Relative Resource Use

[Guidelines for Relative Resource Use Measures](#TOC)

Summary of Changes to HEDIS 2016

* Removed ASM as a related quality EOC measure that must be reported with RAS in *Guideline 1*.
* Removed reference to “regional” in the “expected amount” definition; regional peer groups (regional versions of the O/E) were eliminated in the RRU calculations.
* Removed references to “index ratio” and “index score” in the *Relative Resource Use Results* section; indexing of the O/E ratio was eliminated.

[Description](#TOC)

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| Relative Resource Use measures | Relative Resource Use (RRU) measures are a standardized way to measure relative resource use. When evaluated with the corresponding quality of care measures, they provide more information about the efficiency or value of an organization’s services. RRU measures have the following features:   * They focus on high-cost conditions that have corresponding HEDIS Effectiveness of Care measures. * They differentiate between unit price and utilization variation. * They rely on a transparent risk-adjustment method similar to a proprietary risk-adjustment system. |

[Definitions](#TOC)

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| Major clinical conditions | RRU measures evaluate five major clinical conditions. Members can have more than one major clinical condition. | |
| 1. Diabetes. 2. Cardiovascular conditions. 3. Hypertension. | 1. COPD. 2. Asthma. |
| Age and gender | For the major clinical conditions, stratify members by age and gender. When calculating HCC-RRU risk categories, total cost, service frequency and member months, use the age on the last day of the treatment period to identify the appropriate grouping. | |
| *Required exclusions* | Exclude members with the following dominant medical conditions from all RRU measures:   * Active cancer. * HIV/AIDS. * Organ transplant (other than kidney).   Exclude members with the following dominant medical conditions only from RHY, RCO and RAS:   * ESRD. * Kidney transplant.   Identifying a dominant medical condition is the same for all measures. Refer to the *Exclusions (required)* section in *Guidelines for Relative Resource Use Measures.* | |

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| Treatment period | The period for counting service cost and frequency. The treatment period is the measurement year for all measures. |
| Standard price | The unit price per service that represents standardized, allowed payment levels for provider services, including payer liability and member cost sharing. Unit prices represent data derived from a single source, using a single approach for classifying and pricing services. Pricing algorithms represent average service pricing levels for organizations for the most recent period.  RRU measures use NCQA’s standardized prices. The organization does not report prices based on its contracts and fee schedules; it applies a standard price to each service, multiplies it by the number of units of service and reports the resulting standard cost. Consistent standard prices protect the organization’s proprietary fee schedules and contracts and support measure comparison across organizations and across regions without requiring adjustment for levels of service payment.  Download the SPT for each service category, the Major Surgery Table, the LOS Group Table and the cost cap table from [www.ncqa.org](http://www.ncqa.org):   |  |  |  | | --- | --- | --- | | * SPT-INP-ADSC. * SPT-Surg-Proc. * SPT-EM. | * SPT-Pharm. * SPT-LAB. * SPT-IMG. | * Maj-Surg Table. * SPT-CAP Amount. * LOS Group. |   The SPTs contain the service codes used for the total standard cost estimation and their respective standard unit price. Not all pharmacy or CPT codes are included in these tables; codes included represent a significant portion of expected utilization for the eligible populations. |
| Standard cost | The standard price multiplied by the quantity of the service. A member’s services are aggregated by service categories, and then standard costs are aggregated across services and members to compute the overall cost of care.  Standard cost is reported for the following categories:   * Inpatient Facility. * Surgery and Procedure: * Inpatient Services. * Outpatient Services. * Evaluation and Management (E&M): * Inpatient Services. * Outpatient Services. * Diagnostic Laboratory Services. * Diagnostic Imaging Services. * Pharmacy, Ambulatory. |

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| Service frequency | Service frequency is reported for the following categories:   * Acute Medicine: Discharges, Days. * Acute Surgery: Discharges, Days. * Nonacute Inpatient: Discharges, Days. * ED Discharges. * Pharmacy Utilization: * Name brand only. * Name brand—Generic exists. * Generic only. * Generic name—Name brand exists. * Other condition-specific categories. * RCA and RDI report information on select cardiac procedures.   NCQA calculates:   * Total Inpatient Facility: Discharges, Days, ALOS. * Total Acute Inpatient: Discharges, Days, ALOS: * Total Acute Medicine: ALOS. * Total Acute Surgery: ALOS. * Total Nonacute Inpatient: ALOS. * Generic Utilization, given the existence of the generic option. * Generic Substitution Rate. * Overall Generic Utilization.   ***Note:*** *NCQA’s SPTs will be posted to* www.ncqa.org *by November 2, 2015.* |
| *Inpatient facility standard price* | Standard prices for inpatient facility services are assigned to each stay and based on the standard per diem price. Standard prices include room, board and ancillary services. Organizations use the length of stay and ICD-9-CM/ICD-10-CM Diagnosis codes to assign the appropriate standard price. Refer to *Calculating Total Standard Cost and Frequency: Inpatient Facility*. |
| *E&M; surgery and procedure standard price* | Standard prices for E&M and surgery and procedure services (professional component) use a resource-based, relative value scale (RBRVS) that establishes consistent prices across a wide range of professional services, including those performed by different specialists and other professionals. Additionally, inpatient, E&M and surgery and procedure services are summarized and collected separately from outpatient services. Refer to *Calculating Total Standard Cost: E&M, Surgery and Procedure.* |
| *Diagnostic imaging and laboratory standard price* | | Standard prices for imaging and laboratory services (professional and technical components) use an approach that establishes consistent prices across a wide range of services, including those performed by facilities, specialists and other professionals. An RBRVS is the primary source of data for these prices. |
| *Pharmacy standard price* | | Standard prices for ambulatory prescriptions are based on an index of average wholesale prices for drugs of interest. The standard price is listed per metric quantity for each NDC code. Organizations that do not capture the metric quantity for a prescription can use the standard price per days supply for an NDC. |

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|  | Both the standard price per metric quantity and the standard price per days supply are included in the SPT posted on the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)). Refer to Calculating Total Standard Cost: Pharmacy Services.  **Note:** Medical supplies (e.g., syringes) are not included in these measures. | |
| Metric quantity | | For an ambulatory prescription, the number of metric units dispensed. Metric quantity considers the number of pills (or days supply), as well as pill strength, and is more precise than estimating quantity using “days supply” only. | |
| Observed amount | | Observed amounts represent the organization’s services and costs for the eligible population during the treatment period. | |
| Expected amount | | NCQA calculates expected amounts based on national norms (i.e., based on data submitted to NCQA) after risk adjustment for the organization’s mix of conditions and members. | |
| Risk adjustment | | A method that adjusts each measure’s results based on hierarchical condition categories (HCC) risk adjustment approach. This approach combines diagnosis codes into a reduced code set of condition risk categories. Then, where relevant, condition risk categories and category combinations are mapped to disease groups called Hierarchical Condition Categories (HCC).  The approach further groups patients based on age, gender and condition to determine each patient’s risk weight. Risk weight scores are then assigned to one of 13 risk groups.  Download the risk adjustment tables from [www.ncqa.org](http://www.ncqa.org):   * Table CC—Comorbid. * Table HCC—Rank. * Table RRU—Weight. | |
| Risk-adjusted (expected) peer amount | | For each risk group, NCQA compares the organization’s results with a risk-adjusted peer amount. Peer amounts represent what is expected from an organization that has the same mix of members as other organizations with similar ages and genders. | |

[Overview](#TOC)

RRU measures report the organization’s total resource use, including cost and service frequency for each eligible member, during each measure’s treatment period. For RRU measures, the treatment period is the   
12-month measurement year and resource use is calculated for all services, whether or not they relate to the chronic condition.

