LTSS APM Implementation Manual
Program Year 1

Version 1.3
May 17, 2023

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Version History

EOHHS anticipates that this document will be modified and refined over the course of the program to incorporate feedback and learnings from program participants. The table below will be updated accordingly.

Version Number	Date	Summary of Changes
1.0	March 30, 2022	
1.1	June 1, 2022	• Added *Submission of Home Care Service Utilization Report* to Managed Care measure set for Readiness Period 1 and 2 (see Section III.B.1) • Updated Readiness Incentive Award Determination table to clarify approach to submission of Readiness Period evidence of achievement (see Section III.B.1) • Updated Program Year 1 Reporting Measure Technical Specifications for Home Care Agency Measure 2: Consistent Staff Assignment to incorporate member stratification by hours of home care received (see Appendix B)
1.2	November 14, 2022	• Updated technical specifications for Home Care Agency Measure 1: Employee Retention Rate to specify that employees who have not provided any direct care services within the past three months should be excluded (see Appendix B) • Replaced MCO Measure 6: Medication Adherence with Critical Incident Report of Falls measure (see Appendix B) • Updated technical specifications for MCO Measure 4: Potentially Avoidable ED Visits to change the lookback period from 30 days to two weeks prior to the ED visit (see Appendix B) • Updated technical specifications for MCO Measure 5: Acute Care Hospitalization to change the lookback period from 30 days to two weeks prior to the hospitalization; and exclude surgical and maternity admissions (see Appendix B)
1.3	May 17, 2023	• Updated the Measurement Period dates for Prior Quarter Point in Time Measures (see Section II.B)

LTSS APM Implementation Manual

I. Purpose

This document is an appendix to the *LTSS APM Program Requirements* document. The purpose of this document is to provide detailed specifications for the implementation of the LTSS APM, including measure definitions, performance standards, and required reporting formats and timelines.

This Implementation Manual covers the first 18-months of the LTSS APM program and includes two phases: a six-month Readiness Period and twelve-month Program Year 1 (PY 1):

Performance Period	**Readiness**		**Program Year 1 (PY 1) – CY 2023**			
	Readiness Period 1	**Readiness Period 2**	**Q1**	**Q2**	**Q3**	**Q4**
	Jul – Sep 2022	Oct – Dec 2022	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023

II. Measure Definitions

A. Readiness Measures

	Measure	**Definition**	**Performance Period**
Home Care Agency Readiness Measures	(1) Execution of a contract amendment with MCO to participate in the LTSS APM program	Execution of a contract amendment subject to EOHHS review and approval that meets the criteria outlined below	Readiness Period 1
	(2) Submission of an assessment of the home health agency's readiness to report measures starting in PY 1	Completion and submission of an assessment of the home health agency's reporting readiness that meets the criteria outlined below	Readiness Period 2
Managed Care Readiness Measures	(1) Execution of a contract amendment with home care agency to participate in the LTSS APM program	Execution of a contract amendment subject to EOHHS review and approval that meets the criteria outlined below	Readiness Period 1
	(2) Submission of an assessment of the MCO's readiness to report measures starting in PY 1	Completion and submission of an assessment of the MCO's reporting readiness that meets the criteria outlined below	Readiness Period 2
	(3) Submission of Home Care Service Utilization Report	Data report with all required measure data components (see Program Year 1 Reporting Measures section for details)	Readiness Period 1 and 2

(1) Execution of a Contract Amendment
Incentive funding must be earned by and awarded to participating providers based on a Contract Amendment between the MCO and participating provider. The Contract Amendment shall:

- Be subject to EOHHS review and approval.
- Stipulate that participating providers earn payments through demonstrated performance.
- Include a defined process and timeline for the MCO to evaluate whether a participating provider has met the performance metric and earned the associated incentive payment.
- Stipulate that the MCO will certify to EOHHS that a participating provider has met the performance metric and that HSTP funds will only be released to the MCO for payment to the provider following this certification.
- Stipulate that failure to fully meet a performance metric within the timeframe specified will result in forfeiture of the associated incentive payment and that there will be no payment for partial fulfillment.
- Include an attestation that funds earned under the LTSS APM program will be used in accordance with the *Allowable and Disallowable Uses of Incentive Funds* provisions, as documented in the *LTSS APM Program Requirements*.

