Measure Information Form

Project Title:

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

Project Overview:

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

- People eligible for both Medicare and Medicaid, or "Dual eligible beneficiaries"
- People receiving long-term services and supports (LTSS) through managed care organizations
- People with substance use disorders; beneficiaries with complex care needs and high costs; beneficiaries with physical and mental health needs; or Medicaid beneficiaries who receive LTSS in the community

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

Date:

Information included is current on December 14, 2018.

1. Measure Name (Measure Title De.2):

New Medicaid LTSS Beneficiaries Using HCBS First

2. Descriptive Information

2.1 Measure Type (NQF Submission Form De.1.)

Outcome

2.2 Brief Description of Measure (NQF Submission Form De.3.)

This is the proportion of first-time Medicaid LTSS beneficiaries who, in the first calendar month of ever using LTSS, received HCBS only and not long-term institutional services.

2.3 If Paired or Grouped (NQF Submission Form De.4.)

Not applicable.

3. Measure Specifications

3.1 Measure-specific Web Page (NQF Submission Form S.1.)

Currently not applicable.

3.2 If this is an eCQM (NQF Submission Form S.2a.)
This is not an eCQM.

3.3 Data Dictionary, Code Table, or Value Sets (NQF Submission Form S.2b.)
No data dictionary/code table – all information provided in the Measure Information Form.

3.4 For Instrument-Based Measure (NQF Submission Form S.2c.)
Not applicable. This measure is not instrument-based.

3.5 For Endorsement Maintenance (NQF Submission Form S.3.1. and S.3.2.)
Not applicable.

3.6 Numerator Statement (NQF Submission Form S.4.)
Number of Medicaid beneficiaries included in the denominator (see 3.8 Denominator Statement and 3.9 Denominator Details) who used only HCBS (not long-term institutional services) during the first calendar month of receiving LTSS in measurement year. HCBS use is defined by (1) Medicaid 1915(c) HCBS waiver enrollment or use of 1915(c) HCBS waiver services, (2) use of HCBS offered through programs operating under federal Medicaid authorities (i.e., 1915[i], 1915[j], or 1915[k][1]), (3) use of HCBS state plan benefits, such as personal care services or adult day health services, or (4) enrollment in a managed long-term services and supports (MLTSS) program operating under any type of federal Medicaid authority and use of any HCBS. Institutional service use is defined by long-term nursing facility admissions or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) admissions.[2] LTSS users include both HCBS users and users of long-term institutional services.

3.7 Numerator Details (NQF Submission Form S.5.)
Number of Medicaid beneficiaries who, in the first calendar month of receiving any type of LTSS in measurement year, received HCBS only and not long-term institutional services. HCBS *only* LTSS users for a given month are defined in the following ways:

1. Enrollment in an HCBS 1915(c) waiver covering any of the following groups:
    a. Aged and Disabled
    b. Aged
    c. Physical Disabilities
    d. Intellectual Disabilities
    e. Intellectual and Developmental Disabilities
    f. Brain Injury
    g. HIV/AIDS
    h. Intellectually disabled/developmentally disabled
    i. Technology Dependent or Medically Fragile

[1] Currently, only five states operate the 1915(k) Community First Choice authority: California, Maryland, Montana, Oregon, and Texas.

[2] Nursing facility services may be provided as post-acute care for beneficiaries discharged from acute care settings. In particular, dual eligible beneficiaries may use skilled nursing facilities (SNFs) for post-acute care. This measure focuses on LTSS, so it only includes long-term institutional admissions, as defined in 3.7 Numerator Details.

j. Autism/Autism Spectrum Disorder
k. Developmental Disabilities
l. Mental Illness – Age 18 or Older[3]
m. Enrolled in 1915(c) waiver for unspecified or unknown populations

OR

2. Use of 1915(c) waiver services

OR

3. Use of HCBS offered through programs operating under the following federal Medicaid authorities:
    a. 1915(i) HCBS State Plan Option
    b. 1915(j) Self-Directed Personal Assistance Service Under State Plan
    c. 1915(k) Community First Choice

OR

4. Use of HCBS covered as state plan benefit, such as:
    a. Personal care services
    b. Private duty nursing
    c. Adult day services
    d. Home health services
    e. Residential care services
    f. Rehabilitation for the aged or disabled
    g. Targeted case management for the aged or disabled

OR

5. Enrollment in a MLTSS program operating under any type of federal Medicaid authority and use of any HCBS

AND

6. No long-term institutional care use. Long-term institutional care use is defined as follows by dual eligibility status:
    a. For Medicaid-only beneficiaries:
        i. Nursing facility admission with a length of stay of at least 101 days
        ii. Any ICF/IID admission
    b. For dual eligible beneficiaries:

[3] We excluded 1915(c) waiver for Mental Illness – Under Age 18 because this measure only includes beneficiaries age 18 and older.

i. Any nursing facility admission fully covered by Medicaid
ii. Any ICF/IID admission

3.8 Denominator Statement (NQF Submission Form S.6.)

Number of Medicaid LTSS beneficiaries ages 18 and older in the measurement year who did not receive any LTSS in the year (12 months) prior to first using any LTSS during measurement year.

3.9 Denominator Details (NQF Submission Form S.7.)

The denominator includes beneficiaries who meet the following criteria:

Age: 19 and older by January 1 of measurement year.