[Measurement and Calculation Process](#TOC)

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| *Step 1* | Identify members for each major clinical condition and determine the age and gender category for each member. The medical and pharmacy services for these members are identified for the treatment period. |
| *Step 2* | Calculate total standard costs for each service category using NCQA-provided SPTs. Specifications list services to be measured and SPTs provide the standard price. Refer to the SPT Tables posted on the NCQA Web site (www.ncqa.org). |
| *Step 3* | Report service frequency and standard costs for the eligible population by member cohort, across all service categories. |
| *Step 4* | NCQA uses the stratified data submitted by all organizations to calculate each organization’s expected RRU amounts for each major clinical condition. |

[Guidelines](#TOC)

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| *1.* | **Reporting the RRU measures.** Organizations *must* report the related quality EOC measure when reporting RRU measures, specifically: | | | |
| * RDI and CDC. * RAS with MMA and AMR. | | * RHY and CBP. * RCA and PBH. | * RCO with SPR and PCE. |
| Additional information on quality indicator requirements for RRU reporting is available in the *How NCQA Calculates a Quality Index* *for RRU* document available at [www.ncqa.org/rru](http://www.ncqa.org/rru). | | | |
| *2.* | **Reporting members who switch products and product lines.** Assign members to the product and product line in which they are enrolled on the last day of the treatment period, as specified in each measure’s eligible population criteria. | | | |
| *3.* | **Categorizing members by services.** To identify or further categorize the eligible population (e.g., if an eligible member had major surgery during an inpatient stay), include all services, whether or not the organization paid for them or expects to pay for them (i.e., include denied claims).  **Counting services**. For cost and frequency reporting, report all services the organization paid for or expects to pay for (i.e., claims incurred but not paid yet). *Do not include* any denied service or day. If a member is enrolled retroactively, count all services for which the organization paid or expects to pay.  The organization may have:   * Covered the full amount. * Paid only a portion of the amount (e.g., 80 percent). * Paid nothing because the member covered the entire amount to meet a deductible. * Paid nothing because the service was covered as part of a PMPM payment. * Denied the service.   Count the service if:   * The organization paid the full amount ***or*** a portion of the amount (e.g., 80 percent). * The member paid for the service as part of the benefit offering (e.g., to meet a deductible), ***or*** * The service was covered under a PMPM payment.   Do not count the service if:   * The organization denied the service for any reason, unless the member paid for the service as part of the benefit offering (e.g., to meet a deductible), ***or*** * The claim for the service was rejected because it was missing information or was invalid for another reason. | | | |
| *4.* | **Calculating member months.** Count all eligible members with the relevant benefit during the treatment period. Using the following steps, calculate member months after all optional and required exclusions are applied. | | | |
| *Step 1* | For chronic condition measures, determine member months using a prespecified day  (e.g., the 15th or the last day of the month), which is determined by the organization’s administrative processes. The day selected must be consistent from month to month and year to year. For example*,* if the organization tallies membership on the 15th of the month and Ms. X is enrolled in the organization on January 15, Ms. X contributes one member month in January.  *Retroactive enrollment.* Organizations may count any month in which members were enrolled retrospectively and the organization received a retroactive capitation payment. | | |

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|  | *Step 2* | Use the member’s age on the last day of the treatment period to determine the age group where member months are counted. For example, for *Relative Resource Use for People With Diabete*s, if Ms. X turns 18 on December 31 and is enrolled for the entire treatment period, she contributes 12 member months to the 18–44 age category. | |
| *Step 3* | Attribute all member months to the product line in which the member is enrolled on the last day of the treatment period. | |
| **Note:** Pharmacy member months are the months during the treatment period when the member is covered by a pharmacy benefit. Calculate pharmacy member months using steps 1–3.  *Organizations that report pharmacy services for a member cohort (e.g., males, 18–44 years of age, risk group 1) must also report pharmacy benefit enrollment (i.e., pharmacy member months must be greater than 0) for that member cohort.* | | |
| *5.* | **Reporting outpatient services.** To report outpatient procedures and services, count the number of specified services the organization paid for, or expects to pay for, during the treatment period. Report all services under the member’s age and product on the last day of the treatment period. | | |
| *6.* | **Reporting inpatient services.** | | |
|  | ***Services for pricing and frequency*** | | Identify inpatient stays that occurred during the treatment period, even if the inpatient admission was prior to the treatment period or the inpatient discharge was after the end of the treatment period. Refer to the inpatient stay cost calculation instructions.  When reporting frequency of inpatient services, include all priced stays in the frequency counts. |
| *7.* | **Mapping proprietary or other codes.** Organizations and providers that use proprietary codes, Level II or state-specific Level III HCPCS codes must map them to industry standard codes. Organizations cannot count codes that are not included in the NCQA SPTs. For example, do not count anesthesiology (CPT 00100–01999), which is not included in the NCQA Surgery and Procedure SPT. | | |
| *8.* | **Counting multiple billings for the same date of service.** | | |
|  | *Services for pricing* | | Count *all* services billed for inpatient facility; E&M; surgery and procedure; and pharmacy pricing. For example, if a surgeon submits a bill for professional charges for an inpatient surgery and a hospital submits a separate bill pertaining to the same surgical episode with the same date of service, include each charge in the appropriate service category (Surgery and Procedure and Inpatient Facility, respectively). |
|  | *Services for frequency* | | For inpatient discharges, ED visits and condition-specific frequencies, count discharges, not the frequency of procedure codes billed. For example, if a surgeon submits a bill for professional charges for one inpatient stay, and a hospital submits a separate bill pertaining to the same surgical episode with the same date of service, count only one inpatient discharge. |
| *9.* | **Counting transfers.** Follow the *Guidelines for Utilization and Risk Adjusted Utilization Measures.* | | |
|  | *Mental health  and chemical dependency transfers* | | Follow the *Guidelines for Utilization and Risk Adjusted Utilization Measures.* |

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| *10.* | **Calculating inpatient services length of stay.** Use the formula below to report length of stay (LOS). | |
|  | *LOS* | All paid days from admission up to discharge. Do not count the last day of the stay unless the admission and discharge date are the same. For inpatient stays that start before the treatment period and end during the treatment period, or that start during the treatment period and end after the treatment period, count all paid days during the inpatient stay, even if they occur outside of the treatment period.  LOS = discharge date – admit date – denied days  **Note:** When an inpatient revenue code (i.e., UB Revenue code or equivalent) is associated with a stay, the LOS must equal at least one day. If the discharge date and the admission date are the same, the discharge date minus admission date equals 1 day, not 0 days. |
|  | *LOS per diem multiplier* | If the inpatient stay falls completely within the treatment period, use the total number of paid days as the per diem multiplier. If the inpatient stay does not fall completely inside the treatment period, or the organization did not pay for all days or expect to pay for all days, count only the days within the treatment period (including the last day in the treatment period) that the organization paid for or expected to pay for, to compute the per diem multiplier. |

[HCC-RRU Risk Adjustment](#TOC)

For the resource use measures, the following steps assign each member to a risk group. The steps are implemented after the eligible population is identified, Tables used to classify the eligible population by risk adjustment approach will be released with the SPTs on November 2, 2015.

