community based (HCBS) services for at least one month during the measurement year. This includes enrollees residing in ALFs and AFCHs and excludes those in nursing facilities.

Continuous Enrollment: The measurement year with no more than a one month gap in enrollment.

Exclusions: Enrollees who did not receive covered services during the measurement year.
***Exclusions should be made prior to identifying the eligible population.**

Denominator: The eligible population.

- For Numerators One and Five, –the denominator is those in the eligible population who received HCBS for at least one month during the measurement year.
- For Numerator Six, the denominator is those in the eligible population who received HCBS services for at least one month during the measurement year and who have a caregiver identified in their 701B assessment.

Numerator One - 701B Assessment: The number of enrollees whose record contains documentation of a 701B assessment that was completed within the measurement year at the initial visit for new enrollees or at the annual re-assessment visit for established enrollees. If a

701B form is present in the record but was done outside of the time requirement, the record is non-compliant. A 701B or 701T assessment is acceptable for enrollees who transitioned to a skilled nursing facility during the measurement year.

Numerator Two – Plan of Care/Enrollee Participation: The number of enrollees whose record contains a Plan of Care signed by the enrollee or the enrollee's representative.

Numerator Three – Plan of Care/Primary Care Physician Notification: The number of enrollees whose record indicates that the Plan of Care was sent to the primary care physician within 10 business days of development for new enrollees or within 10 business days of the annual re-assessment for established enrollees.

Numerator Four - Freedom of Choice Form: The number of enrollees whose record contains a completed Freedom of Choice Form signed by the enrollee or the enrollee's representative.

Numerator Five – Plan of Care/LTC Service Authorizations: The number of enrollees whose record contains a Plan of Care that includes LTC service authorizations for maintenance therapies for time periods that are shorter than the end date of the Plan of Care and does not include subsequent service authorizations for the same service.

> ***Note:*** This measure refers to changes to the annual Plan of Care. This measure does not include covered services that are authorized for a duration of less than six months for the treatment of an acute illness or a condition that will be resolved within six months and are supported by the primary care physician's prescription of the service for a shorter duration or objective evidence-based criteria.

Numerator Six – Plan of Care/Availability and Amount of Family/Informal Support Systems: The number of enrollees whose record contains a Plan of Care that includes documentation of the availability of family/informal support systems and the amount of assistance the existing support systems are able to provide to the enrollee. **This numerator will first be reported to the Agency in the July 1, 2019 performance measure reporting, for calendar year 2018.**

Face-to-Face Encounters (F2F)

Description: The percentage of enrollees who had a face-to-face encounter with a care/case manager every three months.

Data Collection Method: Administrative data. No sampling allowed.

Eligible Population: Enrollees receiving services during the measurement year.

Continuous Enrollment: Three consecutive months with no gap in enrollment.

Special Instruction: If an enrollee has two continuous enrollment periods with a gap between periods of enrollment (e.g., January-April followed by September-December), only the most recent enrollment period should be included.

Denominator: The eligible population.

Numerator: The number of enrollees who received a face-to-face encounter by a care/case manager every three months as evidenced by the following encounter counts:

- Three months of enrollment to less than six months of enrollment = one encounter;
- Six months of enrollment to less than nine months of enrollment = two encounters, no more than 90 days apart;
- Nine months of enrollment to less than twelve months of enrollment = three encounters, no more than 90 days apart;
- Twelve months of enrollment = four encounters, no more than 90 days apart.

Note: If more than 90 days elapse between an enrollee's face-to-face encounters with a care/case manager, the enrollee does not meet the criteria to be counted in the numerator. For example, if an enrollee is in a plan for 12 months and has face-to-face encounters on 1/31, 4/29 (88 days later), 7/27 (89 days later), and 11/10 (105 days later), the enrollee has had four encounters but two of the encounters were more than 90 days apart (7/27 to 11/10), so the enrollee should not be included in the numerator for this measure.

Case Manager Training (CMT)

Description: The percentage of case managers who have received four hours of required training on the mandate to report abuse, neglect, and exploitation.

Data Collection Method: Administrative or hybrid.

Eligible Population: Case managers within the plan network.

Continuous Enrollment: N/A

Exclusions: Case managers employed less than 90 days as of December 31 of the reporting year. Case managers who cease working for the plan prior to their anniversary date for receiving annual training. **Exclusions should be made prior to identifying the eligible population.**

Denominator:
Administrative method: The eligible population.

Note: The Health Plan must maintain a credentialing and training database that captures the date and training provided for each case manager in the network.

Hybrid method: A systematic sample drawn from the eligible population following the Healthcare Effectiveness Data and Information Set (HEDIS) Guidelines for Calculations and Sampling.

Numerator: The number of case managers who have been documented to have received training on the mandate to report abuse, neglect, and exploitation within required timeframes:

- Case managers employed less than one year: within 90 days of hire;
- Case managers employed one year or greater: within the calendar year.

Timeliness of Service (TOS)

Description: The percentage of newly enrolled members who receive services no later than14 days after development of their Plan of Care.

Data Collection Method: Administrative or hybrid

Eligible Population: All enrollees whose date of first enrollment occurred January 1 – December 1 of the measurement year, whose Plan of Care has been developed, and who have at least one of the following services in their Plan of Care. If a gap in enrollment occurred, the date of first enrollment should be included and any subsequent enrollment dates should be discarded.

Note: *In order for someone to be eligible for this measure, they must have a Plan of Care. This only measures services that are on the enrollee's Plan of Care. If the services provided are not on the enrollee's Plan of Care, they should not be counted for this measure (e.g., welcome meals).*

Continuous Enrollment: One month.

Exclusions: Enrollees who are in an Assisted Living Facility (ALF), Nursing Home Facility, Participant Directed Option, Inpatient, and enrollees who have refused services no later than 14 days after development of their Plan of Care.
***Exclusions should be applied prior to identifying the eligible population.**

Denominator: All enrollees in the eligible population who meet the continuous enrollment criteria.

Numerator: The number of enrollees who received at least one of the following services no later than 14 days after development of their Plan of Care:

- Home Health Services
    - Adult companion

  - Chore Services
  - Respite
  - Homemaker
  - Personal Care
- Adult Day Health
- Home Delivered Meals