Long-Term Services and Supports Distinction

Standards for Long-Term Services and Supports

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LTSS 1: Core Features

The organization has processes in place that organizations can use as a foundation for coordinating long-term services and supports (LTSS).

Intent

The organization uses current best practices to coordinate LTSS to eligible members.

Element A: Program Description

The description of the organization's case management program includes:

1. **Criteria for identifying members who are eligible for the program.**
2. **Services offered to members.**
3. **Evidence and professional standards used for program operations.***
4. **Defined program goals.**
5. **How case management services are coordinated with the services of others involved in members' care.**
6. **How the organization promotes health equity.**

Critical factors: Score cannot exceed Partially Met if one critical factor is scored "no."

Scoring

Met	Partially Met	Not Met
The organization meets 4-6 ~~5~~ factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source

Documented process

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's program description.

NCQA scores this element for each program the organization brings forward for distinction. The score for the element is the average of the scores for all programs.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

Factor 3 is a critical factor; if this critical factor is scored "no" the organization's score cannot exceed Partially Met for each program.

Case management is a collaborative process of assessment, planning, facilitation, coordination, evaluation and advocacy for supports and services to meet the needs of a member while promoting quality and cost-effective outcomes.

Long-term services and supports is care for older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their

ability to care for themselves. The program description should identify all populations served, and may include:

- Individuals 65 and older.
- Individuals with intellectual/developmental disorders .
- Adults with disabilities.
- Children with disabilities.
- Traumatic brain injury.
- Acquired brain injury.
- Serious mental illness.
- Serious emotional disturbance.
- Mental health/substance use disorder.
- Foster care/adult family care.
- Others.

The overall goal of case management long-term services and supports programs is to help members function optimally in their preferred setting.

Factor 1: **Eligibility criteria**

A **purchaser** is an entity (e.g., state, health plan) that purchases services provided by the organization.

The program description states the eligibility criteria for the case management program. Eligibility criteria may be set by the purchaser. NCQA does not require the organization to use specific criteria.

Factor 2: **Services**

The program description specifies services available to eligible members across all programs the organization brings forward for distinction. The organizations may provide the services directly or may arrange for the services to be provided by other entities.

Factor 3: **Evidence and professional standards**

Professional standards of care are stated ethical or legal requirements to exercise the level of care, diligence and skill prescribed in a profession's code of practice.

The program description specifies the evidence and professional standards the organization uses to determine which services it offers to members and how it provides services.

Evidence derives from:

- Scientific evidence from technical literature or government research sources.
- Literature reviews on best practices (e.g., motivational interviewing, methods to improve health literacy).

Evidence includes:

1. Guidelines.
2. Statements of recommendation.
3. Algorithms or materials created through an unbiased and transparent process of systematic review, appraisal and best practices to aid in the delivery of optimum care.

The program description includes professional standards that may be derived from:

- MCOs or state waiver requirements.
- Standardized techniques.
- Specialized models (e.g., chronic care, patient-centered care nursing model).

***Factor 4*: Program goals**

The program description includes the organization's desired level of achievement expressed in explicit, measurable objectives and targets for the case management program. Goals must go beyond mission and vision statements.

***Factor 5:* Case management coordination**

Coordination is essential to optimizing care delivery for members receiving services through multiple programs. The program description includes how care is coordinated with other programs and services the member is receiving outside the case management organization.

***Factor 6:* Promote health equity**

The World Health Organization defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."

The program description describes its commitment to improving health equity and the actions it takes to promote equity in management of LTSS individual care. The organization determines how, and in what areas, it will promote health equity, and describes a plan for at least one action.

Exceptions

None.

Related information

Factors 2, 3: Services and evidence of professional standards. The organization may have a contractual relationship with a state or other purchaser that specifies services it must offer or tools it must use to operate the program (e.g., a specific needs assessment tool). In this case, the organization provides requirements of the state or purchaser and presents evidence for the models of care or tools it uses for program components that are not dictated by contractual or regulatory requirements.

Examples

***Factor 2:* Services**

- Care coordination, including arranging appointments and referrals to community resources.
- Case management plan development, with person-centered goals.
- Assistance with navigating the appeal process and/or information about resources, agencies or advocacy groups that individuals can use or be connected with to aid the appeal process.
- Self-management plan development and monitoring.
- Self-directed services.
- Personal care assistance.
- Housekeeping and chore services.
- Money management.

- Transportation.
- Housing-related services.

Factor 3: **Evidence and professional standards**

The organization uses a combination of evidence and professional standards to support staff interactions with members, which may be derived from its research or from research organizations such as:

- Administration for Community Living.
- Administration on Aging.
- ADvancing States (formerly National Association of States United for Aging and Disabilities).
- American Case Management Association.
- American Nurse Association Guidelines.
- American Society on Aging.
- Association for Behavioral Analysis International.
- Case Management Society of America.
- Leadership Council of Aging Organizations.
- National Association of Social Workers.
- National Association of State Directors of Developmental Disabilities Services.
- National Coalition of Care Coordination.
- National Core Indicators–Aging and Disabilities.
- National Council on Independent Living.
- Society of Medicaid Medical Directors.
- The John A. Hartford Foundation.
- The SCAN Foundation.

Factor 4: **Program goals**

- 30% of participants served for 6 months or longer report that their quality of life improved since the initial assessment.
- Improve member experience with the program by 20% during the calendar year.
- 85% of members served in the community for at least 6 months have no long-term nursing home stays.
- Reduce 30-day hospital readmissions by 10%.
- Increase rates of supported employment by 25%.

Factor 5: **How case management services are coordinated**

Coordination of case management program and services may include:

- Medical providers, including palliative care providers.
- Behavioral healthcare providers.
- Social services providers, such as housing, employment supports, nutritional assistance.
- Case managers from other organizations the member is affiliated with (discharge care managers, health plan care managers).
- Caregivers.

Element B: Service Authorization

The organization describes the process and criteria used to authorize and deny:

1. **Initial service requests.**
2. **Any additional service requests.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's process for authorizing service for initial requests and making updates to existing requests based on the care plan.

Look-back period

For All Surveys: Prior to the survey date.

Explanation

Service authorization includes the determination of the amount (hours) and types of long-term services supports to be provided to members. The organization describes its process for authorizing long-term services and supports for initial service requests and any additional service requests. The organization's process must outline:

- The criteria used in service authorization for initial requests.
- The criteria used when either reducing or increasing hours to additional service requests.
- Time frames for authorizing service for initial requests and additional service requests.
- The documentation required to authorize service requests.

At a minimum, the organization considers how the care plan and reassessments to the care plan are incorporated in the decision-making process when authorizing or denying service for requests.

Exceptions

None.

Element C: Notification of Service Authorization

The organization has a process for notifying members of service denials that includes the following information:

1. **The specific reasons for the denial, in easily understandable language.**
2. **A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.**
3. **How the care plan is used to determine the denial decision.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's process for notifying members of service denials.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factor 1:* Reason for denial**

The process for notifying members of a denial of service describes the reason for the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and the appropriate professional (e.g., practitioner, case manager, nurses, social workers, social service providers) understands why the organization denied the request and has enough information to file an appeal.

The process states that the notification includes a complete explanation of the grounds for the denial, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

***Factor 2:* Reference to criterion**

The process references the criterion used to make the denial decision that is specific to the member's condition or to the requested services.

The referenced criterion must be identified by name and must be specific to an organization or source. If the criterion's source is the organization, it is acceptable to state "our Criteria for XXX" (e.g., "our Criteria for Treating Adults with an Intellectual/Developmental Disability").

***Factor 3:* Care plan**

The process describes how the member's care plan is used to guide the denial decision.

Exceptions

None.

Examples None.

Element D: Demographic Data Collection

The organization has a process for collecting the following demographic data from individuals:

1. **Race/ethnicity.**
2. **Language.**

Scoring

Met	Partially Met	Not Met
The organization meets 1-2 factors	No scoring option	The organization meets 0 factors

Data source Documented process

Scope of review *For All Surveys:* NCQA reviews the organization's documented process for collecting individual's demographic data, and reviews reports or materials demonstrating the data collection.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

Though it is voluntary for individuals to report race/ethnicity and language, the organization must attempt to collect it. The organization may collect data directly at various points of interaction with individuals or may utilize other mechanisms that make a direct request for the data (electronic health records, health information exchanges, state or local agencies).

The organization's process for collecting race/ethnicity and language includes:

- A defined process for soliciting information from individuals if a response was requested but not provided.
- When data will be collected.
- Where data will be collected (setting).
- How data will be collected (method) and by whom (e.g., case manager, staff member).
- Questions that will be used to collect data (to guide staff who collect or assess data verbally).

Factor 1: **Race/ethnicity**

The organization collects race/ethnicity using the OMB race/ethnicity categories. The organization may use race/ethnicity categories that are more detailed than the OMB race/ethnicity categories, as long as the organization has the ability to roll up to OMB race/ ethnicity categories.

OMB categories. In 1977, the OMB issued the Race and Ethnic Standards for Federal Statistics and Administrative Reporting that are set forth in Statistical Policy Directive No. 15. The federal government uses these standards for recordkeeping, collection and presentation of data on race and Hispanic origin, and they form the

basis for race/ethnicity data collection for many health care organizations. They have been used in two decennial censuses and in surveys of the population; in data collections to meet statutory requirements for civil rights monitoring and enforcement; and in other administrative program reporting.

The organization must be able to report race/ethnicity using the OMB categories, including the response option of "Other." While the OMB recommends a two-question format, asking for ethnicity before race, the organization may also use a combined format. In both cases, the IOM recommends that respondents be instructed to select one or more categories that may apply (Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement http://www.nap.edu/catalog/12696.html).

OMB two-question format

- Ethnicity
  - Hispanic or Latino
  - Not Hispanic or Latino
  - (Declined)
- Race (select one or more)
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - White
  - Asian
  - American Indian or Alaska Native
  - Some other race
  - (Declined)
- OMB combined format (check all that apply)
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Hispanic or Latino
  - Native Hawaiian or Other Pacific Islander
  - White
  - Other, please specify:
  - (Declined)

Organizations may use another method to ask these questions if responses can be systematically aggregated to OMB categories.

***Factor 2:* Language**

The organization collects language data on the individuals it serves and identifies the threshold languages for translation purposes. **Threshold languages** are all languages other than English spoken by 5% percent of the population.

The organization may use the National Academy of Medicine (NAM) recommendation to evaluate language needs or may use another method of asking about language preference if it describes the process. The NAM recommends the use of two questions to determine language needs:

- Spoken English Language Proficiency (Very well, Well, Not well, Not at all), with limited English proficiency , defined as "less than very well."

- Spoken Language Preferred for Health Care, using locally relevant choices from a national standard list, plus a response option for "Other, please specify," and including American Sign Language (ASL) in the spoken language need list.

The NAM also recommends collecting preferred language for written materials where possible, and including Braille, when written language is elicited.

The organization may use language needs information obtained directly from individuals to enable communication in the requested language (e.g., written information in a language other than English). The organization may also share language needs information with practitioners and providers, enabling them to provide language services more effectively. The organization must also disclose to individuals the possibility of the information being shared.

Exception

None.

Related information

The organization should use as many channels as available to collect race/ethnicity and language from individuals. However, asking all individuals to self-identify race/ethnicity and language may yield initial results from only a small percentage of individuals. The organization may utilize estimation methods to supplement its understanding of an individual's race/ethnicity and language. If an individual is unable to provide a response (e.g., due to age or functional inability to communicate), data collected from the individual's caregiver meets the intent.

Examples

Data collection mechanisms and OMB categories

- Enrollment forms, if not prohibited by state law.
- The organization's website.
- Surveys.
- Calls to Member Services.
- Population health management intake or programs involving enrollment or registration.
- Health assessments.
- Data feeds from a state Medicaid agency that directly collects race/ethnicity data that can be rolled up to OMB categories.