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| *Step 1* | Identify the qualified service diagnosis.  Use the following value sets and identify all diagnoses for encounters during the treatment period based on the date of service for outpatient or ED services or on the discharge date for inpatient stays.   * Outpatient (Outpatient Value Set). * Observation (Observation Value Set). * Acute inpatient (Acute Inpatient Value Set). * Nonacute inpatient (Nonacute Inpatient Value Set). * ED (ED Value Set). * Surgery and procedure services. Services with a CPT Procedure code in Table  HCC—Surg.   Use all diagnosis codes for all services that meet the criteria listed above to complete the steps below. |
| *Step 2* | Assign each diagnosis code to one CC category (CC) using Table CC—Comorbid.  Exclude all diagnoses that cannot be assigned to a CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to step 6.  All digits must match exactly when mapping diagnosis codes to the CCs. |

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| *Step 3* | Determine HCCs for each CC identified. Refer to Table HCC—Rank.  For a member’s CC list, match the CC code to the CC code in the table, and assign:   * The ranking group. * The rank. * The HCC.   For CCs that do not match to Table HCC—Rank, use the CC as the HCC and assign a rank  of 1.  **Note:** One CC can map to multiple HCCs; each HCC can have one or more CCs. |
| *Step 4* | Select only the highest-ranked HCC in each ranking group using the *Rank* column (1 is the highest possible rank).  Drop all other HCCs in each ranking group and de-duplicate the HCC list if necessary.  **Note:** Refer to the Plan All-Cause Readmissions (PCR) measure for a Comorbid CC calculation example. |
| *Step 5* | Identify combination HCCs listed in Table HCC—Comb.  Some combinations suggest a greater amount of risk when observed together. For example, when diabetes *and* CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.  Compare each member’s list of unique HCCs to those in the *HCC* column in Table HCC—Comb and assign any additional HCC conditions.  For fully nested combinations (e.g., the diabetes/CHF combination is nested in the diabetes/ CHF/renal combination), use only the more comprehensive pattern. In this example, only the diabetes/CHF/renal combination is counted.  For overlapping combinations (e.g., the CHF, COPD combination overlaps the CHR/renal/ diabetes combination), use both sets of combinations. In this example, both CHF/COPD and CHF/renal/diabetes combinations are counted.  Based on the combinations, a member can have none, one or more of these additional HCCs.  **Note:** Refer to the PCR measure for a combination HCC calculation example. |
| *Step 6* | Identify demographic HCCs for RRU.  Categorize members by age and gender using the age ranges described in Table RRU—Age/ Gender—HCC. Assign a demographic HCC based on gender and the member’s age on the last day of the treatment period.  At the end of step 6, each member will have a final list of HCCs that includes at least one demographic HCC and none, one or more HCCs based on steps 1–5.  **Note:** Each RRU measure has its own demographic criteria. |
| *Step 7* | Calculate the weight for all the HCCs on each member’s list using Table RRU—Weight. Each HCC for RRU carries a predefined risk weight. |
| *Step 8* | Sum each member’s risk weights based on the final list of HCCs. A member’s risk score is the sum of the risk weights for all HCCs on that member’s list. Sum the weights based on the member’s HCC lists. Round the final risk score to four decimal places. |

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| *Step 9* | Use the table below to assign the member to a risk group based on risk score.  For example, a member with a total HCC risk score of 1.2300 is assigned to Risk Group 5. Report all member months and cost information for this member in this risk group, within the appropriate age and gender stratifications. |

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| --- | --- | --- | --- | --- | --- |
| Risk Group | Lower Score | Upper Score | Risk Group | Lower Score | Upper Score |
| 1 | 0.0000 | 0.2499 | 8 | 2.0000 | 2.4999 |
| 2 | 0.2500 | 0.4999 | 9 | 2.5000 | 2.9999 |
| 3 | 0.5000 | 0.7499 | 10 | 3.0000 | 3.9999 |
| 4 | 0.7500 | 0.9999 | 11 | 4.0000 | 4.9999 |
| 5 | 1.0000 | 1.2499 | 12 | 5.0000 | 5.9999 |
| 6 | 1.2500 | 1.4999 | 13 | 6.0000 | 6.9999 over |
| 7 | 1.5000 | 1.9999 |  | | |

Exclusions *(required)*

Exclude members with one or more of the following dominant conditions during the measurement year from all RRU measures.

* *Active cancer.* Members who had any diagnosis of cancer (Malignant Neoplasms Value Set; Other Neoplasms Value Set) with treatment (Cancer Treatment Value Set) during the measurement year.
* *Organ transplant (other than kidney).* Organ transplant (other than kidney) (Organ Transplant Other Than Kidney Value Set) during the measurement year.
* *HIV/AIDS.* Members who met any of the following criteria during the measurement year:
* At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set), on different dates of service, with an HIV diagnosis (HIV Disease Value Set). Visit types need not be the same for the two visits.
* At least one acute inpatient encounter (Acute Inpatient Value Set) with an HIV diagnosis (HIV Disease Value Set).
* At least one ED visit (ED Value Set) with an HIV diagnosis (HIV Disease Value Set).

Exclude members with either of the following dominant conditions during the measurement year from RHY, RCO and RAS.

* *ESRD.* ESRD (ESRD Value Set) during the measurement year.
* *Kidney transplant.* Kidney transplant (Kidney Transplant Value Set) during the measurement year.

[Steps for Calculating Service Categories](#TOC)

[Calculating Service Frequency](#TOC)

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| *Step 1* | Identify eligible members for each major clinical condition and assign them a risk group. |
| *Step 2* | Identify all inpatient, ED, pharmacy and condition-specific services rendered during the treatment period. |
| *Step 3* | Match the services to the codes provided in the specifications then group them into the following utilization categories:   * Acute Medicine: Discharges, Days. * Acute Surgery: Discharges, Days. * Nonacute: Discharges, Days. * ED: Discharges. * Pharmacy Utilization: * Name brand only. * Name brand—Generic exists. * Generic only. * Generic name—Name brand exists. * Other condition-specific categories (e.g., MRI, cardiac procedures): * RCA and RDI report information on select cardiac procedures. |
| *Step 4* | Count the unique services rendered during the treatment period in each utilization category, for each risk group. Refer to *Guideline 8—Counting multiple billings for the same date of service.*  Count the pharmacy prescriptions dispensed during the treatment period in each utilization category. One prescription is an amount lasting 30 days or less. To calculate the number of prescriptions that have a days supply of 30 days or longer, divide the days supply by 30 and round down to convert. |
| *Step 5* | Aggregate and report service frequencies by age, gender and risk group. |

[Calculating Standard Cost](#TOC)

Apply the SPTs to all services in each service category using the following steps. Refer to measure specifications for additional instructions.

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| *Step 1* | Identify eligible members for each major clinical condition and assign them a risk group. |
| *Step 2* | Identify all services rendered during the treatment period for each service category:   * Inpatient Facility (services provided by a facility during an inpatient stay). * E&M (inpatient visits, and outpatient visits including office visits, consultations and other services). * Surgery and Procedure (inpatient and outpatient procedures). * Diagnostic Imaging. * Diagnostic Laboratory. * Pharmacy (ambulatory prescriptions). |
| *Step 3* | Multiply the standard price by the units of service to compute a standard cost for the service. Refer to each service category’s instructions (i.e., *Calculating Total Standard Cost*). |

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| *Step 4* | For each major clinical condition, sum each member’s total standard cost for each service category. |
| *Step 5* | Report the total standard cost by age, gender and risk group. |
| *Step 6* | In each service category, if a member’s standard cost exceeds the cap amount, report the total standard cost, including only the cap amount from Table SPT-CAP. Do not exclude members who exceed the cap. |

Methods used to identify the unit of service and assign standard unit prices vary by service category. Steps required for each category are described below.