(2) Submission of a Reporting Readiness Assessment
A Reporting Readiness Assessment must be completed by participating home health agencies and MCOs in preparation for the required reporting in PY 1. The Reporting Readiness Assessment shall include the following components for each measure:

- Data source(s) that will be used to report on the measure.
- Assessment of ability to report on the measure and identification of any capacity gaps or reporting limitations.
- For any identified gaps, a description of the process to achieve reporting readiness and estimated timeline for completion.

A template of the Reporting Readiness Assessment is included in Attachment A of this document.

B. Program Year 1 Reporting Measures
The table below summarizes the measures home care agencies and MCOs are required to report in PY 1. In PY 1, payment will be made based on home care agency and MCO compliance with reporting requirements. In other words, these are "Pay for Reporting" measures. Data collected during PY 1 will be used to assess whether measures are meaningful and reliable as currently structured, and if appropriate, to set performance targets for PY 2, during which EOHHS expects to condition payment on meeting targets ("Pay for Performance").

Home care agencies and MCOs will report on all measures on a quarterly basis. Detailed specifications for each measure are included in Attachment B of this document. The report submitted at the end of each quarterly Performance Period should cover the Measurement Period described. The Measurement Period is the time period that the report covers.

	Measure Domain	Measure	Measurement Period
Home Care Agency Reported Measures	Workforce Performance	(1) Employee Retention Rate	Prior quarter point in time
		(2) Consistent Staff Assignment	Prior quarter period
		(3) Service Hours Delivered vs. Approved	
Managed Care Reported Measures	Service Utilization	(1) Home Care Service Utilization	Prior quarter period
	Home Care Access	(2) Home Care Wait Time	
	LTSS Rebalancing	(3) LTSS Rebalancing Ratio	Rolling 12-month period • For Q1-Q3 reports: 90-day claims runout, at minimum • For Q4 report: 180-day claims runout, at minimum
	Hospital Avoidance	(4) Potentially Avoidable ED Visits	
		(5) Acute Care Hospitalization	
		(6) Critical Incident Report of Falls	

The table below details the Measurement Period that each quarterly report will cover.

Quarterly Performance Report	Measurement Period for Quarterly Reports		
	Prior Quarter Point in Time Measures	Prior Quarter Period Measures	Rolling 12-Month Period Measures
PY 1 Q1 Report	As of March 31, 2023	October - December 2022	October 2021 - September 2022
PY 1 Q2 Report	As of June 30, 2023	January - March 2023	January 2022 - December 2022
PY 1 Q3 Report	As of September 30, 2023	April - June 2023	April 2022 - March 2023
PY 1 Q4 Report	As of December 31, 2023	July - September 2023	July 2022 - June 2023*

*The Q4 report for rolling 12-month period measures must use a full 180-day claims runout period because it will be the baseline for performance measurement in future years. The Q1-Q3 reports for rolling 12-month period measures must use a 90-day claims runout period, at minimum.

III. Performance Standards and Calculation of Incentive Award

A. Total Eligible Incentive Pool Calculation

The Total Eligible Incentive Pool for each home care agency and MCO will be determined for each quarter based on the following formula:

Total Eligible Incentive Pool	=	**(1) Service Utilization** *15-min Units of Home Care Delivered*	X	**(2) Performance Period Incentive Amount** *per 15-min Unit of Home Care Delivered*

(1) Service Utilization for each participating home care agency is the total volume of 15-min units of home care delivered by the agency to members under the applicable managed care contract. For each MCO, service utilization is the total volume of 15-min units of home care delivered across all home care agencies the MCO has contracted with to participate in the LTSS APM. The following procedure codes will be included in the determination of home care service utilization:

- S5125 (Certified Nursing Assistant personal care services)
- S5125 U1 (Certified Nursing Assistant combined personal care and homemaker services)
- S5130 (Homemaker services)

Service utilization for each performance period will be determined based on the prior quarter, allowing for a 90-day claims runout period, at minimum, to occur before the determination of the service utilization volume that will be used to calculate the Total Eligible Incentive Pool.