HRET Toolkit.[1] The Health Research and Educational Trust (HRET) Toolkit, endorsed by the National Quality Forum (NQF), provides detailed instructions for direct data collection of race/ethnicity data and may serve as a guide for asking about race/ethnicity. The toolkit uses the OMB categories with additional options, including "Declined" and "Multiracial." Although NCQA does not currently require organizations to follow NAM data collection recommendations, organizations are advised to add a response option for "Other (specify)" and to replace the "multiracial" response option with "Select all that apply."

USCDI.[2] The United States Core Data for Interoperability version 2 (USCDI v2), released by the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology (ONC), is a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange. NCQA does not currently require organizations to follow the USCDI data collection categories, which are more granular than OMB categories.

Third-party sources of direct data

- Health plans.
- State Medicaid agencies.
- State or federal agencies (e.g., CMS).
- Health care providers.
- Health care practitioners.

Framework for asking about language

The HRET Toolkit provides detailed instructions for direct collection of language data.

[1]hretdisparities.org
[2]https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v2

Element E: Privacy Protections for Data

The organization has policies and procedures for managing access to and use of race/ethnicity and language data, including:

1. **Controls for physical and electronic access to the data.**
2. **Permissible use of the data.**
3. **Impermissible use of the data, including underwriting and denial of coverage and benefits.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	No scoring option	The organization meets 0-2 factors

Data source Documented process

Scope of review *For All Surveys:* NCQA reviews the organization's policies and procedures in place throughout the look-back period for managing access to and use of race/ethnicity and language data.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation This element is a **structural requirement.** The organization must present its own documentation.

The organization's policies and procedures for managing access to and use of race/ethnicity and language data may be integrated with its HIPAA privacy policies or may be separate. If the organization's privacy policies are intended to include race/ethnicity and language information in addition to HIPAA-defined PHI, this must be explicitly stated.

***Factor 1:* Access to data**

The organization has policies and procedures to govern and track the receipt, removal of and access to devices and media that contain individual-level race/ethnicity and language data or that may be used to access these data. Policies

and procedures cover media, devices and hardware movement, data storage, disposal and reuse of media and devices.

Media include, but are not limited to:

- Diskettes, CDs, tapes and mobile applications.
- Portable drives.
- Laptops.
- Secure portals.

To minimize the risk of impermissible access to sensitive information, the organization has a process for limiting employee access and for terminating access of employees who are no longer authorized to have access.

Factors 2, 3: **Permissible and impermissible uses**

The organization outlines permissible and impermissible uses of the data. Impermissible use explicitly includes underwriting and denial of services, coverage and benefits.

If the organization shares data with entities, it outlines the process for sharing data. The organization describes the methods or systems for data sharing, including how information is securely shared and received.

Exceptions

None.

Examples

Factor 1: **Data access control**

- Maintain paper documents in locked file cabinets.
- Require that protected electronic data remain on physically secure media.
- Maintain electronic data in password-protected files.

Factor 2: **Permissible uses of data**

- Assess health care disparities.
- Design intervention programs.
- Design and direct outreach materials.
- Share data to inform health care practitioners and providers about individuals' language needs and pronouns.
- Provide referrals for nonclinical services.

Factor 3: **Impermissible uses of data**

- Perform underwriting, rate setting or benefit determinations.
- Disclose to unauthorized users or organizations.

Element F: Assessment of Health, Functioning and Communication Needs

The organization's case management process includes the following assessments:

1. **Health status, including condition-specific issues.**
2. **Clinical history, including medications.**
3. **Activities of daily living, including use of supports.**
4. **Instrumental activities of daily living, including use of supports.**
5. **Behavioral health status.**
6. **Cognitive functioning.**
7. **~~Social determinants of health~~ Social needs.***
8. **Social functioning.**
9. **Health beliefs and behaviors.**
10. **Cultural and linguistic needs, preferences or limitations.**
11. **Visual and hearing needs, preferences or limitations.**
12. **Physical environment for risk.**

Critical factors: These factors must be scored "yes" to score at least Partially Met.

Scoring

Met	Partially Met	Not Met
The organization meets 6-12 factors	The organization meets 4-5 factors	The organization meets 0-3 factors

Data source

Documented process

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

For All Surveys: For factor 7: Prior to the survey date.

Explanation

This element is a **structural requirement**. The organization presents its own documentation.

Factor 7 is a critical factor; if this critical factor is scored "no," the organization's score cannot exceed Partially Met for the element.

At a minimum, case management policies and procedures address how the organization documents and confirms that assessments have been completed. Assessments are not required to take place in a single encounter.

If another organization conducts assessments, the case management process explains how the organization obtains and documents the information.

If a state-mandated tool is used for assessments, the organization documents how factors not addressed by the tool are evaluated.

HEDIS LTSS measures

Organizations may submit performance results on the Comprehensive Assessment and Update (LTSS-CAU) measure instead of providing a documented process. If an organization chooses this voluntary option, it must meet the 5% threshold rate on the measure to receive credit.

Assessment

Assessment requires the case manager or other qualified individual to reach and document a conclusion about data or information collected. If the organization's CM system automatically generates suggestions, the case manager or other individual must still document their own conclusions. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

The organization must reach a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.

Case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.

Factor 1: Assessment of members' health status

Case management policies and procedures specify a process for assessing a member's health status, including active diagnoses. Assessment includes:

- Screening for presence or absence of physical conditions and their current status.
- The member's self-reported health status.
- Current medications, including schedules and dosages.

Factor 2: Documentation of clinical history

Case management policies and procedures specify a process for documenting clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Relevant past medications.

The information may be reported by the member or collected from another source.

Factor 2 does not require assessment or evaluation.

Factor 3: Assessment of activities of daily living

Case management policies and procedures specify a process for assessing functional status related to activities of daily living, such as eating, bathing and mobility. Supports include both assistive technology and human assistance needed to complete a certain activity.

Factor 4: Assessment of instrumental activities of daily living

Case management policies and procedures specify a process for assessing functional status related to instrumental activities of daily living, such as housekeeping, money management and ability to navigate transportation.

Supports include both assistive technology and human assistance needed to complete a certain activity.

Factor 5: **Assessment of behavioral health status**

Case management policies and procedures specify a process for assessing behavioral health status, including:

- Mental health conditions.
- Substance use disorders.

Factor 6: **Cognitive functioning**

Case management policies and procedures specify the process for assessing cognitive function, including:

- The member's ability to communicate and understand instructions.
- The member's ability to process information about an illness.

Factor 7: **Assessment of social needs ~~determinants of health~~**

Social needs are the nonclinical needs individuals identify as essential to their well-being. Case management policies and procedures specify a process for assessing at least three of the following social needs that may affect an individual's ability to meet goals:

- Financial insecurity.
- Food insecurity.
- Housing stability.
- Access to transportation.
- Interpersonal safety.

~~Social determinants of health~~ are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. Case management policies and procedures specify a process for identifying social determinants of health that may affect a member's ability to meet goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

Factor 8: **Assessment of social functioning**

Social functioning refers to an ability to interact easily and successfully with other people. Case management policies and procedures specify a process for assessing social functioning that may affect a member's mental and physical health.

Factor 9: **Assessment of health beliefs and behaviors**

Health beliefs and behaviors may reflect cultural and social beliefs about health problems, perceived benefits of action and barriers to action. Case management policies and procedures specify a process for assessing health beliefs and behaviors (e.g., optimism, self-efficacy, nutrition habits, physical activity and alcohol and tobacco use) that could improve or impede a member's ability to adhere to the case management plan.

***Factor 10:* Assessment of cultural and linguistic needs**

Case management policies and procedures specify a process for assessing culture and language to identify potential needs or barriers to effective communication or care and acceptability of specific treatments. Policies and procedures also include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

***Factor 11*: Assessment of visual and hearing needs**

Case management policies and procedures specify a process for assessing vision and hearing needs to identify potential needs or barriers to effective communication, care or well-being.

***Factor 12:* Assessment of risk in physical environment**

Case management policies and procedures specify a process for assessing a member's physical environment to identify risks.

Exceptions

None.

Examples

***Factor 2:* Clinical history**

- Past inpatient stays.
- Medication list.
- Symptom history.
- Exposure to toxins.
- Health care providers regularly seen by the member.

***Factor 3:* Activities of daily living**

- Grooming.
- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).
- Continence.
- Walking.

***Factor 4:* Instrumental activities of daily living**

- Managing finances.
- Shopping.
- Preparing meals.
- Managing medications.
- Housework and basic home maintenance.
- Handling transportation (driving or navigating public transit).
- Using the telephone and other communication devices.

***Factor 5:* Behavioral health status**

- Substance use disorders.
- Suicidal ideation.

- Depression.
- Psychosis.

Factor 6: **Cognitive functioning**

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

~~***Factor 7:*** **Social determinants of health**~~

~~- Current housing and housing security.~~
~~- Access to local food markets.~~
~~- Exposure to crime, violence and social disorder.~~
~~- Residential segregation and other forms of discrimination.~~
~~- Access to mass media and emerging technologies.~~
~~- Social support, norms and attitudes.~~
~~- Access to transportation and financial barriers to obtaining treatment.~~

Factor 8: **Social functioning**

- Engagement with friends and family.
- Social isolation.
- Employment status.

Factor 9: **Health beliefs and behaviors**

- Optimism.
- Self-efficacy.
- Physical activity.
- Smoking.
- Alcohol use.
- Medication adherence.
- Beliefs and concerns about the condition or services the member is receiving.

Factor 10: **Cultural and linguistic preferences**

- Health care treatments or procedures discouraged or forbidden by religious or spiritual beliefs.
- Family traditions related to decision-making, illness, death and dying.
- Health literacy assessment.

Factor 11: **Visual and hearing needs**

- Visual impairment and need for, or use of, visual aids (e.g., talking clocks, large-font prescription labels).

- Hearing impairment and need for, or use of, hearing aids or other supports or devices (e.g., sign language interpreters, bed shakers).

Factor 12: **Physical environment for risk**

- Home-based initial assessment for fall risks, medication risks, accessibility of exits, access to emergency assistance (e.g., telephone, medical alert service).

Element G: Resource Assessment

The organization's case management process specifies assessment of the following resources:

1. **Paid and unpaid caregiver resources, involvement and needs.**
2. **Available benefits within the organization.**
3. **Community resources.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures for assessing resources in place throughout the look-back period.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element is a **structural requirement**. The organization presents its own documentation.

At a minimum, case management policies and procedures address how the organization documents and confirms that assessments have been completed for each member. Assessments are not required to take place in a single encounter.

If a state-mandated tool is used for the assessment, the organization documents how factors not addressed by the tool are evaluated.

HEDIS LTSS measures

Organizations may submit performance results on the Comprehensive Assessment and Update (LTSS-CAU) measure instead of providing a documented process. If an organization chooses this voluntary option, it must meet the 5% threshold rate on the measure to receive credit.

Assessment

Assessment requires the case manager or other qualified individual to reach and document a conclusion about data or information collected. If the organization's CM system automatically generates suggestions, the case manager or other

individual must still document their own conclusions. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

The organization must reach a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.

Case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.

Factor 1: **Assessment of caregiver resources**

Case management policies and procedures specify a process for assessing the adequacy of paid and unpaid caregiver resources (e.g., family involvement in the case management plan and in carrying out the plan). Evaluation assesses availability, skills and caregiver capacity to provide support and considers and anticipates undue burden on the caregiver (e.g., unreasonable stress or strain) and caregiver support needs (e.g., training, respite).

Factor 2: **Assessment of available benefits**

Case management policies and procedures specify a process for assessing the adequacy of health benefits and available resources to fulfill the case management plan.