*[Calculating Total Standard Cost and Frequency:](#TOC)* [Inpatient Facility](#TOC)

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| *Step 1* | Identify all inpatient stays that occurred during the treatment period. Include stays that started before the treatment period or ended after the close of the treatment period. Create a unique record describing the member’s inpatient stay. |
| *Step 2* | Determine the LOS for frequency reporting. Compute the LOS in days, using paid for or expected-to-be-paid-for days only. Include all paid days in the calculation, whether or not they fall inside the treatment period. Use this LOS when reporting the frequency counts for each inpatient stay. |
| *Step 3* | Determine the LOS category for standard cost reporting. Assign the appropriate LOS group using Table C. |

Table C: Length of Stay Group

|  |  |  |
| --- | --- | --- |
| LOS (Days) | | LOS GRP |
| 1 | | A |
| 2 | | B |
| 3-4 | | C |
| 5-6 | | D |
| 7-8 | | E |
| 9-15 | | F |
| 16 or more | | G |
| *Step 4* | | Determine the LOS per diem multiplier. If the inpatient stay falls within the treatment period,  use the total days the organization paid for or expects to pay for as the per diem multiplier. If the inpatient stay does not fall inside the treatment period, or if the organization did not pay for all days or does not expect to pay for all days, count *only* the days within the treatment period (including the last day of the treatment period) that are paid for or expected to be paid for, as the per diem multiplier. | | |
| *Step 5* | | Determine if the inpatient stay is acute or nonacute. Nonacute stays include nursing home, skilled nursing facility, rehabilitation, hospice, hospital transitional care, swing bed and respite; all other inpatient stays are acute.  Report acute and nonacute stays separately when reporting frequency of inpatient stays.  **Note:** SPT-INP tables assign the acute field a value of “1” if the discharge was from an acute inpatient stay and a value of “0” if the discharge is from a nonacute stay. | | |
| *Step 6* | | Assign an *Aggregate Diagnostic Service Category (ADSC)* for the inpatient stay using the principal discharge diagnosis. To assign ADSC, download the ADSC Table from the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)) and match the principal ICD-9-CM Diagnosis code from the discharge claim to an ADSC. If the principal ICD-9-CM Diagnosis code is invalid or missing, or cannot be determined, map the inpatient stay to the ADSC Table’s *MISA* category. | | |
| *Step 7* | | Determine if the member underwent major surgery during the inpatient stay. Identify major surgeries by using the list of codes from the Maj-Surg Table. Flag members if one procedure code in the Maj-Surg Table is present from any provider during the stay.  If the inpatient stay is acute and has a major surgery, include it in the *Acute Surgery* category for frequency reporting. If the stay is acute but does not have a major surgery, include it in the *Acute Medicine* category. Nonacute stays are not categorized as surgical or nonsurgical for frequency reporting.  **Note:** SPT-INP-ADSC assigns the field MAJSURG a value of “1” to indicate the standard price when a major surgery is identified and a value of “0” if no major surgery is identified during the member’s inpatient stay. | | |
| *Step 8* | | Match each ADSC, LOS group, major surgery flag and acute or nonacute assignment for the stay to the NCQA-provided SPT to obtain the assigned standard price. Multiply the per diem multiplier by the per diem standard price to compute the total standard cost for the stay.  For frequency reporting, report the stay in the appropriate category based on the acute or nonacute assignment and surgery or medicine assignment. | | | |
| Example | | The treatment period is January 1–December 31 of the measurement year and a member  had an inpatient stay that started on December 25 of the measurement year and ended on January 4, with a primary discharge diagnosis from the ADSC category Cardiovascular—A and these characteristics:   * LOS of 10 paid days (LOS GRP = F). * Acute inpatient stay. * No major surgery event during the stay. * Per diem multiplier of 7 days (December 25–31).   Use the per diem multiplier with the original LOS GRP derived. The member’s total inpatient cost is 7 x $1,825 = $12,775. | | | |
| Example | | An member with an inpatient admission has a primary discharge diagnosis from the ADSC category Cardiovascular—A with these characteristics:   * LOS of 4 paid days (LOS GRP = E). * Acute inpatient stay. * Major surgery event during the stay. * Per diem multiplier of 4 days.   The total inpatient standard cost of 4 x $4,000 = $16,000 is counted in the Acute Surgery Inpatient category for frequency counting. | | | |

### *Sample Table:* SPT-INP-ADSC—Inpatient Facility Services

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ADSC | MAJSURG | ACUTE | LOS GRP | Per Diem Std Unit Price ($) |
| Cardiovascular—A | 0 | 1 | A | 6,400.00 |
| Cardiovascular—A | 0 | 1 | B | 3,400.00 |
| Cardiovascular—A | 0 | 1 | C | 3,100.00 |
| Cardiovascular—A | 0 | 1 | D | 2,950.00 |
| Cardiovascular—A | 0 | 1 | E | 1,850.00 |
| Cardiovascular—A | 0 | 1 | F | 1,825.00 |
| Cardiovascular—A | 0 | 1 | G | 1,775.00 |
| Cardiovascular—A | 1 | 1 | A | 7,700.00 |
| Cardiovascular—A | 1 | 1 | B | 5,500.00 |
| Cardiovascular—A | 1 | 1 | C | 4,900.00 |
| Cardiovascular—A | 1 | 1 | D | 4,450.00 |
| Cardiovascular—A | 1 | 1 | E | 4,000.00 |
| Cardiovascular—A | 1 | 1 | F | 3,700.00 |
| Cardiovascular—A | 1 | 1 | G | 3,400.00 |

**Note:** Standard prices are examples only and may not be the prices assigned to Cardiovascular—A.

*[Calculating Total Standard Cost:](#TOC)* [E&M](#TOC)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Step 1* | Identify all E&M services that occurred during the treatment period. The valid E&M codes used to select these services are listed in Table SPT-EM. | | | | |
| *Step 2* | Match each E&M service to the CPT codes in Table SPT-EM and assign the standard price to the E&M service. | | | | |
| *Step 3* | Multiply the standard price by the number of units associated with the E&M service. Most services have one unit. | | | | |
| *Step 4* | Sum the standard prices across the E&M services to calculate the total cost. Include all units of service on a claim line. Sum E&M services labeled as inpatient separate from those labeled as outpatient services. | | | | |
| Example | Calculate E&M cost using Sample Table SPT-EM—Outpatient Services for two eligible members, one with outpatient procedure codes and one with inpatient procedure codes during the treatment period. | | | | |
| Member E&M Outpatient Visits | Units of Service | Standard Price ($) |
| 99201 | 1 | 37.50 |
| 99201 | 1 | 37.50 |
| 99363 | 3 | 123.50 |
| ***Total*** | | 445.50 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | In this example, the member’s total E&M *outpatient* cost is $445.50 ($37.50 + $37.50 + ($123.50\*3). Sample Table SPT-EMprovides standard unit price information. | | | | |
| Member E&M Inpatient Visits | Units of Service | Standard Price ($) |
| 99433 | 1 | 33.50 |
| 99436 | 1 | 80.50 |
| 99440 | 1 | 157.50 |
| ***Total*** | | 271.50 |
|  | In this example, the member’s total E&M *inpatient* cost is $271.50 ($33.50 + $80.50 + 157.50). Sample Table SPT-EMprovides standard unit price information. | | | | |

### *Sample Table:* SPT-EM—E&M Outpatient Services

|  |  |  |
| --- | --- | --- |
| CPT | Description | Standard Unit Price ($) |
| 99201 | Office/outpatient visit, new | 37.50 |
| 99202 | Office/outpatient visit, new | 67.00 |
| 99203 | Office/outpatient visit, new | 99.25 |
| 99204 | Office/outpatient visit, new | 140.25 |
| 99205 | Office/outpatient visit, new | 178.00 |
| 99289 | Clinical care services | 85.00 |
| 99363 | Anticoag mgmt, init | 123.50 |

**Note:** Standard prices are examples only and may not be the prices assigned to these CPT codes.

### *Sample Table:* SPT-EM—E&M Inpatient Services

|  |  |  |
| --- | --- | --- |
| CPT | Description | Standard Unit Price ($) |
| 99315 | Nursing fac discharge day | 66.50 |
| 99316 | Nursing fac discharge day | 86.50 |
| 99318 | Annual nursing fac assessmnt | 93.50 |
| 99324 | Domicil/r-home visit new pat | 62.50 |
| 99433 | Normal newborn care/hospital | 33.50 |
| 99436 | Attendance, birth | 80.50 |
| 99440 | Newborn resuscitation | 157.50 |

Services provided *in an inpatient setting* are under the Excel workbook tab labeled “Std Price—IP E&M.”

Services provided *in an outpatient setting* are under the Excel workbook tab labeled “Std Price—OP E&M.”