(2) The Performance Period Incentive Amount is a uniform dollar amount per 15-min unit of home care delivered.

- During the Readiness Period, the home care agencies will be eligible to earn **$0.85** per 15-minute unit of home care delivered and the MCO will be eligible to earn **$0.09** per 15-minute unit of home care delivered.
- During PY 1, the home care agencies will be eligible to earn **$0.64** per 15-minute unit of home care delivered and the MCO will be eligible to earn **$0.07** per 15-minute unit of home care delivered.

To ensure that the MCO is adequately funded to implement and administer the LTSS APM program, a Total Eligible Incentive Pool minimum funding threshold for managed care will be observed. The minimum funding threshold is $100,000 for the Readiness Period ($50,000 per quarter), and $150,000 for PY 1 ($37,500 per quarter). If the Total Eligible Incentive Pool for managed care falls below the minimum funding threshold in any performance quarter, the Performance Period Incentive Amount for that performance quarter will be re-calculated based on the formula: Minimum Funding Threshold / Service Utilization = Performance Period Incentive

Amount. For example, with a Minimum Funding Threshold of $50,000, and Service Utilization of 250,000 15-min units, the Performance Period Incentive Amount would be $0.20.

B. Performance Standards and Calculation of Incentive Award Amount for the Performance Period

Incentive award amounts for each home care agency and MCO will be determined based on demonstrated achievement of the performance standards associated with each performance period. Each measure is tied to a Measure Weight that represents the portion of the Total Eligible Incentive Pool allocated to that measure. Participants earn the amount associated with each measure achieved; to earn the full pool, participants must achieve all measures. Incentive award amounts will be determined on a quarterly basis, based on the measures achieved in the performance period.

Measures that are not achieved within the associated performance period can be reclaimed during a subsequent performance period, within the program year (i.e., Readiness measures must be achieved by the end of the Readiness Period; PY 1 measures must be achieved by the end of PY 1). To reclaim a measure during a subsequent performance period, participants should submit a request for extension with the performance period report in which the measure is due and indicate the expected timeline for completion. Past-due measures with an approved extension should be submitted with the standard quarterly report for the performance period in which they were achieved.

(1) Readiness Incentive Award Determination

	Measure	Measure Weight	Performance Period	Evidence of Achievement
Home Care Agency Measure Set	(1) Execution of a contract amendment with MCO to participate in the LTSS APM program	100%	Readiness Period 1	Approved model contract amendment signature page
	(2) Submission of an assessment of the home health agency's readiness to report measures starting in PY 1	100%	Readiness Period 2	Approved agency Reporting Readiness Assessment
Managed Care Measure Set	(1) Execution of a contract amendment with home care agency to participate in the LTSS APM program	70%	Readiness Period 1	Approved model contract amendment, submitted for EOHHS approval by August 1, 2022*
	(2) Submission of an assessment of the MCO's readiness to report measures starting in PY 1	70%	Readiness Period 2	Approved MCO Reporting Readiness Assessment
	(3) Submission of Home Care Service Utilization Report	30%	Readiness Period 1 and 2	Data report with all required measure data components

*Or within 30 calendar days of MMP contract execution, whichever is later; August 1, 2022, deadline assumes contract is executed by July 1, 2022

(2) Program Year 1 Incentive Award Determination

	Measure Domain	Measure	Measure Weight	Evidence of Achievement	P4R/ P4P*	Reporter
Home Care Agency Measure Set	Workforce Performance	(1) Employee Retention Rate	40%	Data report with all required measure data components	P4R	Agency
		(2) Consistent Staff Assignment	30%			
		(3) Service Hours Delivered vs. Approved	30%			
	Hospital Avoidance**	(4) Potentially Avoidable ED Visits	0%	N/A – MCO reported pay-for-reporting only measure in Year 1	P4R	MCO
		(5) Acute Care Hospitalization	0%			
		(6) Critical Incident Report of Falls	0%			
Managed Care Measure Set	Service Utilization	(1) Home Care Service Utilization	15%	Data report with all required measure data components	P4R	MCO
	Home Care Access	(2) Home Care Wait Time	20%			
	LTSS Rebalancing	(3) LTSS Rebalancing Ratio	20%			
	Hospital Avoidance	(4) Potentially Avoidable ED Visits	15%			
		(5) Acute Care Hospitalization	15%			
		(6) Critical Incident Report of Falls	15%			

*"P4R" = Pay-for-reporting; "P4P" = Pay-for-performance

**Measures in the Hospital Avoidance domain are MCO reported for each home care agency's population. These measures are pay-for-reporting in Year 1; measures in this domain will only be tied to a share of the home care agency's incentive funds as they transition to pay-for-performance over time.