Time Period: The measurement period is 12 months, with up to an additional 12 months of data for the prior year to determine previous LTSS use, for a total data period of 24 months.

Benefit: Medicaid-only LTSS beneficiaries must be eligible for full Medicaid benefits (i.e., not restricted benefits) in each eligible month. Medicare-Medicaid dually eligible beneficiaries must also be eligible for full Medicaid benefits (i.e., not restricted benefits).

LTSS beneficiaries are defined for each month in measurement year and 12 months prior to first LTSS use in measurement year in two ways:

1. **HCBS user**: Any beneficiary who has any of the following characteristics: (1) enrollment in 1915(c) waiver or use of 1915(c) waiver services; (2) use of HCBS offered through programs operating under other federal authorities (i.e., 1915[i], 1915[j], or 1915[k]), (3) use of HCBS covered under state plan benefit, or (4) enrollment in a MLTSS program operating under any type of federal Medicaid authority and use of any HCBS (see Numerator Details 3.7 for more information on HCBS).

2. **Institutional care user**:
    a. For Medicaid-only beneficiaries: nursing facility admission with a length of stay of at least 101 days or any ICF/IID admission
    b. For dual eligible beneficiaries: any nursing facility admission or any ICF/IID admission that was fully covered by Medicaid (i.e., no cross-over benefits where Medicare partially paid for the institutional admission)

New LTSS user inclusionary criteria: To be included in the denominator, beneficiaries must have (1) LTSS service use during the measurement year (either HCBS or long-term institutional care, as defined above) and (2) no LTSS service use (either HCBS or long-term institutional care) in the 12 months prior to first LTSS use in measurement year.

3.10 Denominator Exclusions (NQF Includes “Exceptions” in the “Exclusion” Field) (NQF Submission Form S.8.)

Denominator exclusions will be determined during measure testing.

3.11 Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) (NQF Submission Form S.9.)

Denominator exclusions will be determined during measure testing.

3.12 Stratification Details/Variables (NQF Submission Form S.10.)

Stratification details will be determined during measure testing.

3.13 Risk Adjustment Type (NQF Submission Form S.11.)

Risk adjustment will be determined during measure testing.

3.14 Type of Score (NQF Submission Form S.12.)

Continuous variable.

3.15 Interpretation of Score (NQF Submission Form S.13.)

Better quality = higher score.

3.16 Calculation Algorithm/Measure Logic (NQF Submission Form S.14.)

Calculation of Unadjusted Rate

Step 1: Identify the denominator.

> Determine the denominator by identifying and counting all Medicaid LTSS beneficiaries ages 18 and older during measurement year who did not receive any LTSS (either HCBS or long-term institutional care service) in each month of the year (12 months) prior to using any LTSS (either HCBS or long-term institutional case service) during measurement year (see 3.9 Denominator Detail for definition of LTSS).

Step 2: Identify the numerator.

> Step 2A: For all beneficiaries included in the denominator population, determine the first month in which each beneficiary received LTSS during the measurement year (see 3.9 Denominator Detail for definition of LTSS).
>
> Step 2B: Identify and count all beneficiaries who used HCBS only and not long-term institutional services during their first month of LTSS use, as determined in Step 2A. HCBS use is defined by (1) Medicaid 1915(c) HCBS waiver enrollment or use of 1915(c) waiver services, (2) use of HCBS offered through programs operating under federal Medicaid authorities (i.e., 1915[i], 1915[j], or 1915[k]), (3) HCBS covered under state plan benefit, or (4) enrollment in a MLTSS program operating under any type of federal Medicaid authority and use of any HCBS. Long-term institutional service use is defined by nursing facility admissions with a length of stay of at least 101 days (for Medicaid-only beneficiaries), any nursing facility admissions (for dual eligible beneficiaries), or any ICF/IID admissions (for both Medicaid-only and dual eligible beneficiaries).

Step 3: Calculate the proportion of Medicaid LTSS beneficiaries first receiving HCBS by dividing the number of beneficiaries who used HCBS first in measurement year

(numerator as described in Step 2) by the number of Medicaid LTSS beneficiaries who did not receive any LTSS in the year (12 months) prior to using any LTSS during the measurement year (denominator as described in Step 1).

Calculation of Risk-Adjusted Rate

Risk-adjusted rates will be calculated after measure testing.

3.17 Sampling (NQF Submission Form S.15.)
Not applicable. This measure does not use sampling.

3.18 Survey/Patient-Reported Data (NQF Submission Form S.16.)
Not applicable.

3.19 Data Source (NQF Submission Form S.17.)
Claims

3.20 Data Source or Collection Instrument (NQF Submission Form S.18.)
Medicare and Medicaid Claims:

- Medicaid claims – T-MSIS Analytic Files (TAF):
  - TAF Beneficiary Summary File (BSF)
  - TAF Other Services file (OT)
  - TAF Long-Term Care file (LT)

3.21 Data Source or Collection Instrument (Reference) (NQF Submission Form S.19.)
Not applicable. No data collection instrument provided.

3.22 Level of Analysis (NQF Submission Form S.20.)
Population Level: State (total state-level first-time Medicaid LTSS population)

3.23 Care Setting (NQF Submission Form S.21.)
Home Care (HCBS)

Other: Long-term care in nursing facilities, ICF/IID

3.24 Composite Performance Measure (NQF Submission Form S.22.)
Not applicable. This measure is not a composite measure.