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[*Calculating Total Standard Cost:* Surgery and Procedure](#TOC)

|  |  |  |  |
| --- | --- | --- | --- |
| *Step 1* | | Identify all surgery and procedure services provided by physicians and other professional providers during the treatment period. The valid procedure codes for these services are listed in Table SPT-Surg-Proc. | |
| *Step 2* | | Identify modifier codes. Procedure modifiers are sometimes used to define a service in more detail. The standard price for procedure modifiers varies, so these modifiers are combined with the procedure code to match to the appropriate row in the SPT. Use only the applicable modifiers contained in the SPTs. If a specific modifier is not included in the SPT, it is considered a no applicable modifier.  If a procedure code is billed with a no applicable modifier, set the modifier to blank. If the procedure code has no modifiers or if there are no applicable modifiers for a specific procedure code, price the procedure code with a blank modifier.  Surgery and Procedure CPT codes that have a proprietary modifier indicating an anesthesiology bill are not priced. | |
| *Step 3* | | Identify surgeries or procedures provided during an acute or nonacute inpatient stay. In the SPT, services provided in an inpatient setting are under the Excel workbook tab labeled “Std Price—IP Surgery” and services provided in an outpatient setting are under the Excel workbook tab labeled “Std Price—OP Surgery.” Organizations can distinguish between services provided in an inpatient or outpatient setting in several ways:   * Treat a surgery or procedure as outpatient unless it has a POS code of 21, 31, 39, 51  or 61. * If the POS code is not available, determine if the member was admitted overnight for the surgery or procedure. If so, treat the surgery or procedure as inpatient; if not, treat it as outpatient. * Treat a surgery as inpatient if it falls between the dates of an inpatient stay. If a surgery was used to classify an inpatient stay as surgical, price the surgery as inpatient. | |
| *Step 4* | | Download Table SPT-Surg-Proc for surgery and procedure services from the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)). | |
| *Step 5* | | Match each procedure code, applicable modifier and POS to obtain the assigned standard price for the service. | |
| *Step 6* | | Multiply the standard price by the number of units associated with the service. Most services have one unit. | |
| *Step 7* | | Sum the standard prices across the surgery and procedure services to calculate the total cost. Sum inpatient and outpatient costs separately. | |
| Example | | Calculate surgery and procedure cost. The tables below show examples of calculating cost based on CPT modifiers. | |

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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Example Organization | MODIFIERS | | CLAIMS DATA | | | RRU PRICING | |
| Total | Applicable Modifiers of Interest | CPT/ HCPCS | Modifier 1 | Modifier 2 | Codes to Be Priced | Standard Price ($) |
| A | 0 | 0 | 27598 |  |  | 27598 | 1,056 |
| B | 1 | 1 | 27598 | .50 |  | 27598.50 | 1,584 |
| C | 1 | 0 | 27598 | .RT |  | 27598 | 1,056 |
| D | 2 | 2 | 27598 | .50 | .62 | 27598.50, 27598.62 | 1,584 1,320 |
| E | 2 | 1 | 27598 | .62 | .RT | 27598.62 | 1,320 |
| F | 2 | 0 | 27598 | .RT | .T5 | 27598 | 1,056 |

*Note*

* *Surgeries must be classified correctly as inpatient or outpatient because the overhead charges for inpatient surgeries are included in the Inpatient Facility Cost category. The overhead for outpatient surgeries is included in the total cost of the surgery. If the health care facility bills the plan for overhead charges using codes in the SPT-Surg-Proc table, do not count those costs in this category.*
* *Do not include services provided by anesthesiologists. If an anesthesiologist submits a claim or encounter with codes included in Table SPT-Surg-Proc, do not include the claim or encounter for these services in the total cost.*

### *Sample Table*: SPT-Surg-Proc—Surgery and Procedure Services

|  |  |  |
| --- | --- | --- |
| CPT | Modifier | Price ($) |
| 27598 |  | 1,056 |
| 27598 | 50 | 1,584 |
| 27598 | 51 | 528 |
| 27598 | 52 | 792 |
| 27598 | 54 | 728 |
| 27598 | 55 | 222 |
| 27598 | 56 | 106 |
| 27598 | 62 | 1,320 |
| 27598 | 78 | 728 |
| 27598 | 80 | 169 |
| 27598 | 81 | 169 |
| 27598 | 82 | 169 |

**Note:** Standard prices are examples only and may not be the prices assigned to these CPT codes.

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*[Calculating Total Standard Cost:](#TOC)* [Diagnostic Laboratory Services](#TOC)

|  |  |
| --- | --- |
| *Step 1* | Identify all laboratory services during the treatment period. The valid procedure and revenue codes for these services are listed in Table SPT-LAB. |
| *Step 2* | Identify codes to price. CPT procedure codes are the preferred codes for pricing laboratory services. If a CPT code is present for a service, price the service using the available CPT code and procedure modifier (if applicable) using Table SPT-LAB. If a CPT code is not present for a service, price the service using the available revenue code.  Identify modifier codes when a CPT code is present. Procedure modifiers are sometimes used to define a service in more detail. In Table SPT-LAB, the standard price for the same CPT code can include multiple rows, reflecting the combinations of CPT codes and modifiers.  For laboratory services, Table SPT-Lab recognizes the following applicable modifiers:   * 26 = Professional Component. * TC = Technical Component.   *If a laboratory service is billed with a blank modifier,* match the procedure code and blank modifier on the service to the appropriate row in Table SPT-LAB.  *If a laboratory service is billed with an applicable modifier,* match the procedure code and modifier on the service to the appropriate row in Table SPT-LAB.  *If a laboratory service is billed with a no applicable modifier,* set the procedure modifier to blank and match the procedure code and blank modifier on the service to the appropriate row in Table SPT-LAB.  *If the procedure code has no modifiers* or if all modifiers for a specific procedure code are not applicable, price the procedure code with a blank modifier.  Refer to the “Example” table in *Calculating Total Standard Cost: Surgery and Procedure.*  If the same service is billed by multiple providers, include and price all services. For example, if a physician and a facility bill for the same service, price both. |
| *Step 3* | Download Table SPT-LAB from the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)). |
| *Step 4* | Match each applicable procedure and applicable procedure modifier or revenue code to obtain the assigned standard price for the service. |
| *Step 5* | Multiply the standard price by the number of units associated with the service. Most services have one unit. |
| *Step 6* | Sum the standard prices across the laboratory services to calculate total cost. |

***Note:*** *Codes for laboratory services in Table SPT-LAB are separated into CPT and revenue codes.*

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*[Calculating Total Standard Cost:](#TOC)* [Diagnostic Imaging Services](#TOC)

|  |  |
| --- | --- |
| *Step 1* | Identify all imaging services during the treatment period. The valid procedure and revenue codes for these services are listed in Table SPT-IMG. |
| *Step 2* | Identify codes to price. CPT procedure codes are the preferred codes for pricing imaging services. If a CPT code is present for a service, price the service using the available CPT code and procedure modifier (if applicable) using Table SPT-IMG. If a CPT code is not present for a service, price the service using the available revenue code.  Identify modifier codes when a CPT code is present. Procedure modifiers are sometimes used to define a service in more detail. In Table SPT-IMG, the standard price for the same CPT code can include multiple rows, reflecting the combinations of CPT codes and modifiers.  For imaging services, Table SPT-IMG recognizes the following applicable modifiers:   * 26 = Professional Component. * TC = Technical Component.   *If an imaging service is billed with a blank modifier,* match the procedure code and blank modifier on the service to the appropriate row in Table SPT-IMG.  *If an imaging service is billed with an applicable modifier,* match the procedure code and modifier on the service to the appropriate row in Table SPT-IMG.  *If an imaging service is billed with a no applicable modifier,* set the procedure modifier to blank and match the procedure code and blank modifier on the service to the appropriate row in Table SPT-IMG.  *If the procedure code has no modifiers* or if all modifiers for a specific procedure code are not applicable, price the procedure code with a blank modifier.  Refer to the “Example” table in *Calculating Total Standard Cost: Surgery and Procedure.*  If the same service is billed by multiple providers, include and price all services. For example, if a physician and a facility bill for the same service, price both. |
| *Step 3* | Download Table SPT-IMG from the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)). |
| *Step 4* | Match each applicable procedure or revenue code to obtain the assigned standard price for the service. |
| *Step 5* | Multiply the standard price by the number of units associated with the service. Most services have one unit. |
| *Step 6* | Sum the standard prices across the imaging services to calculate total cost. |