IV. Required Reports and Timeline for Submission

Incentive funds will be distributed on a quarterly basis, according to the payment terms articulated in this document. Incentive payments will be made to the MCO separately from capitation rate payments. EOHHS will specify and distribute reporting templates for the Quarterly Performance Report (QPR) that the MCO must submit to EOHHS to request release of any earned incentive funds. All required evidence of measure achievement must be submitted along with the QPR.

Deadlines for the submission of the QPR and distribution of earned incentive funds are detailed below:

Performance Period		Readiness		PY 1			
		Period 1	Period 2	Q1	Q2	Q3	Q4
Quarterly Performance Report Due	MCO submits the QPR to EOHHS within 30 calendar days of the close of the quarter	10/30/22	1/30/23	4/30/23	7/30/23	10/30/23	1/30/24
Earned Funds Payment to MCO	EOHHS distributes earned funds to MCO within 30 calendar days of approving the QPR*	11/29/22	3/1/23	5/30/23	8/29/23	11/29/23	2/29/24
Earned Funds Payment to Home Care Agency	MCO distributes earned funds to home care agencies within 30 calendar days of receiving earned funds from EOHHS	12/29/22	3/31/23	6/29/23	9/28/23	12/29/23	3/30/24

*EOHHS approval of the QPR is dependent on the submission of a complete and accurate report. Clarifications or requests for additional information will add to the time required to approve the report. The payment dates shown assume minimum approval time and will be adjusted to reflect any additional time required to approve the QPR, if necessary

Attachment A: Reporting Readiness Assessment Template

Home Care Agency Reporting Readiness Assessment

Contact Information

Agency:	
NPI #:	
Name of agency lead contact:	
Job title of lead contact:	
Email of lead contact:	
Phone for lead contact:	

Section 1: Data Sources

Identify the data source(s) that will be used to report on each of the following measures.

Measure	**Data Source(s)**
(1) Employee Retention Rate	
(2) Consistent Staff Assignment	
(3) Service Hours Delivered vs. Approved	

Section 2: Assessment of Gaps and Limitations

Assess current ability to report on each measure, using a scale from 0-3, where:

- **0 =** no capability to report on the measure – data is not currently collected
- **1 =** low capability to report on the measure – some, but not all, the data is currently collected
- **2 =** medium capability to report on the measure – all data is currently collected, but requires manipulation/ analysis to produce the measure
- **3 =** full capability to report on the measure – all data is currently collected, and in a form that would allow for the measure to be readily produced and reported

For any measure that does not score a 3, please identify and describe the gaps and limitations to reporting on the measure.

Measure	**Readiness Assessment (0-3)**	**Description of Gaps and Limitations**
(1) Employee Retention Rate		

(2) Consistent Staff Assignment		
(3) Service Hours Delivered vs. Approved		

Section 2a: Employee Data Collection Gaps and Limitations
Please indicate below if the following employee information is currently collected and describe any gaps or limitations to reporting this data.
This will inform planning for future years.

Employee Data	Currently Collected? (Y/N)	Description of Gaps and Limitations
Part-Time/ Full-Time		
Years of Service		
Ethnicity of Employee		
Race of Employee		
Languages Spoken		

Section 3: Process to Achieve Reporting Readiness
For any measure that did not score a 3 in Section 2, please describe the steps that will need to be taken to address the identified gaps and limitations, and estimate the time required to complete these steps.

Measure	Steps to Achieve Reporting Readiness	Estimated Date of Completion
(1) Employee Retention Rate		
(2) Consistent Staff Assignment		
(3) Service Hours Delivered vs. Approved		

Managed Care Reporting Readiness Assessment

Contact Information

MCO:	
Name of MCO lead contact:	
Job title of lead contact:	
Email of lead contact:	
Phone for lead contact:	

Section 1: Data Sources
Identify the data source(s) that will be used to report on each of the following measures.