Factor 3: **Assessment of community resources**

Case management policies and procedures specify a process for assessing eligibility for supplemental community resources (e.g. organizations, facilities, services) that can address social determinants of health or other needs or barriers identified in the assessment. The assessment includes a determination of eligibility for supplemental community resources.

Exceptions

None.

Examples

Factor 1: **Caregiver resources**

- The member is independent and does not need caregiver assistance.
- Number of caregivers, and current assistance provided.
- Caregiver needs for training supportive services.

Factor 2: **Available benefits**

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization is contracted to provide, such as:
  - Community mental health.
  - Subsidized housing.
  - Palliative care programs.

Factor 3: **Community resources**

- Community mental health.
- Vocational programs.
- Volunteer companion services.
- Government aid (e.g., food stamps, maternal-child health programs, housing assistance).
- Senior centers.
- Adult day care.
- Support groups.
- Poverty outreach groups.
- Housing resources.
- Legal aid.
- Palliative care programs.

Element H: Comprehensive Assessment Implementation

An NCQA review of a sample of the organization's case management files demonstrates that the organization follows its documented processes for assessing:

1. **Health status, including condition-specific issues.**
2. **Clinical history, including medications.**
3. **Activities of daily living, including use of supports.**
4. **Instrumental activities of daily living, including use of supports.**
5. **Behavioral health status.**
6. **Cognitive functioning.**
7. **~~Social determinants of health~~ Social needs.**
8. **Social functioning.**
9. **Health beliefs and behaviors.**
10. **Cultural and linguistic needs, preferences or limitations.**
11. **Visual and hearing needs, preferences or limitations.**
12. **Physical environment for risk.**
13. **Paid and unpaid caregiver resources, involvement and needs.**
14. **Available benefits within the organization.**
15. **Community resources.**

Scoring

Met	Partially Met	Not Met
High (90-100%) on file review for at least 8 factors and medium (60-89%) on file review for any remaining factors	Low (0-59%) on file review for no more than 5 factors and high (90-100%) or medium (60-89%) on file review for any remaining factors	Low (0-59%) on 6 or more factors

Data source Records or files

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews assessments in a random sample of up to 40 case management files. Files are selected from active or closed cases that were identified during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for case management.

The organization must provide the identification date for each case in the file universe

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

For All Surveys: For factor 7: Prior to the survey date.

Explanation This element evaluates the organization's assessment of health status, functioning, communication needs and resources, according to the policies evaluated in Element B and Element C.

HEDIS LTSS measures

Organizations may submit performance results on the Comprehensive Assessment and Update (LTSS-CAU) measure instead of completing the file review. If an organization chooses this voluntary option, it must meet the 90% threshold rate on the measure to receive credit.

Documentation to meet the factors includes evidence that assessments were completed and results were documented. A checklist of assessments without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member's family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient's family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified for case management.

Dispute file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment

Assessment requires the case manager or other qualified individual to reach and document a conclusion about data or information collected. If the organization's CM system automatically generates suggestions, the case manager or other

individual must still document their own conclusions. For factors that require assessment, raw data or answers to questions do not meet the requirement.

There is a documented summary of the information's meaning or its implications for the member's situation, for use in the case management plan.

The organization must reach a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.

Files excluded from review

The organization excludes files from review that meet these criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members enrolled in case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence of the member's identification date and that the member was in case management for less than 60 calendar days during the look-back period.
- Employees of the organization and their dependents.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors. NCQA confirms that the files met the criteria for an NA score.

***Factor 1: A*ssessment of member's health status**

The file or case record documents a case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.
- Current medications, including dosages and schedule.

***Factor 2:* Documentation of clinical history**

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Past medications.

Dates are a necessary component of accurate documentation of the member's clinical history. To the extent possible, the organization collects dates as part of documenting clinical history; however, NCQA does not penalize an organization if a member or other individual providing the information cannot provide dates.

Factor 2 does not require assessment or evaluation.

Factor 3: **Assessment of activities of daily living**

The file or case record documents the results of the assessment of activities of daily living.

For activities the member needs assistance with, the case manager documents the reason and type of assistance. The case manager is not required to describe activities for which the member does not need assistance.

If the member needs no assistance with activities of daily living, the file or case record documents this (e.g., "Member is fully independent").

Factor 4: **Assessment of instrumental activities of daily living**

The file or case record documents the results of the assessment of instrumental activities of daily living.

For activities the member needs assistance with, the case manager documents the reason and type of assistance. The case manager is not required to describe activities for which the member does not need assistance.

If the member needs no assistance with instrumental activities of daily living, the file or case record documents this (e.g., "Member is fully independent").

Factor 5: **Assessment of behavioral health status**

The file or case record documents the case manager's assessment of:

- Mental health conditions.
- Substance use disorders.

Factor 6: A**ssessment of cognitive functioning**

The file or case record documents the case manager's assessment of:

- Cognitive functions.
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.

Factor 7: **Assessment of social needs ~~determinants of health~~**

The case manager assesses social needs ~~determinants of health~~, which are the nonclinical needs individuals identify as essential to their well-being. The file or case record documents the case managers assessment of at least three of the following:

- Financial insecurity.
- Food insecurity.
- Housing stability.
- Access to transportation.
- Interpersonal safety.

~~economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes, and assesses risks that may affect a member's ability to meet goals.~~

~~Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.~~

Factor 8: **Assessment of social functioning**

The file or case record documents the case manager's assessment of social functioning that may affect a member's mental and physical health.

Factor 9: **Assessment of health beliefs and behaviors**

The file or case record documents the case manager's assessment of health beliefs and behaviors (e.g., optimism, self-efficacy, nutrition habits, physical activity and alcohol and tobacco use).

Factor 10: **Assessment of cultural and linguistic needs**

The file or case record documents the case manager's assessment of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.
- Preferred languages.

Factor 11**: Assessment of visual and hearing needs**

The file or case record documents the case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

Factor 12**: Assessment of physical environmental risk**

The file or case record documents the case manager's assessment of the member's physical environment and identifies risks.

Factor 13: **Assessment of caregiver resources**

The file or case record documents the case manager's assessment of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) whether paid or unpaid, during initial member assessment. Documentation describes the resources in place and whether they are sufficient for the member's needs, and notes specific gaps to address.

Factor 14: **Assessment of available benefits**

The file or case record documents the case manager's evaluation of the adequacy of the member's health insurance benefits in relation to the needs of the case management plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether the resources available to the member are adequate to fulfill the case management plan.

Factor 15: **Assessment of community resources**

The file or case record documents the case manager's evaluation of the member's eligibility for community resources and the resources the member may need, and their availability.

If the member needs no community resources, the file or case record reflects this (e.g., "Member does not need community resources").

Exceptions

None.

Examples None.

Element I: Person-Centered Assessments

The organization has a process to:

1. **Assess members' service needs.***
2. **Assess members' ~~prioritized~~ person-centered goals.***
3. **Assess members' preferences.***
4. **Assess members' life planning activities.**
5. **Identify members' preferred method of communication.**

Critical factors: Score cannot exceed Partially Met if one critical factor is scored "no." Score cannot exceed Not Met if two or more critical factors are scored "no."

Scoring

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source

Documented process

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's process for completing person-centered assessments.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element is a **structural requirement**. The organization presents its own documentation.

Factors 1, 2 and 3 are critical factors; if one critical factor is scored "no" the organization's score cannot exceed Partially Met for the element. If two or more critical factors are scored "no," the organization's score cannot exceed Not Met for the element.

HEDIS LTSS measures

Organizations may submit performance results on the Comprehensive Care Plan and Update (LTSS-CPU) measure instead of providing a documented process. If an organization chooses this voluntary option, it must meet the 5% threshold rate on the measure to receive credit.

Person-centered planning involves viewing, listening to and supporting members, based on their strengths, abilities, aspirations and preferences, to make decisions for maintaining a life that is meaningful to them. The resulting care plan reflects the goals and interests of the member. Members should be involved in the care planning process to the extent they prefer.

A caregiver who is involved in the plan development process may contribute to discussions about goals and other aspects of the process, but may not define goals for a member.

***Factor 1:* Assessment of service needs**

Case management policies and procedures specify a process for assessing which services the member needs. The assessment includes a documentation of the services the member receives.

***Factor 2:* Assessment of ~~prioritized~~ person-centered goals**

A member's goals are the foundation of person-centered care planning and address a desired outcome. Person-centered goals must be SMART: specific, measurable, attainable, relevant and time-bound (have a target completion date). Case management policies and procedures specify a process for assessing members' goals and priorities, which the organization uses to develop a person-centered case management plan (assessed in Element F). Designating goals as long-term or short-term is not sufficient to meet the requirement. The organization must rank or prioritize goals.

***Factor 3*: Assessment of preferences**

Preferences refer to members' inclinations toward lifestyle, living situation and how care is to be provided. Case management policies and procedures specify a process for assessing personal preferences for how case management and LTSS are delivered.

***Factor 4*: Assessment of life-planning activities**

A member's expressed preferences can influence a case management plan. Case management policies and procedures specify a process for assessing whether members have completed life-planning activities such as wills, living wills, advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment forms.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If life planning activities are determined not to be appropriate, the case manager documents the reason in the case management record or file. A designated representative can make decisions on behalf of members who are incapacitated and cannot communicate life-planning preferences.

Documentation that the organization provided life planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this requirement.

***Factor 5*: Preferred communication methods**

Case management policies and procedures specify a process for assessing a member's preferred method to receive communications from the organization (e.g., email, text, mail, phone).

Exceptions

None.

Examples

***Factor 1:* Service needs**

- Modifications to the home.
- Transportation services.
- Meal delivery.

Factor 2: **Goals**

- Go back to school.
- Volunteer at the local shelter.
- Go out with friends.
- Continue to live in my own home.
- Go to church.
- Attend my card game.

Factor 3: **Preferences**

- Where to live.
- With whom to live.
- When to go to bed.
- When and what to eat.
- Whom to involve in care planning.
- Which services and service providers to use.

Factor 4: **Life-planning activities**

- Legal documents, including wills, health care power of attorney.
- Designation of people permitted to make decisions on behalf of the member, obtain information about the member's health status and services received, be notified about transitions in care.
- Providing life-planning information (e.g., brochure, pamphlet) to all members in case management.
- Plan for caregiver transition in the event of death or illness that would prevent the caregiver from assisting the member.

Element J: Person-Centered Care Planning Process

The organization's care planning procedures address:

1. **Development of an individualized case management plan that includes services needed members' preferences and ~~prioritized~~ person-centered goals.***
2. **Identification of barriers to meeting members' goals and preferences or implementing the plan.**
3. **Development of a schedule for follow-up and communication with members.**
4. **Development of a plan for follow-up and communication with LTSS providers.**
5. **Development of an emergency back-up plan.**
6. **Development of a self-management plan.**
7. **Facilitation of referrals to resources and a follow-up process to determine whether members acted on referrals.**
8. **A process to capture whether members received services identified in the case management plan.**
9. **A process to assess members' progress against case management plans, at least every 12 months.**
10. **Assessing progress against one person-centered goal.**

Critical factors: Score cannot exceed Partially Met if one critical factor is scored "no."

Scoring

Met	Partially Met	Not Met
The organization meets 8-10 ~~9~~ factors	The organization meets 4-7 factors	The organization meets 0-3 factors

Data source Documented process

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's process for creating individualized, person-centered case management plans.

Look-back period

For First Surveys: 6 months; prior to the survey date for factor 10.

For Renewal Surveys: 24 months; prior to the survey date for factor 10.

Explanation

This element is a **structural requirement**. The organization presents its own documentation.

Factor 1 is a critical factor; if this critical factor is scored "no" the organization's score cannot exceed Partially Met for the element.

HEDIS LTSS measures

Organizations may choose to meet this element by submitting performance results on the Comprehensive Care Plan and Update (LTSS-CPU) measure instead of providing a documented process. If an organization chooses this voluntary option, it must meet the 5% threshold rate on the measure to receive credit.