***Note:*** *Codes for imaging services in Table SPT-IMG are separated into CPT and revenue codes.*

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*[Calculating Total Standard Cost and Frequency:](#TOC)* [Pharmacy Services](#TOC)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Step 1* | Identify all ambulatory prescriptions dispensed (pharmacy services) during the treatment period. | | | | |
| *Step 2* | Identify the NDC code and the metric quantity for each prescription. If metric quantity is available, the organization must use it to determine standard price. If the metric quantity is not available, use the standard unit price per day.  Organizations that use proprietary or regional codes must map them to standard NDC codes. | | | | |
| *Step 3* | Download Table SPT-Pharm from the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)). The table contains:   * The NDC code. * A standard unit price per metric quantity. * A standard unit price per day. * Prescription category: | | | | |
|  | * Name brand only (N1). * Name brand—Generic exists (N2). | | | * Generic only (G1). * Generic name—Name brand exists (G2). | |
| *Step 4* | Match each NDC code to the appropriate row in Table SPT-Pharm. | | | | |
| *Step 5* | For pharmacy prescription utilization, aggregate and report service frequencies by organization, in each prescription category, at the total level.  One prescription is an amount lasting 30 days or less. To calculate the number of prescriptions when the days supply is 30 days or more, divide the days supply by 30 and round down to convert. | | | | | |
| *Step 6* | If the metric quantity is available, multiply the metric quantity dispensed by the standard price per metric quantity for each prescription. | | | | | |
| *Step 7* | If the metric quantity is unavailable, multiply the days supply dispensed by the standard unit price per day for each prescription. | | | | | |
| *Step 8* | Sum the unit prices for all unique prescription dispensing events. | | | | | |
| Example | Calculate total pharmacy cost with metric quantityusing Sample Table SPT—Pharmforan eligible member with prescriptions that have metric quantities.  In this example, the member’s total pharmacy cost is $1,330.00. | | | | | |
| Member Prescriptions | | Metric Quantity Prescribed | Standard Unit Price ($) per Metric Quantity | | Standard Cost ($) | |
| 11111111111 | | 8 | 10.00 | | 80.00 | |
| 11111111111 | | 12 | 10.00 | | 120.00 | |
| 22222222222 | | 10 | 20.00 | | 200.00 | |
| 66666666666 | | 8 | 30.00 | | 240.00 | |
| 66666666666 | | 8 | 30.00 | | 240.00 | |
| 66666666666 | | 15 | 30.00 | | 450.00 | |
| ***Total*** | | — | — | | 1,330.00 | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Example | Calculate total pharmacy cost without metric quantity using Sample Table SPT—Pharm for a member with the same prescriptions, but without metric quantity.  In this example, the member’s total pharmacy cost is $1,336.00. | | | | |
| Member Prescriptions | | Metric Quantity Prescribed | Days Supply | Standard Unit  Price per Day ($) | Standard Cost ($) | |
| 11111111111 | | NA | 10 | 8.00 | 80.00 | |
| 11111111111 | | NA | 15 | 8.00 | 120.00 | |
| 22222222222 | | NA | 8 | 25.00 | 200.00 | |
| 66666666666 | | NA | 10 | 24.00 | 240.00 | |
| 66666666666 | | NA | 10 | 24.00 | 240.00 | |
| 66666666666 | | NA | 19 | 24.00 | 456.00 | |
| ***Total*** | | — | — | — | 1,336.00 | |

### *Sample Table:* SPT-Pharm—Pharmacy Services

|  |  |  |
| --- | --- | --- |
| NDC | Standard Unit Price per Metric Quantity ($) | Standard  Unit Price per Day ($) |
| 11111111111 | 10.00 | 8.00 |
| 22222222222 | 20.00 | 25.00 |
| 33333333333 | 30.00 | 10.00 |
| 44444444444 | 10.00 | 12.00 |

**Note:** Standard prices are examples only and may not be the prices assigned to these NDC codes.

[Relative Resource Use Results](#TOC)

Using the data submitted by all organizations, NCQA estimates the observed and expected RRU amounts for each clinical condition for each organization. Results can be assessed at an overall basis, across all members and major clinical conditions, by service category or for a member cohort within a condition.

NCQA uses the following approach and formulas to compute the expected standard cost and utilization frequency metrics for each submission.

* **C** Organization standard costs.
* **i** Indexes eligible members.
* **s** Indexes service categories.
* **m** Indexes member cohorts.
* **o** Indexes reporting organizations.

Standard costs are reported by service category across all eligible members in a member cohort. Member cohorts are defined by HCC-RRU risk group, age and gender grouping. Following the assignment of standard price to services provided to eligible members, the organization sums standard costs across eligible members for each member cohort to compute total costs for a service category (for Organization O).

Cs,m,o = ∑iCi,s,m,o

In addition to standard costs, organizations report total member months (Totmm) and pharmacy member months (Rxmm) for each member cohort.

Totmmm,o = ∑iTotmmi,m,o

Rxmmm,o = ∑iRxmmi,m,o

NCQA collects this information for all organizations. Data are pooled across organizations in a “peer group” and used to compute normative benchmarks that can be used to estimate expected standard costs for each organization. Peer benchmarks are created at the per member per month (PMPM) level; standard cost benchmarks (BenchC) are created for each member cohort and service category. For example, for standard costs, NCQA first aggregates costs across organizations in a peer group:

BenchCs,m = ∑oCs,m,o

Total and pharmacy member months are also summed.

BenchTotmmm = ∑oTotmmm,o

BenchRxmmm = ∑oRxmmm,o

**Note:** These calculations use only the values for p included in the peer benchmark group.

*For nonpharmacy service categories,* the benchmark PMPM for a peer group is:

BenchCpmpms,m = BenchCs,m/BenchTotmmm

*For pharmacy service categories,* the benchmark PMPM for a peer group is:

BenchCpmpms,m = BenchCs,m/BenchRxmmm

To compute expected amounts for standard costs, values are computed as follows.

*For nonpharmacy services:*

E(Cs,m,o) = BenchCpmpms,m \* Totmmm,o

*For pharmacy services:*

E(Cs,m,o) = BenchCpmpms,m \* Rxmmm,o

At this point, expected and actual values can be compared and an RRU ratio calculated for each combination of service category and member cohort. The expected amount can also be aggregated and an RRU ratio calculated at any level. An overall ratio across all HCC-RRU risk categories and member cohorts would be (for organization p):

RRUo = ∑s ∑m Cs,m / ∑s ∑m E(Cs,m).

After calculating RRU findings, NCQA provides organizations with their relative resource observed-to-expected ratio at the service category and major clinical condition level.

* A score of *1.00* indicates that the observed amounts for standard costs or utilization are equal to the expected amounts.
* A score *>1.00* indicates that the observed amounts for standard costs or utilization are greater than the expected amounts.
* A score *<1.00* indicates that the observed amounts for standard costs or utilization are lower than the expected amounts.

For example, an organization whose O/E calculation is 1.10 for pharmacy services in its *Relative Resource Use for* *People With Diabetes* measure has a total standard cost for pharmacy services for RDI that is 10 percent higher than the expected total pharmacy services cost.