Measure	**Data Source(s)**
(1) Home Care Service Utilization	
(2) Home Care Wait Time	
(3) LTSS Rebalancing Ratio	
(4) Potentially Avoidable ED Visits	
(5) Acute Care Hospitalization	
(6) Critical Incident Report of Falls	

Section 2: Assessment of Gaps and Limitations
Assess current ability to report on each measure, using a scale from 0-3, where:

- **0 =** no capability to report on the measure – data is not currently collected
- **1 =** low capability to report on the measure – some, but not all, the data is currently collected
- **2 =** medium capability to report on the measure – all data is currently collected, but requires manipulation/ analysis to produce the measure
- **3 =** full capability to report on the measure – all data is currently collected, and in a form that would allow for the measure to be readily produced and reported

For any measure that does not score a 3, please identify and describe the gaps and limitations to reporting on the measure.

Measure	**Readiness Assessment (0-3)**	**Description of Gaps and Limitations**
(1) Home Care Service Utilization		
(2) Home Care Wait Time		
(3) LTSS Rebalancing Ratio		

(4) Potentially Avoidable ED Visits		
(5) Acute Care Hospitalization		
(6) Critical Incident Report of Falls		

Section 3: Process to Achieve Reporting Readiness

For any measure that did not score a 3 in Section 2, please describe the steps that will need to be taken to address the identified gaps and limitations, and estimate the time required to complete these steps.

Measure	Steps to Achieve Reporting Readiness	Estimated Date of Completion
(1) Home Care Service Utilization		
(2) Home Care Wait Time		
(3) LTSS Rebalancing Ratio		
(4) Potentially Avoidable ED Visits		
(5) Acute Care Hospitalization		
(6) Critical Incident Report of Falls		

Attachment B: Program Year 1 Reporting Measures Technical Specifications

Program Year 1 Reporting Measures

For PY 1, all measures are "Pay for Reporting" only. The data collected during PY 1 will be used to evaluate whether the measures are meaningful as structured, and to assess whether denominator sizes meet minimum standards of reliability. As such, there are no reporting exclusions for small sample size in the PY 1 technical specifications. EOHHS anticipates that measures may need to be refined or replaced based on reporting results and measure testing activities that will be conducted in PY 1.

Note that PY 1 measure testing will also inform additional measure stratification guidelines for future program years (e.g., by race/ethnicity, language, geography, diagnosis, and/or employee characteristics).

Employee Retention Rate	Home Care Agency Measure 1

Steward: Rhode Island Executive Office of Health and Human Services

Description

The percentage of Direct Care Workers employed by the home care agency at the start of the measurement year who are currently employed as of the report date.

Denominator

Denominator	Total **Direct Care Workers** directly employed by the **home care agency** as of **December 31, 2022**. **Direct Care Workers** include: Frontline paraprofessional employees who provide care and services directly to Rhode Island Medicaid beneficiaries and are not licensed by the RI Department of Health. Direct care workers shall also include Nursing Assistants. Administrative/management staff who spend at least 50% of their time on frontline direct care may be considered a Direct Care Worker. **Home care agency** refers to the Rhode Island based entity licensed by the RI Department of Health; this reporting should be specific to the workforce providing services in Rhode Island. **December 31, 2022** sets the baseline that should be used to report this measure throughout the year; the denominator population does not change.
Denominator Exclusions	• Employees who have not provided any direct care services within the past three months. • Exempt employees under the FLSA • Employees who are contracted or subcontracted through a third-party vendor or staffing agency

Numerator

Numerator	Total **Direct Care Workers** directly employed by the home care agency as of December 31, 2022 who are currently employed as of the report date. (i.e. Denominator – Total Terminations in Denominator population)

FAQs/ Examples

FAQs/ Examples	

Consistent Staff Assignment	Home Care Agency Measure 2

Steward: Rhode Island Executive Office of Health and Human Services
(Adapted from TennCare and the National Nursing Home Quality Improvement Campaign)