***Factor 1:* Individualized case management plan**

Case management policies and procedures specify a process for working with members to develop an individualized case management plan based on the services needed and the ~~prioritized~~ person-centered goals and preferences assessed in Element E. Designating goals as long-term or short-term is not sufficient to meet the requirement. The personalized case management plan meets member needs and includes:

- Services needed.
- ~~Prioritized~~ Person-centered goals.
  - ~~Prioritized~~ Person-centered goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Resources to be utilized, including appropriate level of care, to make progress on person-centered goals.
- Collaborative approaches to be used, including level of family participation.

***Factor 2:* Identification of barriers**

Case management policies and procedures specify a process for assessing barriers to receipt of services or to implementing the agreed-on case management plan. The organization may use assessments completed in Element B and Element C to identify barriers. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.

- Understanding of a condition.
- Motivation.
- Insurance issues such as eligibility disputes, reduction of benefits, denial of services or appeals.
- ~~Financial or insurance issues.~~
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed for the presence of barriers, even if none are identified.

Factor 3: **Follow-up schedule**

Case management policies and procedures have a process for determining if follow-up is appropriate or necessary (e.g., after a member is referred to a disease management program or health resource). The case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Member education.
- Frequency of in-person and telephone check-ins.
- Self-management support.
- Determining when follow-up is not appropriate.

Factor 4: **Communication with LTSS providers**

LTSS providers are paid and unpaid providers and organizations that provide long-term services and supports. Case management policies and procedures specify the roles and responsibilities of LTSS providers, case management plan details that are communicated to providers and a process for developing a follow-up schedule.

Factor 5: **Emergency back-up plans**

Emergency back-up plans account for short-term and long-term needs, and may address circumstances such as temporary replacements for personal care attendants and how to respond to power outages that affect equipment. The case management plan includes an emergency back-up plan customized to the member.

If the member resides in a short-term or long-term facility, the organization must either develop an emergency back-up plan customized to the member or confirm that the facility has developed an emergency back-up plan that meets the requirements specified above. If the member resides in a short-term or long-term facility, documentation in the member's file or case record that the facility has developed an emergency back-up plan is acceptable.

Factor 6: **Self-management plans**

Self-management is a member's role in managing the effects, physical and social consequences and lifestyle changes inherent in living with a chronic condition or a functional limitation. **Self-management plans** are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

Case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing).

Factor 7: **Referrals to resources**

Case management policies and procedures specify a process for facilitating referrals to other available resources that may benefit members. The organization may assist in the referral process; but members choose whether to act on referrals.

Factor 8: **Receipt of services**

Case management policies and procedures specify a process for verifying whether the member has received the services included in the case management plan.

Factor 9: **Assessing progress against case management plan**

Case management policies and procedures specify a process for assessing member progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed, at least every 12 months. Time frames for reevaluation of goals are specified in the case management plan.

Factor 10: **Assessing progress against one person-centered goal**

Case management policies and procedures specify a process for assessing progress against at least one person-centered goal. The organization's process specifies that it uses either goal attainment scaling or a patient-reported outcome measure (PROM; e.g., PHQ-9, GAD-7, PROMIS) in its approach to continuously track progress on goal attainment.

- *Goal attainment scaling* is a scale of five possible quantifiable outcomes for the prioritized goal.
- *PROM* captures progress using a standardized questionnaire related to health, quality of life, mental well-being, or health care experience. The PROM should best fit the goal or should be related to a barrier to progress or to achieving the goal.

Exceptions

None.

Examples

Factor 2: **Assessment of barriers**

- Does the member understand the condition and treatment?
- Does the member want to participate in the case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

Source: Lorig, K., Patient Education, A Practical Approach (Thousand Oaks, CA: Sage Publications, 2001) 186–92.

Factor 3: **Follow-up schedule**

- Monthly telephone check-ins.
- Biannual home visits to assess progress and update the plan.

- Planned telephone check-in after a scheduled intervention (e.g., home modification) to assess its impact.

Factor 5: **Emergency back-up plans**

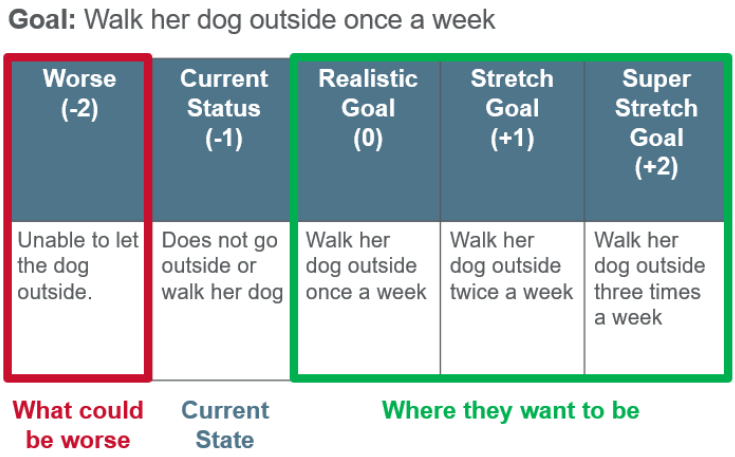
- Whom to call in the event of equipment failure.
- What to do if power goes out.
- What to do in the event of a natural disaster.

Factor 6: **Self-management plan**

- Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
- Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).
- Using adaptive equipment (wheel chair, walker, cane).
- Ability to monitor their condition.
- Reporting an exacerbation of a condition or change in caregiver availability that requires a change in services.
- Money management.
- Paperwork (e.g., annual assessments, financial redetermination, utility assistance, food benefits, transportation).
- Engaging in community resources.

Factor 10: **Assessing progress against one person-centered goal**

For goal attainment scaling, the individual's current status is documented in "-1" and the goal is documented in "0." Scale the goal up in the "+1" and "+2" boxes. The "-2" box is the outcome if the individual did not work toward the goal. The case management plan provides the steps needed to achieve the goal. Refer to the illustration for an example of goal attainment scaling.



When tracking a goal over time, select the PROM that best fits the goal or that is related to a barrier to progress or achieving a goal. Refer to the table below.

Goal	PROM Chosen	Reason PROM Chosen
Go out with friends 2 times per month	GAD-7	Individual has anxiety that causes them to stay home
Be able to live at home	PROMIS Self-Efficacy to Manage Daily Activities	Individual has difficulty managing everyday activities
Walk around the block	PROMIS Physical Function	PROM related to goal

NCQA National Training Session on Person-Centered Outcomes: https://www.ncqa.org/videos/national-training-session-person-centered-outcomes-march-2022/

Element K: Implementing the Care Planning Process

NCQA's review of a sample of the organization's case management files demonstrates that the organization follows its documented processes for:

1. **Assessment of members' need for service needs.**
2. **Assessment of members' ~~prioritized~~ person-centered goals.**
3. **Assessment of members' preferences.**
4. **Development and communication of self-management plans.**
5. **Assessment of members' life-planning activities.**
6. **Identification of members' preferred method of communication.**
7. **Development of an individualized case management plan that includes members' preferences and ~~prioritized~~ person-centered goals.**
8. **Identification of barriers to meeting goals or implementing the plan.**
9. **Development of a schedule for follow-up and communication with members.**
10. **Development of a plan for follow-up and communication with LTSS providers.**
11. **Development of an emergency back-up plan.**
12. **Documentation of whether members received the services identified in the case management plan.**
13. **Assessment of progress against case management plans and goals, and modification as needed.**

Scoring

Met	Partially Met	Not Met
High (90-100%) on file review for at least 7 factors and medium (60-89%) on file review for any remaining factors	Low (0-59%) on file review for no more than 5 factors and high (90-100%) or medium (60-89%) on file review for any remaining factors	Low (0-59%) on file review for 6 or more factors

Data source Records or files

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews assessments in a random sample of up to 40 case management files. Files are selected from active or closed cases that were identified during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

HEDIS LTSS measures

Organizations may submit performance results on the Comprehensive Care Plan and Update (LTSS-CPU) measure instead of completing the file review. If an organization chooses this voluntary option, it must meet the 90% threshold rate on the measure to receive credit.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment

Assessment requires the case manager or other qualified individual to reach and document a conclusion about data or information collected. For factors that require assessment, raw data or answers to questions do not meet the requirement. There is a documented summary of the information's meaning or its implications for the member's situation, for use in the case management plan.

The organization must reach a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.

Files excluded from review

The organization excludes files from review that meet these criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members enrolled in case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence of the member's identification date and that the member was in case management for less than 60 calendar days during the look-back period.
- Employees of the organization and their dependents.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors. NCQA confirms that the files met the criteria for an NA score.

Factor 1: **Assessment of service needs**

The case manager documents the services the member needs in the care plan.

Factor 2: **Assessment of case management plans and goals**

The organization documents a plan for case management that:

- Is specific to the member's situation and needs.
- Includes goals that reflect issues identified in the member assessment and the supporting rationale for each selected goal.
    - Goals are SMART: specific, measurable, attainable, relevant and time-bound (i.e., have a target completion date).

Case management goals are prioritized by high/low, numeric rank or similar designation. Priorities reflect the member or caregiver's input and preferences and priorities. Designating goals as long-term or short-term is not sufficient to meet the requirement; the organization must rank or prioritize goals.

Factor 3: **Assessment of member preferences**

The file or case record documents the member's personal preferences for how case management and LTSS are delivered.

Factor 4: **Self-management plans**

The self-management plan includes actions the member agrees to take to manage a condition or circumstances. The file or case record documents that the plan was communicated to the member. Communication may be verbal or written. The self-management plan documents the member's acknowledgment of an agreement with prescribed actions.

Factor 5: **Assessment of life-planning activities**

The file or case record documents the case manager's assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney.

If life planning activities are determined appropriate, the case manager documents the member's activities and the documents that are in place.

If life planning activities are determined not appropriate, the case manager documents the reason in the case management record or file.

As an alternative to an assessment of life planning needs, the organization may provide life planning information (e.g., brochure, pamphlet) to members in complex case management during the timeframe allowed for completing the initial assessment. The file must document that the information was provided and the date.

Factor 6: **Identification of preferred method of communication**

The file or case record documents the members' preferred method of communication. Member communication may be documented in the form of in-person appointments, telephone, email, or use of member web portals.

Factor 7: **Development of case management plan**

The file or case record documents a plan for case management that is specific to the member's situation and needs, and includes goals that reflect issues identified in the member assessment and the supporting rationale for goal selection.

Factor 8: **Identification of barriers**

The file or case record identifies barriers related to the member or to the member's circumstances, not to the case management process. The organization documents barriers to the member meeting the goals specified in the case management plan.

Factor 9: **Follow-up and communication with members**

The file or case record documents the next scheduled contact with the member, including the scheduled time or time frame which may be an exact or relative (e.g., "October 15," "in 2 weeks") date, and the contact method.

Factor 10: **Follow-up and communication with LTSS providers**

The file or case record documents the roles and responsibilities of LTSS providers, case management plan details and the follow-up schedule that are communicated to providers.

Factor 11: **Assessment of emergency back-up plans**

The file or case record documents an emergency back-up plan that accounts for short-term and long-term needs, and may address circumstances such as temporary replacements for personal care attendants and how to respond to power outages that affect equipment. The file includes an emergency back-up plan customized to the member.

If the member resides in a short-term or long-term facility, documentation in the member's file or case record that the facility has developed an emergency back-up plan is acceptable.

Factor 12: **Documentation of services received**

The file or case record documents whether the individual received the services specified in the case management plan.

Factor 13: **Assessment of progress**

The organization documents the member's progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate.

Exceptions

None.

Examples None.