[Relative Resource Use Pharmacy Prescription Frequency Results](#TOC)

NCQA reports the following rates:

* Total Prescription Rate.
* Generic Utilization, given the existence of the generic option.
* Generic Substitution Rate.
* Overall Generic Utilization.

NCQA will use the following formulas to compute the prescription utilization rates:

* Total Prescription = (N1 + N2 + G1 + G2).
* Generic Utilization, given the existence of the generic option = [(G1 + G2)/(N2+G1+G2)].
* Generic Substitution Rate = [G2/(N2+G2)].
* Overall Generic Utilization = [(G1+G2)/(N1+N2+G1+G2)].

**Note:** One prescription is an amount lasting 30 days or less. To calculate the number of prescriptions which have a days supply of 30 days or longer, divide the days supply by 30 and round down to convert.

Data Elements for Reporting

NCQA defines a set of building blocks (data elements) for each measure and requires the use of XML. Each measure specification includes a reporting table containing these building blocks: metric specification name, risk groups, age groups and gender options associated with the measure. The IDs for each building block are in the XML (schema) file posted on the NCQA Web site (www.ncqa.org/rru).

## [Relative Resource Use for People With Diabetes (RDI)](#TOC)

Summary of Changes to HEDIS 2016

* Removed the optional exclusion for polycystic ovaries.

Description

The relative resource use by members with diabetes during the measurement year.

Eligible Population

**Note:** Organizations must report the quality measure (CDC) when reporting RDI.

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 18–75 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year.  To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage  (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/ diagnosis | There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. Organizations must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.  *Claim/encounter data.* Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):   * At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. * At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of diabetes (Diabetes Value Set).   *Pharmacy data.* Members who were dispensed insulin or hypoglycemics/antihyper-glycemics during the measurement year or the year prior to the measurement year, on an ambulatory basis (Table CDC-A). |

Exclusions *(optional)*

Identify members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year **and** who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

**Note:** If the optional exclusions are applied for the CDC measure, they must be applied for the RDI measure. If the optional exclusions are not applied for the CDC measure, they may not be applied to the RDI measure. Because RDI is administrative only, do not exclude members from this measure based on exclusions found during chart review for the CDC measure. Members must be included in RDI even if they are excluded during chart review for CDC.

Exclusions *(required)*

Refer to *Required Exclusions* in the *Guidelines for Relative Resource Use.*

Categorization of Eligible Population

|  |  |
| --- | --- |
| Major clinical condition | Diabetes. |
| Risk group | Refer to the *RRU Risk Adjustment* in the *Guidelines for Relative Resource Use.* |

Standard Cost Calculations

The organization reports total standard costs of all services for which the organization has paid or expects to pay for the eligible population during the treatment period. Total standard costs are assigned by matching codes for services rendered to codes listed in the NCQA SPTs (the tables will be posted to NCQA’s Web site by November 2, 2015).

|  |  |  |
| --- | --- | --- |
| Apply standard price | SPTs categorize services as follows:   * Inpatient Facility. * E&M: * Inpatient Services. * Outpatient Services. * Laboratory Services. | * Surgery and Procedure: * Inpatient Services. * Outpatient Services. * Imaging Services. * Pharmacy. |
| Count all services listed in the SPTs rendered to members in the eligible population during the treatment period. Refer to the *Calculating Standard Cost* instructions in the *Guidelines for Relative Resource Use* for steps on categorizing services and linking service data to NCQA’s SPTs. | |
| Calculate total cost | Sum the total standard cost for each eligible member. Within each service category,  if a member’s standard cost exceeds the service category cap amount, report the  total standard cost specified in the NCQA Cost Cap Amounts table (released with  the SPTs).  Sum and report the total standard cost for the eligible population in each service category by member cohort. | |

Service Frequency Calculations

|  |  |
| --- | --- |
| Total frequency of service | Service frequency counts are reported for all services for which the organization  has paid or expects to pay for the eligible population during the treatment period. An organization reports each eligible member’s services rendered during the treatment period for the following utilization categories:   * Acute Medicine: Discharges, Days. * Acute Surgery: Discharges, Days. * Nonacute: Discharges, Days. * ED Discharges. * Pharmacy Utilization: * Name brand only (N1). * Name brand—Generic exists (N2). * Generic only (G1). * Generic name—Name brand exists (G2).   ***Other Condition-Specific Categories***   * Cardiac Catheterization. * PCI. * CABG. * Carotid Endarterectomy. * Carotid Artery Stenosis Diagnostic Test. * Cardiac Computed Tomography. * CAD Diagnostic Test Using EBCT/Nuclear Imaging Stress Test.   Refer to the instructions in the *Guidelines for Relative Resource Use.* The *Pharmacy Utilization* categories are included in Table SPT-Pharm. |
| Inpatient Facility | This category measures the number of acute and nonacute inpatient facility discharges and days regardless of diagnosis. Count each discharge once. Include data from any institution that provides acute or long-term/specialty nonacute care.  Refer to the *Guidelines for Relative Resource Use* to identify acute inpatient (including medicine and surgery) and nonacute discharges and days. |
| ED Discharges | This category measures use of ED services.  Count each visit to an ED during the treatment period that does not result in an inpatient stay that was paid, or expected to be paid, by the organization, regardless of the intensity of care required during the stay or the length of stay. Count only one ED visit per date of service. Do not count visits to urgent care centers. Services for members admitted to the hospital from an ED visit are included in the Inpatient Facility category only.  Identify ED visits using either of the following:   * An ED visit (ED Value Set). * A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set). |

|  |  |
| --- | --- |
| Pharmacy Utilization | Use Table SPT-Pharm to identify the prescription categories for each drug dispensed in the treatment period.  Sum and report the number of prescriptions in each of the four categories in the Pharmacy—Total Service Frequency by Prescription Category table. |

Other Condition-Specific Categories

Use the information below and refer to the instructions in the *Guidelines for Relative Resource Use.*

|  |  |
| --- | --- |
| Cardiac Catheterization | Cardiac catheterization (Cardiac Catheterization Value Set). Report all cardiac catheterizations performed separately. Do not report a cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a PCI in the cardiac catheterization rate; report only the PCI.  Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG. |
| PCI | Percutaneous coronary intervention (PCI Value Set).Report all PCIs performed separately. Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG. |
| CABG | Coronary artery bypass graft (CABG Value Set). Report each CABG only once for each date of service per patient, regardless of the number of arteries involved or the number or types of grafts involved.  Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG. |
| Carotid Endarterectomy | Carotid endarterectomy (Carotid Endarterectomy Value Set). Report the number of carotid endarterectomies. |
| CAS Diagnostic Test | Carotid artery stenosis diagnostic test (CAS Tests Value Set). Report the number of CAS diagnostic tests. |
| Cardiac CT | Cardiac computed tomography (Cardiac CT Value Set). Report the number of cardiac CTs. |
| CAD Diagnostic Test Using EBCT/ Nuclear Imaging Stress Tests | Coronary artery disease diagnostic tests using EBCT and nuclear imaging stress tests (CAD Tests Value Set). Report the number of CAD diagnostic tests using EBCT and nuclear imaging stress tests. |

Data Elements for Reporting

Table RDI-A-1/2/3: Data Elements for Relative Resource Use for People   
With Diabetes

|  |  |
| --- | --- |
| **Metadata ID** | **Metadata Specification Name** |
| EligiblePopulation | Eligible Population |
| Exclusions | Exclusions |
| NameBrandOnlyCount | Pharmacy: Name Brand only (N1) |
| NameBrandGenericExistsCount | Pharmacy: Name Brand—Generic Exists (N2) |
| GenericOnlyCount | Pharmacy: Generic Only (G1) |
| GenericNameBrandExistsCount | Pharmacy: Generic—Name Brand Exists (G2) |