Description

The average number of caregivers per Rhode Island Medicaid member served by the agency, for members who received ___ hours of home care in the quarterly measurement period:

(1) Under 150 hours
(2) 150 – 300 hours
(3) Over 300 hours

Denominator

Denominator	Total **Rhode Island Medicaid members served by the agency,** who received __ hours of home care in the quarterly measurement period. **Rhode Island Medicaid members served by the agency** include all members with RI Medicaid coverage (managed care and Medicaid FFS members) receiving **home care services** from the agency in the quarterly measurement period. **Home care services** include the procedure codes S5125, S5125 U1, and S5130.
Denominator 1	Under 150 hours
Denominator 2	150 - 300 hours
Denominator 3	Over 300 hours

Numerator

Numerator	Total number of caregivers per member, summed across all members who received __ hours of home care in the quarterly measurement period. *Step 1:* Count the total number of caregivers each member had in the measurement period *Step 2:* Sum the total number of caregivers per member for all members who received __ hours of home care in the quarterly measurement period
Numerator 1	Under 150 hours
Numerator 2	150 - 300 hours
Numerator 3	Over 300 hours

FAQs/ Examples

FAQs/ Examples	• This measure is agency specific – it captures the number of caregivers from the reporting agency only. • The numerator should reflect the total number of caregivers per member, not the unduplicated number of caregivers across members. For example, if Member 1 and 2 both have 5 caregivers in the measurement period, the total number of caregivers per member is 10, even if the same caregiver provided services to both members.

Service Hours Delivered vs. Approved	Home Care Agency Measure 3

Steward: Rhode Island Executive Office of Health and Human Services
(Adapted from National Quality Forum, *Quality in Home and Community-Based Services to Support Community Living*, Delivery Domain)

Description

The percentage of total home care service hours approved for Rhode Island Medicaid members served by the agency, that were delivered within the measurement period.

Denominator

Denominator	Total **home care service hours approved** for **Rhode Island Medicaid members served by the agency** within the measurement period. **Home care service hours approved** is the total service authorization (in hours) for procedure codes S5125, S5125 U1, and S5130. Sum authorized hours for all Rhode Island Medicaid members served by the agency in the measurement period. **Rhode Island Medicaid members served by the agency** include all members with RI Medicaid coverage (managed care and Medicaid FFS members) receiving home care services from the agency at any point within the measurement period.

Numerator

Numerator	Total **home care service hours delivered** for Rhode Island Medicaid members served by the agency within the measurement period. **Home care service hours delivered** is the total units of service provided (in hours) for procedure codes S5125, S5125 U1, and S5130. Sum the number of service hours provided for all Rhode Island Medicaid members served by the agency in the measurement period.

FAQs/ Examples

FAQs/ Examples	

Home Care Service Utilization	Managed Care Measure 1

Steward: Rhode Island Executive Office of Health and Human Services

Description

The total volume of 15-min units of home care service delivered in the measurement period, stratified by home care agency.

Measure

Measure	The total volume of 15-min units of **home care service** delivered in the measurement period. **Home care services** include the procedure codes S5125, S5125 U1, and S5130. *Note:* This report will be used to calculate the Total Eligible Incentive Pool for home care agencies and MCO. A 90-day claims runout period should be applied to ensure results are reliable.

Measure Stratification

Home Care Agency	Service volume stratified by home care agency.

Home Care Wait Time	Managed Care Measure 2

Steward: Rhode Island Executive Office of Health and Human Services

Description

Three measures:

(1) Number of instances of new or increased need for home care services in the measurement period
(2) Number of instances of new or increased need for home care services in the measurement period that went on the waitlist for home care services
(3) Average time on waitlist for home care services

Measures

Measure 1	Number of instances of new or increased need for **home care services** in the measurement period. **Home care services** include the procedure codes S5125, S5125 U1, and S5130. ***Measure stratification:*** member characteristics
Measure 2	Number of instances of new of increased need for home care services in the measurement period that went on the waitlist for home care services. ***Measure stratification:*** time on waitlist and member characteristics
Measure 3	Average time on waitlist for home care services (in days). ***Measure stratification:*** time on waitlist and member characteristics

Measure Stratification

Stratify measures by time on waitlist and member characteristics as indicated above.