Element L: Critical Incident Management System

The organization uses a critical incident management system that:

1. **Defines what constitutes a critical incident.**
2. **Identifies responsibility for managing, following-up and acting on critical incidents.**
3. **Tracks critical incidents.**
4. **Prompts an investigation.**
5. **Implements appropriate interventions.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's process for managing critical incidents.

NCQA also reviews the organization's reports documenting incidents tracked and implementation of interventions.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

Critical incidents are events or occurrences that cause harm to a member or LTSS provider, or that indicate risk (e.g., abuse, neglect, exploitation) to a member or LTSS provider's health or welfare.

Critical incident management systems are organization wide systems that can eliminate an immediate threat or investigate allegations that a member may be at risk.

Critical incident management system policies and procedures specify task time frames and how the program meets factor requirements. The organization provides access to the critical incident management system or to reports detailing system operations.

Factor 1: **Defining critical incidents**

The organization defines what constitutes a critical incident (subject to its policy), and may use the state's definition.

Factor 2: **Identifying responsibility**

Managing, following up on and acting on critical incidents may require participation from staff in multiple roles and functions. Quality, risk management or compliance staff or supervisors may be responsible for investigating an incident, oversight of the process and communicating with oversight agencies; case managers may be responsible for following up with the member and others. Each person involved in the process must understand the requirements of their role.

Factor 3: **Tracking critical incidents**

The organization documents critical incidents and tracks them from the initial report through follow-up. Reports may be used to track patterns and prevalence of serious adverse events among members and to inform strategies for managing risk, preventing errors and focusing quality improvement efforts.

Factor 4: **Investigating critical incidents**

The organization investigates critical incidents promptly, and may involve outside agencies (e.g., adult protective services, law enforcement), as appropriate.

Factor 5: **Implementing interventions**

The nature and scope of a critical incident may require immediate response. The organization has a process for determining appropriate actions and for intervening in emergent situations.

Exceptions

None.

Examples

Factor 1: **Defining critical incidents**

The definition of "critical incident" may include an actual or alleged event, such as:

- Member is physically restrained.
- Member does not receive needed services.
- Member's money or belongings are stolen.
- Member attempts suicide.
- Member is sexually exploited or abused.

Factor 5: **Implementing interventions**

- Immediately remove threats from the environment.
- Provide back-up if providers are removed after an incident.

Element M: Qualifications and Assistance for LTSS Providers

The organization:

1. **Specifies qualifications for paid LTSS providers.**
2. **Requires background checks for paid LTSS providers.**
3. **Requires at least one additional screening tool to verify qualifications for paid LTSS providers.**
4. **Requires that paid LTSS providers have access to assistance to deliver services.**

Scoring

Met	Partially Met	Not Met
The organization meets 4 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's documented processes or materials for LTSS provider qualifications and the assistance available to them.

NCQA also reviews the organization's reports for the results from the background checks and results from the additional screening tool.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

LTSS providers are paid and unpaid providers and organizations that provide long-term services and supports.

Factor 1: **Defining qualifications**

Qualifications refers to the type and amount of experience and/or the type and amount of education the paid LTSS provider must have before providing services. To promote member safety in the home, the organization sets qualifications for paid LTSS providers, including those who provide self-directed services. The organization may set different qualifications for providers of self-directed services.

Factors 2, 3: **Background checks and additional screening tool**

For factor 2, the organization requires statewide background checks for criminal history, abuse and neglect for paid LTSS providers, prior to or within 90 calendar days of hire. The organization or state requirements may determine disqualifying crimes. The organization may conduct background checks or rely on background checks conducted by other agencies. NCQA does not consider it delegation if the organization uses another entity to conduct background checks.

For factor 3, the organization selects and uses an additional appropriate screening tool to verify that paid LTSS providers meet the defined qualifications. An attestation alone is only acceptable for job history.

For factors 2 and 3, the organization's policies and procedures specify the types of paid LTSS providers included in the screening process. The organization may differentiate requirements between regular providers (i.e., who have a regular schedule) and ad hoc or back-up providers.

Source: Galantowicz, S., Crisp, S., Karp, N., Accius, J. Safe at Home? Developing Effective Criminal Background Checks and Other Screening Policies for Home Care Workers. (AARP, 2010).

Factor 4: **Providing assistance**

The organization's policies and procedures require that paid LTSS providers:

- Have access to necessary supports and resources to enable them to appropriately and safely complete assigned tasks.
- Have access to emergency services for their safety and protection.
- Have a means to communicate grievances.

Exceptions

None.

Examples

***Factor 1:* Defining qualifications**

- Disqualifying offenses from a background check.
- Certifications.
- Education history.
- Job history.
- Relevant experience.
- Relevant training.

***Factor 2:* Background checks**

- National FBI checks.
- Office of the Inspector General List of Excluded Members/Entities.
- State and county criminal records check.
- State Adult Protective and Child Protective Services registries.
- National and state sex offender registry.
- DMV records.
- Commercial databases.

***Factor 3:* Screening tools**

- Reference checks.
- Interviews.
- Signed statements about job history.
- Alcohol/drug screening.
- Credit checks.

***Factor 4:* Providing assistance**

- 24-hour advice.
- Emergency hotline to address risks to the member.
- Immediate telephone and emergency assistance to address threats to the LTSS provider.

QUESTIONS FOR PUBLIC COMMENT LTSS DISTINCTION 1: CORE FEATURES			
Question LTSS Distinction	**Applicable Element**	**Recommendation**	**Targeted Questions**
Q.1A	LTSS 1, Element A: Program Description	Update the explanation to include examples of populations that can be served by the organization.	Do you support updating the element to require organizations to describe the populations included in their LTSS program?
Q. 1B	***NEW:*** LTSS 1, Element A, factor 6: Promote health equity	Add a factor requiring the organization's program description to describe its commitment to improving health equity and include at least one action to promote equity in management of individual care.	Do you support adding a factor requiring the organization's program description to describe its commitment to improving health equity and include at least one action to promote equity in management of individual care?
Q. 1C	***NEW:*** LTSS 1, Element B: Service Authorization	Add an element requiring organizations to describe their process and criteria for authorizing/denying initial service requests and additional service requests.	Do you support adding an element requiring organizations to describe their process and criteria for authorizing/denying initial service requests and additional service requests?
Q. 1D	***NEW:*** LTSS 1, Element C: Notification of Service Authorization	Add an element requiring organizations to have a process for notifying members of service denials, with requirements for specific reasons in easily understandable language, a reference to benefit provision, criteria on which the denial decision is based and how the care plan was used to determine the denial decision.	Do you support adding an element requiring organizations to have a process for notifying members of service denials, with requirements for specific reasons in easily understandable language, a reference to benefit provision, criteria on which the denial decision is based and how the care plan was used to determine the denial decision?
Q. 1E	***NEW:*** LTSS 1, Element D: Demographic Data Collection	Add an element requiring organizations to collect race, ethnicity and language data.	Do you support adding an element requiring organizations to collect race, ethnicity and language data?
Q. 1F			***Note:*** NCQA does not measure completeness of race, ethnicity and language data, only that organizations are attempting to collect the data. What are your organization's biggest challenges and barriers to collecting race and ethnicity data?
Q. 1G	***NEW:*** LTSS 1, Element E: Privacy Protections for Data	Add an element requiring organizations to have policies and procedures for managing access to and use of race, ethnicity and language data.	Do you support adding an element requiring organizations to have policies and procedures for managing access to and use of race, ethnicity and language data?

Question LTSS Distinction	Applicable Element	Recommendation	Targeted Questions
Q. 1H	LTSS 1: Element F: Assessment of Health, Functioning and Communication Needs Factor 7: Assessment of social needs *(critical factor)* Element H: Comprehensive Assessment Implementation	Update the elements to replace "social determinants of health" with "social needs." Organizations must specify a process for assessing at least two of five social needs listed in the standards. Designate factor 7 as a critical factor in Element D.	Do you support updating the elements to replace "social determinants of health" with "social needs," requiring organizations to specify a process for assessing at least three of five social needs listed in the standards?
Q. 1I	LTSS 1:Element F: Assessment of Health, Functioning and Communication Needs Factor 7: Assessment of social needs *(critical factor)* Element H: Comprehensive Assessment Implementation	Update the elements to replace "social determinants of health" with "social needs." Organizations must specify a process for assessing at least two of five social needs listed in the standards. Designate factor 7 as a critical factor in Element D.	Do you support designating factor 7 as a critical factor in Element D?
Q. 1J	LTSS 1, Element I, factor 2: Assessment of person-centered goals	Update the factor to reflect SMART (specific, measurable, attainable, realistic, and time-bound), person-centered goals.	Do you support updating the factor to reflect SMART (specific, measurable, attainable, relevant, time-bound), person-centered goals?
Q. 1K	***NEW:*** LTSS 1, Element J, factor 10: Assessing progress against one person-centered goal	Add a factor requiring organizations to assess progress against at least one person-centered goal using a standardized approach.	Do you support adding a factor requiring organizations to assess progress against at least one person-centered goal using a standardized approach?

LTSS 2: Measure and Improve Performance

The organization measures member experience, program effectiveness and participation rates, and works to improve.

Intent

The organization identifies opportunities to improve the way it coordinates services through a structured process of evaluating member experience, program effectiveness and participation rates.

Element A: Experience With Case Management

At least annually, the organization evaluates experience with its case management program by:

1. **Obtaining feedback from members.**
2. **Analyzing complaints from members.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

For First Surveys: NCQA reviews the organization's most recent annual data collection and evaluation report that it collects feedback from members and analyzes member complaints.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual data collection and evaluation reports that it collects feedback from members and analyzes member complaints.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Obtaining feedback from members**

At least annually, the organization obtains member feedback through focus groups or experience surveys. Feedback is specific to the LTSS program submitted for distinction.

To identify complaint patterns, the organization collects data on member complaints from the entire population of LTSS members or draws statistically valid samples from the population. If the organization uses a sample, it describes the sample universe and the sampling methodology.

***Factor 2:* Analyzing complaints from members**

The organization analyzes complaints to identify opportunities to improve member experience with its case management program.

For initial measurement, the organization conducts quantitative and qualitative analysis of data.

For remeasurement, the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that stated goals were not met.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Exceptions

None.

Examples

***Factor 1:* Obtaining feedback**

Measures of experience

- Overall experience with the program.
- Respectful treatment by LTSS providers.
- Care manager helpfulness.
- Perception of quality of care/services.

Access to supports and services

- Limited access to care manager.
- Dissatisfaction with care manager.
- Dissatisfaction with care management plan.
- Timeliness of case management services.

***Factor 2:* Analyzing complaints**

- Themes and significance in complaints about a specific service area or service provider.
- Themes and significance of complaints about a care manager.
- Themes and significance of complaints about a case management strategy.
- Volume of complaints provided by a member or population group.
- Changes in trends of complaints.

Element B: Track and Analyze a Measure of Effectiveness

At least annually, the organization monitors one measure and stratifies the measure by race/ethnicity or language to evaluate the effectiveness of its case management program. For the measure, the organization:

1. **Identifies a relevant process or outcome.**
2. **Uses valid methods that provide quantitative results.**
3. **Sets a performance goal.**
4. **Clearly identifies measure specifications.**
5. **Collects and analyzes results.**
6. **Identifies opportunities for improvement, if applicable.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-6 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

For First Surveys: NCQA reviews the organization's most recent report of assessment of the first measure of program effectiveness.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reports of assessment of the first measure of program effectiveness.

NCQA scores this element for each program the organization brings forward for distinction.

The score for the element is the average of the scores for all programs.

Look-back period

For All Surveys: Prior to the survey date.

~~*For First Surveys:* At least once during the prior year.~~

~~*For Renewal Surveys:* 24 months.~~

Explanation

Measures

Organizations are required to track three measures of effectiveness. The organization presents its results and analysis of each measure separately in Elements B–D. The intent of these elements is to establish a basis for sound quality measurement and improvement. Because different programs have different population bases, enrollment methods, service obligations and data access, the organization may select any measure that is most relevant and useful for its quality improvement program. Organizations may select process or outcome measures.

Note: NCQA does not publish or compare organizations based on measure results submitted for these elements.

Stratification

The organization stratifies at least one measure by using individual-level race/ethnicity or language data and focus on subgroups most relevant to the demographics of the population served and that are feasible, given the number of individuals in the groups.

Some subgroups may have sufficient numbers of individuals to be analyzed individually (e.g., White, Black/African American), while some subgroups represented in the organization's population by a small number of individuals may need to be grouped together for the purpose of analysis. In some organizations, it may be possible to stratify distinct subgroups—Chinese, Japanese, Korean or Vietnamese, rather than "Asian," or Mexican/Mexican American/Chicano, Puerto Rican or Cuban rather than "Hispanic or Latino." NCQA does not prescribe racial or ethnic subgroups for stratification, nor does it prescribe performance measures, but suggests that the organization focus on disparity-sensitive measures specified by the NQF; in particular, measures of care processes or outcomes relevant to the organization's population.

Factor 1: Relevant process or outcome

Relevant process measures are measures of evidence-based case management actions, or policies or procedures that have a direct or indirect effect on the well-being or social outcomes of the case management of members served.

Relevant outcome measures assess how case management programs or interventions improve member well-being.

Evidence-based information is based on the best available scientific evidence, on professional standards or on expert opinion.

Factor 2: Valid methods and quantitative results

Measurement of case management effectiveness includes the use of quantitative information derived from valid methodology. NCQA considers the following criteria when evaluating a measure's validity:

- Numerator and denominator.
- Sampling methodology.
- Sample size calculation.
- Measurement periods and seasonality effects.

Factor 3: Performance goal

A **performance goal** is the organization's desired level of achievement. The organization establishes an explicit, quantifiable performance goal for the measure. The goal may be based on external benchmarks (i.e., known levels of best performance) or on the organization's actual performance from prior years.

Factor 4: Measure specifications

The organization describes the data source, the eligible population, the coding or other means of identifying the process or outcome. The intent is to provide detailed measure specifications that can guide valid measurement.

Factor 5: Quantitative and qualitative analysis

For initial measurement, the organization conducts quantitative and qualitative analysis of data.

For remeasurement, the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that stated goals were not met.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Factor 6: Opportunities for improvement

The organization uses the results of its analysis to prioritize opportunities for improvement, which may be different each time the organization measures and analyzes the data. The organization is not required to identify a specific number of improvement opportunities.

Exception

Factor 6 is NA if the organization's analysis of results shows that there are no opportunities for improvement. NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

***Factor 1:* Process measures**

- Timeliness of completion of initial assessment.
- Timeliness of completion of case management plan.
- Timeliness of contact (e.g., phone, visits, assessments).
- Timeliness of reporting critical incidents and complaints.
- Timeliness of initiation of services.
- Comprehensiveness of case management plan (addresses all prioritized goals).
- Percentage of transitions from the community in which the case management plan is shared with the receiving facility.
- Participation rates.

Outcome measures

- Improved quality of life.
- Percentage of members who have made progress toward achieving priority goals.
- Health status (e.g., SF-36® or SF-12® results).
- Experience with case management services.
- Readmission rates.
- Unmet needs addressed.
- Percentage of members admitted to skilled nursing facility.

***Factor 4:* Measure specifications**

Table 1: Measure Specifications

Name of Measure:	Long-Term Community Residence
Activity Objective:	Increase the percentage of enrolled members residing in the community (noninstitutional)
Quantifiable Measure:	Percentage of members residing in the community
Population Included:	100% of enrolled program participants
Data Source:	Care Management Record, field: current residence
Numerator:	Enrollees residing in a community setting (noninstitutional)
Denominator:	All members enrolled in the program
Exclusion:	Short-term institutional stays (e.g., rehabilitation)
Baseline Goal:	>80%
Time Frame:	January–December 31, 2023

Element C: Track and Analyze a Second Measure of Effectiveness

At least annually, the organization monitors a second measure to evaluate the effectiveness of its case management program. For the measure, the organization:

1. **Identifies a relevant process or outcome.**
2. **Uses valid methods that provide quantitative results.**
3. **Sets a performance goal.**
4. **Clearly identifies measure specifications.**
5. **Collects and analyzes results.**
6. **Identifies opportunities for improvement, if applicable.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-6 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

For First Surveys: NCQA reviews the organization's most recent report of assessment of the second measure of program effectiveness.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reports of assessment of the second measure of program effectiveness.

NCQA scores this element for each program the organization brings forward for distinction. The score for the element is the average of the scores for all programs.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

Measures

Organizations are required to track three measures of effectiveness. The organization presents its results and analysis of each measure separately in Elements B–D. The intent of these elements is to establish a basis for sound quality measurement and improvement. Because different programs have different population bases, enrollment methods, service obligations and data access, the organization may select any measure that is most relevant and useful for its quality improvement program. Organizations may select process or outcome measures.

Note: *NCQA does not publish or compare organizations based on measure results submitted for these elements*.

Factor 1: **Relevant process or outcome**

Relevant process measures are measures of evidence-based case management actions, or policies or procedures that have a direct or indirect effect on the well-being or social outcomes of the case management of members served.

Relevant outcome measures assess how case management programs or interventions improve member well-being.

Evidence-based information is based on the best available scientific evidence, on professional standards or on expert opinion.

Factor 2: **Valid methods and quantitative results**

Measurement of case management effectiveness includes the use of quantitative information derived from valid methodology. NCQA considers the following criteria when evaluating a measure's validity:

- Numerator and denominator.
- Sampling methodology.
- Sample size calculation.
- Measurement periods and seasonality effects.

Factor 3: **Performance goal**

A **performance goal** is the organization's desired level of achievement. The organization establishes an explicit, quantifiable performance goal for the measure. The goal may be based on external benchmarks (i.e., known levels of best performance) or on the organization's actual performance from prior years.

Factor 4: **Measure specifications**

The organization describes the data source, the eligible population, the coding or other means of identifying the process or outcome. The intent is to provide detailed measure specifications that can guide valid measurement.

Factor 5: **Quantitative and qualitative analysis**

For initial measurement, the organization conducts quantitative and qualitative analysis of data.

For remeasurement, the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that stated goals were not met.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Factor 6: **Opportunities for improvement**

The organization uses the results of its analysis to prioritize opportunities for improvement, which may be different each time the organization measures and analyzes the data. The organization is not required to identify a specific number of improvement opportunities.

Exception

Factor 6 is NA if the organization's analysis of results shows that there are no opportunities for improvement. NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

Factor 1: **Process measures**

- Timeliness of completion of initial assessment.
- Timeliness of completion of case management plan.
- Timeliness of contact (e.g., phone, visits, assessments).
- Timeliness of reporting critical incidents and complaints.

- Timeliness of initiation of services.
- Comprehensiveness of case management plan (addresses all prioritized goals).
- Percentage of transitions from the community in which the case management plan is shared with the receiving facility.
- Participation rates.

Outcome measures

- Improved quality of life.
- Percentage of members who have made progress toward achieving priority goals.
- Health status (e.g., SF-36® or SF-12® results).
- Experience with case management services.
- Readmission rates.
- Unmet needs addressed.
- Percentage of members admitted to skilled nursing facility.

Factor 4: Measure specifications

Table 2: Measure Specifications

Name of Measure:	Long-Term Community Residence
Activity Objective:	Increase the percentage of enrolled members residing in the community (noninstitutional)
Quantifiable Measure:	Percentage of members residing in the community
Population Included:	100% of enrolled program participants
Data Source:	Care Management Record, field: current residence
Numerator:	Enrollees residing in a community setting (noninstitutional)
Denominator:	All members enrolled in the program
Exclusion:	Short-term institutional stays (e.g., rehabilitation)
Baseline Goal:	>80%
Time Frame:	January–December 31, 2023

Element D: Track and Analyze a Third Measure of Effectiveness

At least annually, the organization monitors a third measure to evaluate the effectiveness of its case management program. For the measure, the organization:

1. **Identifies a relevant process or outcome.**
2. **Uses valid methods that provide quantitative results.**
3. **Sets a performance goal.**
4. **Clearly identifies measure specifications.**
5. **Collects and analyzes results.**
6. **Identifies opportunities for improvement, if applicable.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-6 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

For First Surveys: NCQA reviews the organization's most recent report of assessment of the third measure of program effectiveness.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reports of assessment of the third measure of program effectiveness.

NCQA scores this element for each program the organization brings forward for distinction. The score for the element is the average of the scores for all programs.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

Measures

Organizations are required to track three measures of effectiveness. The organization presents its results and analysis of each measure separately in Elements B–D. The intent of these elements is to establish a basis for sound quality measurement and improvement. Because different programs have different population bases, enrollment methods, service obligations and data access, the organization may select any measure that is most relevant and useful for its quality improvement program. Organizations may select process or outcome measures.

Note: NCQA does not publish or compare organizations based on measure results submitted for these elements.

Factor 1: **Relevant process or outcome**

Relevant process measures are measures of evidence-based case management actions, or policies or procedures that have a direct or indirect effect on the well-being or social outcomes of the case management of members served.

Relevant outcome measures assess how case management programs or interventions improve member well-being.

Evidence-based information is based on the best available scientific evidence, on professional standards or on expert opinion.

Factor 2: **Valid methods and quantitative results**

Measurement of case management effectiveness includes the use of quantitative information derived from valid methodology. NCQA considers the following criteria when evaluating a measure's validity:

- Numerator and denominator.
- Sampling methodology.
- Sample size calculation.
- Measurement periods and seasonality effects.

Factor 3: **Performance goal**

A **performance goal** is the organization's desired level of achievement. The organization establishes an explicit, quantifiable performance goal for the measure. The goal may be based on external benchmarks (i.e., known levels of best performance) or on the organization's actual performance from prior years.

Factor 4: **Measure specifications**

The organization describes the data source, the eligible population, the coding or other means of identifying the process or outcome. The intent is to provide detailed measure specifications that can guide valid measurement.

Factor 5: **Quantitative and qualitative analysis**

For initial measurement, the organization conducts quantitative and qualitative analysis of data.

For remeasurement, the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that stated goals were not met.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Factor 6: **Opportunities for improvement**

The organization uses the results of its analysis to prioritize opportunities for improvement, which may be different each time the organization measures and analyzes the data. The organization is not required to identify a specific number of improvement opportunities.

Exception

Factor 6 is NA if the organization's analysis of results shows that there are no opportunities for improvement. NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

Factor 1: **Process measures**

- Timeliness of completion of initial assessment.
- Timeliness of completion of case management plan.
- Timeliness of contact (e.g., phone, visits, assessments).
- Timeliness of reporting critical incidents and complaints.

- Timeliness of initiation of services.
- Comprehensiveness of case management plan (addresses all prioritized goals).
- Percentage of transitions from the community in which the case management plan is shared with the receiving facility.
- Participation rates.

Outcome measures

- Improved quality of life.
- Percentage of members who have made progress toward achieving priority goals.
- Health status (e.g., SF-36® or SF-12® results).
- Experience with case management services.
- Readmission rates.
- Unmet needs addressed.
- Percentage of members admitted to skilled nursing facility.