Time on Waitlist	• <1 – 7 days • 8 - 14 days • 15 – 30 days • 31 – 60 days • 61 – 90 days • > 90 days

Race	Use the following race categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2022: • White • Black • American Indian/Alaska Native • Asian • Native Hawaiian and Other Pacific Islander • Some Other Race • Two or More Races • Declined • Unknown
Ethnicity	Use the following ethnicity categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2022: • Hispanic/Latino • Not Hispanic/Latino • Declined • Unknown
Language	Use the following language categories: • English • Spanish • Portuguese • Cape Verdean Creole • Haitian Creole • Khmer • Lao • Other • Unknown
Geography	Use the following counties of member residence: • Bristol • Kent • Newport • Providence • Washington

LTSS Rebalancing Ratio	Managed Care Measure 3

Steward: Centers for Medicare & Medicaid Services (CMS)

Description

Spending on Home and Community Based Services (HCBS) as a Percentage of Total Medicaid Long Term Services and Supports (LTSS) Expenditures.

The LTSS Rebalancing Ratio metric was first calculated about 40 years ago and remains the most widely used measure of rebalancing.[1] CMS calculates and reports this metric on a national and state-by-state basis annually; results are released in the annual LTSS Expenditure Report.[2] Specifications for this measure are consistent with CMS' standardized data collection template and guidance for state-reported MLTSS data.

Denominator

Denominator	Total **Medicaid LTSS Expenditures** in the measurement period. **Medicaid LTSS Expenditures** include Institutional LTSS and HCBS LTSS Expenditures, as below. Institutional LTSS: • Nursing Facility Services • Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) • Mental Health Facility Services • Institutional LTSS – Other* HCBS LTSS: • Personal Care • Home Health • Rehabilitative Services • Case Management • Community First Choice/ 1915(k) • HCBS – Other** *Other relevant Institutional LTSS costs not otherwise categorized, e.g.: short-term residential care at behavioral health facilities and nursing home supplemental funds **Other relevant HCBS LTSS costs not otherwise categorized, e.g.: home delivered meals, transportation services, habilitation, assistive technology

[1] Lipson, Debra, *Measures of State Long-Term Services and Supports System Rebalancing*, November 2019, https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-3-rebalancing.pdf

[2] For additional details, and to access the annual LTSS Expenditure Report see: https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html

Numerator

Numerator	Total **Medicaid HCBS LTSS Expenditures** in the measurement period, as defined above.

Note on Alignment with OHIC TME Data Reporting

OHIC TME Reporting: Long-Term Care Definition	**Claims: Long-Term Care:** All TME data from claims to providers for: (1) nursing homes and skilled nursing facilities; (2) intermediate care facilities for individuals with intellectual disability (ICF/ID) and assisted living facilities; and (3) providers of home- and community- based services, including personal care (e.g., assistance with dressing, bathing, eating, etc.), homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, etc.), and programs designed to assist individuals with long-term care needs who receive care in their home and community, such as PACE and Money Follows the Person. Does not include payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner. Excerpted from: *Rhode Island Health Care Cost Growth Target and Primary Care Spend Obligation Implementation Manual*, Version 7.2, Appendix A: Insurer TME Data Specification, August 20, 2021
Comparison	The LTSS Rebalancing Ratio measure is expected to be consistent at the total expenditure level with OHIC TME reporting for Long-Term Care, but differs in terms of the segmentation of LTSS expenditures as Institutional vs. HCBS. The three categories of expenditure delineated in the OHIC TME definition should be mapped to the Institutional vs. HCBS categories as follows: (1) Institutional LTSS (2) Divide: • Intermediate care facilities for individuals with intellectual disability (ICF/ID) = Institutional LTSS • Assisted living facilities = HCBS LTSS (3) HCBS LTSS Note: The CMS definition also differs from the OHIC TME definition in including Mental Health Facility Services in the Institutional LTSS category; however, no expenditures in this category have historically been reported by RI MLTSS for the purposes of the CMS LTSS Expenditure Report, so no effective difference in total reported expenditures is anticipated vs. OHIC TME reporting.