Factor 4: Measure specifications

Table 3: Measure Specifications

Name of Measure:	Long-Term Community Residence
Activity Objective:	Increase the percentage of enrolled members residing in the community (noninstitutional)
Quantifiable Measure:	Percentage of members residing in the community
Population Included:	100% of enrolled program participants
Data Source:	Care Management Record, field: current residence
Numerator:	Enrollees residing in a community setting (noninstitutional)
Denominator:	All members enrolled in the program
Exclusion:	Short-term institutional stays (e.g., rehabilitation)
Baseline Goal:	>80%
Time Frame:	January–December 31, 2023

Element E: Action and Remeasurement

Based on the results of its measurement and analysis of case management effectiveness, the organization:

1. **Acts to improve on one measure of effectiveness, if applicable.**
2. **Acts to improve on one measure of experience, if applicable.**
3. **Remeasures to determine the action's impact on effectiveness, if applicable.**
4. **Remeasures to determine the action's impact on experience, if applicable.**

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Reports

Scope of review

Product lines

This element applies to Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's most recent and previous year's reports on annual improvement and remeasurement activities.

NCQA scores this element for each program the organization brings forward for distinction.

The score for the element is the average of the scores for all programs.

Look-back period *For Renewal Surveys:* 24 months.

Explanation The organization implements at least one intervention that addresses one or more opportunities identified in Elements B–D.

***Factors 1, 2:* Acts to improve**

The organization selects interventions that have a reasonable chance of affecting results and describes the interventions, including the date of implementation and the period of interventions, when possible.

***Factor 3:* Impact on effectiveness**

Using the methodology and performance measure specifications described in Elements B–D, the organization remeasures to determine the impact of interventions. Additional process measures regarding interventions may supplement remeasurement.

The organization continues to remeasure to determine the effectiveness of the interventions, using methods consistent with initial measurements.

***Factor 4:* Impact on experience**

Using the methodology and experience measure specifications described in Element A, the organization remeasures to determine the impact of interventions.

Additional experience measures regarding interventions may supplement remeasurement.

Exceptions

This element is NA for First Surveys.

Factors 1 and 3 are NA if the organization does not identify opportunities for improvement of effectiveness. NCQA evaluates whether this conclusion is reasonable, given the organization's analysis.

Factors 2 and 4 are NA if the organization does not identify opportunities for improvement of experience. NCQA evaluates whether this conclusion is reasonable, given the organization's analysis.

Examples None.

Element F: ~~Active~~ Diversity of Participation Rates

At least annually, the organization measures and reports on the diversity of participation rates.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

For First Surveys: NCQA reviews the most recent participation report completed during the look-back period for each program the organization brings forward.

For Renewal Surveys: NCQA reviews the most recent and previous year's participation report completed during the look-back period for each program the organization brings forward.

If the organization measures participation separately for each purchaser, NCQA reviews up to three reports that were distributed to purchasers during the look-back period.

NCQA scores this element for each program the organization brings forward for distinction.

The score for the element is the average of the scores for all programs.

Look-back period

For All Surveys: Prior to the survey date.

~~*For*~~ *First Surveys:* At least once during the prior year.

~~*For Renewal Surveys:* 24 months.~~

Explanation

Case management participation rate

The **participation rate** is the number of members who received an initial assessment and at least one additional interactive contact, divided by the number of members identified as eligible for the program.

Eligible members are members for whom the organization has been contracted to provide case management services.

Calculating ~~active~~ participation

The organization may not use the enrollment rate to calculate the active participation rate. The ~~active~~ participation rate is:

- *Numerator:* The number of members with completed assessments and at least one additional interactive contact.
- *Denominator*: Total number of eligible members.

Interactive contact is two-way interaction in which the member receives self-management support, health education or care coordination through one of the following methods:

- Phone.
- In-person contact (i.e., member or group).
- Online contact:
  - Interactive web-based module.
  - Live chat.
  - Secure email.

Interactive contact does not include:

- Completion of a health appraisal, except as noted in the client restrictions section below.
- Contacts made only to make an appointment, leave a message or acknowledge receipt of materials.

The organization reports on the diversity of the participation rate. **Diversity** describes the presence of differences in characteristics (e.g., race/ ethnicity, preferred language, age, mobility, geography) in the individuals that are actively participating in the programs. NCQA does not prescribe the characteristics the organization chooses to review for differences, but the organization must select at least one characteristic in order to determine the diversity of the participating individuals.

Client restrictions

Some programs do not identify eligible members because of restrictions by the client organization. These programs are based on attracting participation (e.g., using contacts through newsletters) from an employee population or a health plan's member population at large. NCQA expects that for these programs, the organization will calculate its rate of participation using an expected percentage of the at-large population with a specific condition. For example, if the rate of diabetes in the general U.S. population is 4% and the organization recruits 200 diabetics from an employer population of 10,000, it can estimate the participation rate as 50% of 400 diabetics (10,000 x 4% = 400).

Exceptions

None.

Related information

If the organization is required to use a regulatory agency's definition of ~~active~~ participation that is different from NCQA's, it may use the regulatory agency's definition, if it also provides the definition to NCQA. NCQA will use the regulatory

agency's definition to determine whether the organization's active participation is consistent with the definition.

Examples

The organization is contracted to provide case management to 100 members (the denominator) identified as needing LTSS.

- Of the 100 members identified, the organization is able to contact 80 members (the organization is unable to find or reach 20 members).
- Of the 80 members reached, the organization can schedule an initial assessment with 78 members (2 members refused).
- The organization conducts an initial scheduled assessment of 75 members (1 member dies, 1 is admitted to a skilled nursing facility, 1 refuses to meet the case manager on the day of the scheduled assessment).
- Of the 75 assessments completed, case managers have interactive contact (in-person visits or telephone check-ins) with 60 members.

In this scenario, the participation rate is 60/100. Of the 60 participating individuals, the organization reports the following breakdown of diversity between race/ethnicity:

- White: 35
- Black or African American: 15
- American Indian or Other Pacific Islander: 6
- Asian: 4

Element G: Improving Participation Rates

At least annually, the organization:

1. **Analyzes participation rates.**
2. **Identifies at least two ~~one~~ opportunities for improvement.**
3. **Identifies at least one opportunity to improve the diversity in participation rates.**
4. **Implements at least two ~~one~~ actions to improve participation rates.**

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source

Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

For First Surveys: NCQA reviews the organization's most recent report for evidence that the organization analyzed participation rates.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's reports for evidence that the organization analyzed participation rates.

If the organization identifies opportunities for improvement by purchaser, NCQA reviews reports on at least three purchasers or a single report with information about all purchasers.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months, prior to the survey date for factors 2–4.

Explanation

Improving participation rates increases the number of eligible members who receive case management interventions.

Quantitative and qualitative analysis

For initial measurement, the organization conducts quantitative and qualitative analysis of data.

For remeasurement, the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that stated goals were not met.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

***Factor 1:* Analysis**

Quantitative and qualitative data collection and analysis may be performed across all purchasers or by each purchaser, depending on the organization's preference.

***Factors 2, 3:* Opportunities for improvement**

Based on the results from the analysis in factor 1, the organization identifies at least one opportunity for improvement and one opportunity to improve the diversity of participating individuals.

Factor 4 ~~3~~

The organization identifies at least two actions to improve participation rates. At a minimum, one of the actions must improve the diversity of participation rates.

~~No additional explanation required.~~

Exceptions

Factors 2 and 3 are NA if the organization's analysis of results shows that there are no opportunities for improvement. NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

None.

Element H: Transparency in Reporting Participation

The organization reports program participation rates to purchasers and is transparent about measure specifications by reporting:

1. **The defined population included in the denominator.**
2. **How members are included in the numerator.**
3. **The specified measurement period and how it affects inclusion and exclusion in the numerator and denominator.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews up to three reports or materials that were distributed to purchasers during the look-back period, for evidence that the organization was transparent about its calculation method.

If participation is measured by the purchaser, NCQA reviews the organization's documented process for providing measure specifications to each purchaser.

NCQA also reviews evidence that the organization reports its active participation rate, as defined in Element F.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation Measure components (e.g., denominator, numerator) may be defined in materials provided to purchasers with measure reports.

Purchaser organization

NCQA expects the primary audience for this disclosure to be the organization's purchasers.

Factors 1–3

No additional explanation required.

Exception

This element is NA if the organization does not report, or is not required to report, measurement quality information to the state or to purchasers. The organization provides documentation (e.g., contracts, other service agreements) demonstrating that no clients receive measurement quality data reporting.

Examples None.

QUESTIONS FOR PUBLIC COMMENT LTSS DISTINCTION 2: MEASURE AND IMPROVE PERFORMANCE			
Question LTSS Distinction	**Applicable Element**	**Recommendation**	**Targeted Questions**
Q.2A	LTSS 2, Element B: Track and Analyze a Measure of Effectiveness	Update the element stem to require organizations to stratify the measure by race, ethnicity or language to evaluate the effectiveness of the case management program.	Do you support updating the element stem to require organizations to stratify the chosen measure of effectiveness by race, ethnicity or language to evaluate the case management program?
Q. 2B	LTSS 2, Element F: Diversity of Participation Rates	Update the element title and stem to reflect that the organization measures and reports on the diversity of participation rates at least annually.	Do you support updating the element title and stem to require that the organization measures and reports on the diversity of participation rates at least annually?
Q. 2C	***NEW:*** LTSS 2, Element G, factor 3: Identifies at least one opportunity to improve the diversity in participation rates	Add a factor requiring organizations to identify and report on at least one opportunity to improve diversity of participating individuals.	Do you support adding a factor requiring organizations to identify and report on at least one opportunity to improve diversity of participating individuals?
Q. 2E	LTSS 2, Element G, factor 4: Identifies at least two actions to improve participation rates	Update the factor to require at least two actions to improve participation rates. At a minimum, one opportunity must improve the diversity of participating individuals.	Do you support updating the factor to require at least two actions to improve participation rates, including (at minimum) one opportunity dedicated to improving the diversity of participating individuals?

LTSS 3: Care Transitions

The organization has a process to manage care transitions, identify problems that could cause care transitions and prevent unplanned transitions, when possible.

Intent

The organization works to reduce unplanned transitions by managing transitions and identifying problems that can result in transitions of care.

Element A: Process for Transitions of Care

To facilitate safe transitions of care, the organization has a documented process to:

1. **Identify members who transition between settings.**
2. **Notify members' usual providers of a transition within a specified time frame.**
3. **Assign a consistent person or unit within the organization responsible for supporting a member throughout a transition within a specified timeframe.**
4. **Communicate necessary information with the receiving setting within a specified time frame.**
5. **Communicate the care transition process to members and their designated representatives within a specified time frame.**
6. **Track transition status.**
7. **Collaborate with the discharge team on the discharge plan.**
8. **Reassess the appropriateness of an existing case management plan within a specified time frame, and modify as needed.**
9. **Discuss changes to the case management plan with members and their designated representatives within a specified time frame.**
10. **Document medications with members and their designated representatives and communicate identified discrepancies to an appropriate provider.**

Scoring

Met	Partially Met	Not Met
The organization meets 7-10 factors	The organization meets 5-6 factors	The organization meets 0-4 factors

Data source Documented process

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's documented process for managing planned and unplanned care transitions.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element is a **structural requirement**. The organization presents its own documentation.

HEDIS LTSS measures

Organizations may choose to meet this element by submitting performance results on the Reassessment/Care Plan Update After Discharge (LTSS-RAC) measure instead of providing a documented process. If an organization chooses this voluntary option, it must meet the 5% threshold rate on the measure to receive credit.

A **care transition** is movement of members between care settings (e.g., from home to hospital) as their condition and care needs change during the course of a chronic or acute illness. Members moving between settings are particularly vulnerable to receiving fragmented and unsafe care if transitions are poorly coordinated. If the organization does not manage care transitions for all members who receive services, the documented process must describe the population for which it manages transitions.

Planned transitions include elective surgery or a decision to enter a long-term care facility. **Unplanned transitions** include sudden hospitalizations resulting from emergencies.

A **care setting** is a provider or place that delivers health care and health-related services, and includes:

- Acute care facilities.
- Emergency departments.
- Skilled nursing facilities.
- Custodial nursing facilities.
- Rehabilitation facilities.
- The home and community.