Potentially Avoidable ED Visits	Managed Care Measure 4

Steward: New York University, Modified by Rhode Island Executive Office of Health and Human Services

Description

Two measures:

(1) The number of ED visits per member within the measurement period.
(2) The total potentially avoidable ED visits divided by all ED visits.

Measure 1

Denominator 1	Number of members in the population, per measure stratification specifications below.
Numerator 1	Number of ED visits within the measurement period (for members in the population, per measure stratification specifications below).

Measure 2

Denominator 2	Numerator 1: Number of ED visits within the measurement period (for members in the population, per measure stratification specifications below).
Numerator 2	The total sum of the probabilities of 1) preventable/avoidable emergent ED visits, 2) non-emergent ED visits, and 3) emergent ED visits that could have been avoided by regular primary care, using the probabilities supplied by NYU for the primary diagnosis code (ICD-10) of each ED visit. Additional Information on the NYU methodology, including a list of ICD-10 codes can be found here: https://wagner.nyu.edu/faculty/billings/nyued-background

Measure Stratification

MCO	All members enrolled in the MMP, excluding custodial IC60 members residing in a nursing facility.
Members Receiving Home Care	All members enrolled in the MMP receiving home care services (inclusive of procedure codes: S5125, S5125 U1, and S5130). • **Denominator Limitations:** Limited to members receiving home care services within the measurement period

	• **Numerator Limitations:** Limited to ED visits associated with members that were receiving home care services within two weeks prior to the ED visit
Members Receiving Home Care, by Home Care Agency	Assign members that were receiving home care services within two weeks prior to an ED visit to all home care agencies that provided services within that period. • **Denominator Limitations:** Limited to members receiving home care services within the measurement period • **Numerator Limitations:** Limited to ED visits associated with members that were receiving home care services within two weeks prior to the ED visit

Acute Care Hospitalization	Managed Care Measure 5

Steward: Rhode Island Executive Office of Health and Human Services

Description

The number of acute care hospital admissions per member within the measurement period.

Denominator

Denominator	Number of members in the population, per measure stratification specifications below.

Numerator

Numerator	Admissions to an acute care hospital within the measurement period, per measure stratification specifications below. *Admissions count excludes surgical and maternity admissions.*

Measure Stratification

MCO	All members enrolled in the MMP, excluding custodial IC60 members residing in a nursing facility.
Members Receiving Home Care	All members enrolled in the MMP receiving home care services (inclusive of procedure codes: S5125, S5125 U1, and S5130). • **Denominator Limitations:** Limited to members receiving home care services within the measurement period • **Numerator Limitations:** Limited to hospitalizations associated with members that were receiving home care services within two weeks prior to the hospitalization
Members Receiving Home Care, by Home Care Agency	Assign members that were receiving home care services within two weeks prior to a hospitalization to all home care agencies that provided services within that period. • **Denominator Limitations:** Limited to members receiving home care services within the measurement period • **Numerator Limitations:** Limited to hospitalizations associated with members that were receiving home care services within two weeks prior to the hospitalization

Critical Incident Report of Falls	Managed Care Measure 6

Steward: Rhode Island Executive Office of Health and Human Services

Description

The number of Critical Incident Report of Falls per member within the measurement period.

Denominator

Denominator	Number of members in the population, per measure stratification specifications below.

Numerator

Numerator	Number of falls, as documented through a Critical Incident Report, per measure stratification specifications below.

Measure Stratification

MCO	All members enrolled in the MMP, excluding custodial IC60 members residing in a nursing facility.
Members Receiving Home Care	All members enrolled in the MMP receiving home care services (inclusive of procedure codes: S5125, S5125 U1, and S5130). • **Denominator Limitations:** Limited to members receiving home care services within the measurement period • **Numerator Limitations:** Limited to falls associated with members that were receiving home care services within two weeks prior to a fall
Members Receiving Home Care, by Home Care Agency	Assign members that were receiving home care services within two weeks prior to a fall to all home care agencies that provided services within that period. • **Denominator Limitations:** Limited to members receiving home care services within the measurement period • **Numerator Limitations:** Limited to falls associated with members that were receiving home care services within two weeks prior to a fall