The **receiving setting** is the setting responsible for care after a transition.

Factor 1: **Identify members who transition**

The organization has a process to identify members who transition between settings.

Because members may transition between various types of settings for different reasons, the process should address transitions that impact the delivery of services provided by the organization. For example, an organization arranging for provision of LTSS in a home-based setting may chose to focus its process on transitions out of the home and into inpatient or residential facilities.

Factor 2: **Notify usual providers**

Usual care providers include LTSS providers, primary care practitioners or specialists responsible for members' care. The organization attempts to connect members with primary care practitioners if they do not have one.

Case management policies and procedures specify the process for:

- Notifying members' usual care providers about transitions between settings.
- The defined time frames for notification.
  - The organization establishes a time frame for carrying out activities after being notified of a transition.

Factor 3: **Support during transition**

The organization's policies and procedures specify a process for assigning a consistent person or unit to support members during a transition. When the organization is notified of a transition, the organization contacts the member or their designated representative within a specified time frame to communicate the person or unit responsible for supporting them during their transition.

Factor 4: **Communicate key information**

Sharing necessary information can facilitate continuity of care across settings. Case management policies and procedures specify a process for conveying information to the receiving setting, to help a member continue to receive vital care. Key information can include how the member's health status and goals impact the transition and how the transition impacts the plan of care. Sharing a case management plan meets the intent of this factor, but is not the only way organizations can share pertinent information during a transition between settings.

Factor 5: **Communicate about the care transition process**

The organization establishes a time frame for carrying out activities after being notified of a transition.

Case management policies and procedures specify a process for communicating about the transition process with members and their designated representatives. Members decide their designated representatives' level of involvement.

Factor 6: **Track the status of transitions**

Case management policies and procedures specify a process for tracking members who have transitioned to another care setting. Tracking the status of transitions will alert the organization when to resume services and when to initiate new services.

Factor 7: **Collaborate with the discharge team**

Case management policies and procedures specify a process (e.g., discharge plan) for collaborating with the discharge team to resume or initiate services for members who are transitioning back to their usual setting.

Factor 8: **Reassess the existing case management plan**

Case management policies and procedures specify a process for determining if the case management plan continues to meet a member's needs. The organization works with the member to modify the plan, if necessary. This may include screening for eligibility for additional services or reassessing goals or other components included in LTSS 1, Element B, Element C and Element G.

Factor 9: **Communicate changes to the case management plan**

The organization's case management policies and procedures specify a time frame and process for discussing changes to the case management plan with members and their designated representatives during transition from a care setting.

Factor 10: **Documentation of medications**

Case management policies and procedures specify a process for documenting new and existing medications during a transition between settings, and for informing an appropriate provider of discrepancies between the medication list and documented medications.

Exceptions

None.

Examples

***Factor 1:* Identify members who transition**

- Organization A's process indicates that the organization receives automated notifications when members are admitted to the local hospital.
- Organization B's process indicates that a coordinator has been assigned to check the admissions reports from the local hospitals on a daily basis to determine if members enrolled in the program have experienced a transition.

***Factor 6:* Track the status of transitions**

The organization establishes a process to document:

- The current location of the member in the care record.
- The planned date of transfer to another location.
- The anticipated receiving setting.
- Contact information for those coordinating care at the current setting.

***Factor 7:* Collaborate with the discharge team**

- Email correspondence.
- Telephone correspondence.
- Meeting notes.
- Documentation of information submitted to the receiving setting such as, but not limited to:
  - Original care plan information.
  - Description of the home environment.
  - Detail about informal supports available to the members.
  - Resources and support the LTSS case management organization is able to provide to the member upon return to the community.
- Updated discharge plan reflecting the roles and responsibilities of both the discharge setting and the LTSS case management organization.
- Updated care plan based on discharge orders.

***Factor 10:* Documentation of medications**

The organization's process indicates that when a member experiences a care transition, the organization obtains a medication list from the last setting the member received care in. The organization's process also indicates that an LTSS care manager compares the medication list provided at discharge and the medications currently in the home. The LTSS care manager then identifies, documents and reports discrepancies to the member's appropriate provider.

Element B: Reducing Unplanned Transitions for Members

The organization uses available case management information to:

1. **Identify members at high risk of an unplanned transition, at least monthly.**
2. **Take action to mitigate risk of unplanned transitions.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Reports, Materials

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews reports for evidence that the organization identifies members at high risk of unplanned transition and acts to reduce unplanned transitions.

NCQA also reviews evidence that the organization takes action to mitigate risk by providing information to members.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Identifying members at risk**

To minimize avoidable and unplanned transitions, the organization monitors members' information (e.g., self-reported, case manager reports) and identifies members who are at risk of experiencing an unplanned transition.

The more frequently the organization receives reports or analyzes information, the better it can respond to a health issue before it results in an admission or a change in level of care.

NCQA does not prescribe a method for determining at-risk members.

***Factor 2:* Mitigating risk**

As part of identifying and coordinating care to prevent potential problems, the organization takes action to mitigate risks of unplanned transitions identified in factor 1.

Exceptions

None.

Examples

***Factor 1:* Identifying members at risk**

Use predictive modeling to identify members at risk by considering information from the following sources:

- In-home assessment.
- Case manager reports.
- LTSS provider reports.
- Reports from family/friends/caregivers.

- Information reported by the member.
- Redacted reports that show predictive modeling to assign members a risk score.

Factor 2: **Mitigating risk**

- Arrange for meal delivery to improve nutritional status.
- Work with the member and arrange for home modifications to reduce fall risk (e.g., increase physical therapy, reduce clutter, tape down loose rugs, eliminate long electrical cords, install grab bars in the bathroom).
- Provide a brochure on prescription adherence.
- Provide educational materials on how to manage chronic conditions such as diabetes.
- Arrange for companion service or adult day program to reduce social isolation.
- Develop a triggering criterion to identify members whose condition might trigger an intervention.
- Care coordination for at-risk members.

Element C: Reducing Unplanned Transitions for the Population

At least annually, the organization uses available information to:

1. **Analyze rates of unplanned admissions to facilities and emergency department visits, to identify areas for improvement.**
2. **Take action to address areas identified for improvement.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's reports for evidence that it annually analyzes rates of unplanned admissions and takes action on areas identified for improvement.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months; prior to the survey date for factor 1.

Explanation

Quantitative and qualitative analysis

For initial measurement, the organization conducts quantitative and qualitative analysis of data.

For remeasurement, the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that stated goals were not met.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Factor 1: **Analyzing population-based data and taking action**

The organization completes a quantitative and qualitative analysis of admission rates for the population and defined subpopulations that receives services and identifies opportunities for improvement across each. NCQA is not prescriptive in the subpopulations the organization chooses, it may choose to analyze admission rates by race/ ethnicity, preferred language, age, mobility, geography or other characteristics.

Analysis may include a clinical focus on patterns of unplanned admissions; readmissions; ED visits and repeat visits; and admission to participating and nonparticipating facilities, in addition to assessing receipt of identified non-clinical services based on a social needs assessment.

~~NCQA does not specify the type of information the organization uses to analyze admission rates.~~ The organization is not required to include all these areas in its analysis, but at a minimum, it must evaluate rates of unplanned admissions to facilities, ~~and~~ ED visits and analysis of services received based on a social needs assessment to identify areas for improvement. If the organization has no access to patient record systems, it may gather information about unplanned admissions during visits with participants.

Factor 2: **Taking action**

The organization implements interventions based on the causes of unplanned transitions for the population identified in factor 1.

Exceptions

None.

Examples

Factor 1: **Reports**

- Redacted reports that identify members who experienced an unplanned transition, using claims data, assessment data, care plan data or other data.
- Reports on analysis of root causes and opportunities for improvement.

Factor 2: **Taking action**

- Increase contact with subpopulations identified as having higher rates of unplanned admissions.
- Address unmet needs that lead to unplanned transitions.

QUESTIONS FOR PUBLIC COMMENT LTSS DISTINCTION 3: CARE TRANSITIONS			
Question LTSS Distinction	**Applicable Element**	**Recommendation**	**Targeted Questions**
Q.3A	LTSS 3, Element C, factor 1: Analyzing population-based data and taking action	Update the factor to include defined subpopulations in the analysis.	Do you support updating the factor to include subpopulations in the analysis?

LTSS 4: Delegation of LTSS

If the organization delegates LTSS activities, there is evidence of oversight of delegated activities

Intent

The organization carefully monitors functions performed by other organizations.

Element A: Delegation Agreement

The written delegation document:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegate.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegate's performance.**
5. **Describes the remedies available to the organization, including revocation of the delegation, if the delegate does not fulfill its obligations.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Materials

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews delegation agreements in effect during the look-back of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect within the look-back period.

The delegation agreement describes all delegated LTSS activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: **Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of the last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factor 2: **Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the LTSS activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
  - The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other LTSS functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

Factor 3: **Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or members in the organization).

Factor 4: **Performance monitoring**

The delegation agreement specifies the organization's process for evaluating delegate performance.

Factor 5: **Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that result in revocation of the agreement.

Exception

This element is NA if the organization does not delegate LTSS activities.

Examples None.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity before the delegation document was signed.

Scoring

Met	Partially Met	Not Met
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

This element applies if delegation was implemented in the look-back period.

Documentation

NCQA reviews the organization's predelegation evaluation of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

NCQA-Accredited delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited in Case Management for Long-Term Services and Supports (CM-LTSS), unless the element is NA.

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the organization's structure, processes and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional LTSS activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate LTSS activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of LTSS Program

For delegation arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's LTSS program.**
2. **Annually audits case management files against NCQA standards for each year that delegation has been if effect, if applicable.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
4. **Semiannually evaluates regular reports, as specified in Element A.**

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source

Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four.

For First Surveys: NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: Once during the prior year.

For Renewal Surveys: 24 months.

Explanation This element may not be delegated.

NCQA-Accredited delegates

Automatic credit is available for factors 2 and 3 if all delegates are NCQA-Accredited in Case Management for Long-Term Services and Supports (CM-LTSS), unless the element is NA.

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Factor 1: **Review of the LTSS program**

Appropriate organization staff or committee reviews the delegate's LTSS program. At a minimum, the organization reviews parts of the LTSS program that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates case management, it audits the delegate's case management files against NCQA standards. The organization uses one of the following to audit the files:

- 5% or 50 of its files, whichever is less.
- The NCQA "8/30 methodology" available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate LTSS activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is scored NA if the organization does not delegate case management activities.

Examples None.

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

Met	Partially Met	Not Met
The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys all product lines.

Documentation

NCQA reviews reports of opportunities for improvement, of up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys, NCQA reviews the organization's most recent annual review and follow-up on improvement activities.

For Renewal Surveys, NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation This element may not be delegated.

NCQA-Accredited delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited in Case Management for Long-Term Services and Supports (CM-LTSS), unless the element is NA.

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate LTSS activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

QUESTIONS FOR PUBLIC COMMENT LTSS DISTINCTION: GLOBAL QUESTIONS	
Question LTSS Distinction	**Targeted Questions**
Q. GA	Would your organization be able to provide evidence for caregiver assessment and support? (The current requirement in CM-LTSS 2, Element F, factor 1 only asks for a documented process.)
Q. GB	Will the proposed updates enable your organization to better demonstrate its capabilities, enhance contracting opportunities or increase alignment with state contracting requirements?
Q. GC	In addition to the proposed updates, should NCQA consider updates to other areas? Specify the standard/element/factor and give a brief rationale.
Q. GD	Are there activities in this program that do not add value or are inappropriate for certain types of organizations (or for organizations in general)?
Q. GE	Will any proposed activities or language used in the standards perpetuate or exacerbate health inequities?
Q. GF	Are key expectations not addressed in the proposed requirements?