Table RDI-B-1/2/3: Data Elements for Relative Resource Use for People   
With Diabetes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender | Age | Risk Group | Type | Metric Specification Name |
| Male | 18-44 | 1 | Cost | Inpatient Facility |
| Female | 45-54 | 2 | Cost | E&M Inpatient Services |
|  | 55-64 | 3 | Cost | E&M Outpatient Services |
|  | 65-75 | 4 | Cost | Surgery & Procedure Inpatient Services |
|  |  | 5 | Cost | Surgery & Procedure Outpatient Services |
|  |  | 6 | Cost | Imaging Services |
|  |  | 7 | Cost | Laboratory Services |
|  |  | 8 | Cost | Pharmacy |
|  |  | 9 | Count | Inpatient Facility: Acute Inpatient: Medical Days |
|  |  | 10 | Count | Inpatient Facility: Acute Inpatient: Medical Discharges |
|  |  | 11 | Count | Inpatient Facility: Acute Inpatient: Surgery Days |
|  |  | 12 | Count | Inpatient Facility: Acute Inpatient: Surgery Discharges |
|  |  | 13 | Count | Inpatient Facility: Nonacute: Days |
|  |  |  | Count | Inpatient Facility: Nonacute: Discharges |
|  |  |  | Count | ED Discharges |
|  |  |  | Count | Cardiac Catheterization |
|  |  |  | Count | PCI |
|  |  |  | Count | CABG |
|  |  |  | Count | Carotid Endarterectomy |
|  |  |  | Count | Carotid Artery Stenosis Diagnostic Test |
|  |  |  | Count | Cardiac Computed Tomography |
|  |  |  | Count | CAD Diagnostic Test Using EBCT/Nuclear Imaging Stress Test |
|  |  |  | Mem | Member Months Medical |
|  |  |  | Mem | Member Months Pharmacy |

Table RDI-C-1/2/3: Data Elements for Relative Resource Use for People   
With Diabetes

|  |
| --- |
| Data Element |
| Eligible Population |
| Exclusions |
| Eligible Population per 1,000 MY Medical |
| Eligible Population per 1,000 MY Pharmacy |
| Name Brand Only Count (N1) |
| Name Brand Generic Exists Count (N2) |
| Generic Only Count (G1) |
| Generic Name Brand Exists Count (G2) |
| Total Prescriptions (N1+N2+G1+G2) |
| Generic Utilization Rate [(G1 + G2)/(N2+G1+G2)] |
| Generic Substitution Rate [(G2)/(N2+G2)] |
| Overall Generic Utilization [(G1+G2)/(N1+N2+G1+G2)] |
| Inpatient Facility PMPM |
| E&M Inpatient Services PMPM |
| E&M Outpatient Services PMPM |
| Surgery & Procedure Inpatient Services PMPM |
| Surgery & Procedure Outpatient Services PMPM |
| Imaging Services PMPM |
| Laboratory Services PMPM |
| Pharmacy PMPM |
| Inpatient Facility: Acute Inpatient: Medical Days per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Medical Discharges per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Surgery Days per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Surgery Discharges per 1,000 MY |
| Inpatient Facility: Nonacute Days per 1,000 MY |
| Inpatient Facility: Nonacute Discharges per 1,000 MY |
| Inpatient Facility Acute Medical ALOS |
| Inpatient Facility Acute Surgery ALOS |
| Inpatient Facility Nonacute ALOS |
| Total Inpatient Facility Acute ALOS |
| Total Inpatient Facility ALOS |
| ED Discharges per 1,000 MY Medical |
| Cardiac Catheterization per 1,000 MY Medical |
| PCI per 1,000 MY Medical |
| CABG per 1,000 MY Medical |
| Carotid Endarterectomy per 1,000 MY Medical |
| Carotid Artery Stenosis Diagnostic Test per 1,000 MY Medical |
| Cardiac Computed Tomography per 1,000 MY Medical |
| CAD Diagnostic Test Using EBCT/Nuclear Imaging Stress Tests per 1,000 MY Medical |

**Note:** This table indicates the calculated fields that NCQA provides for the age-gender-risk totals.

## [Relative Resource Use for People With Cardiovascular Conditions (RCA)](#TOC)

Summary of Changes to HEDIS 2016

* Added a method and value sets to identify discharges for the event/diagnosis.

Description

The relative resource use by members with cardiovascular conditions during the measurement year.

Eligible Population

**Note:** Organizations must report the quality measure (PBH) when reporting RCA.

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 18–75 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year and the year prior to the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/ diagnosis | Members are identified for the eligible population by event or by diagnosis. The organization must use *both* to identify the eligible population, but a member need only be identified in one to be included in the measure.  *Event.* Any of the following during the year prior to the measurement year meet criteria:   * *AMI*. Discharged from an inpatient setting with an AMI (AMI Value Set). To identify discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.  * *CABG*. Discharged from an inpatient setting with a CABG (CABG Value Set).  To identify discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.  * *PCI*. Members who had PCI (PCI Value Set) in any setting (e.g., inpatient, outpatient, ED). |

|  |  |
| --- | --- |
|  | *Diagnosis.* Identify members as having IVD who met at least either of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.   * At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set). * At least one acute inpatient visit (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set). |

Exclusions *(required)*

Refer to *Required Exclusions* in the *Guidelines for Relative Resource Use.*

Categorization of Eligible Population

|  |  |
| --- | --- |
| Major clinical condition | Cardiovascular condition. |
| Risk Group | Refer to the *RRU Risk Adjustment* in the *Guidelines for Relative Resource Use.* |

Standard Cost Calculations

The organization reports total standard costs of all services for which the organization has paid or expects to pay for the eligible population during the treatment period. Total standard costs are assigned by matching codes for services rendered to codes listed in the NCQA SPTs (the tables will be posted to NCQA’s Web site by November 2, 2015).

|  |  |  |
| --- | --- | --- |
| Apply standard price | SPTs categorize services as follows:   * Inpatient Facility. * E&M: * Inpatient Services. * Outpatient Services. * Laboratory Services. | * Surgery and Procedure: * Inpatient Services. * Outpatient Services. * Imaging Services. * Pharmacy. |
| Count all services listed in the SPTs rendered to members in the eligible population during the treatment period. Refer to the *Calculating Standard Cost* instructions in the *Guidelines for Relative Resource Use* for steps on categorizing services and linking service data to NCQA’s SPTs. | |
| Calculate total cost | Sum the total standard cost for each eligible member. Within each service category,  if a member’s standard cost exceeds the service category cap amount, report the  total standard cost specified in the NCQA Cost Cap Amounts table (released with  the SPTs).  Sum and report the total standard cost for the eligible population in each service category by member cohort. | |

Service Frequency Calculations

|  |  |
| --- | --- |
| Total frequency of service | Service frequency counts are reported for all services for which the organization has paid or expects to pay for the eligible population during the treatment period. The measure captures each eligible member’s services rendered during the treatment period for the following utilization categories:   * Acute Medicine: Discharges, Days. * Acute Surgery: Discharges, Days. * Nonacute: Discharges, Days. * ED Discharges. * Pharmacy Utilization: * Name brand only (N1). * Name brand—Generic exists (N2). * Generic only (G1). * Generic name—Name brand exists (G2).   ***Other Condition-Specific Categories***   * Cardiac Catheterization. * PCI. * CABG. * Carotid Endarterectomy. * Carotid Artery Stenosis Diagnostic Test. * Cardiac Computed Tomography. * CAD Diagnostic Test Using EBCT/Nuclear Imaging Stress Test.   Refer to the instructions in the *Guidelines for Relative Resource Use*. The *Pharmacy Utilization* categories are included in Table SPT—Pharm. |
|  |
| Inpatient Facility | This category measures the number of acute and nonacute inpatient facility discharges and days, regardless of diagnosis. Count each discharge once. Include data from any institution that provides acute or long-term/specialty nonacute care.  Refer to the *Guidelines for Relative Resource Use* to identify acute inpatient (including medicine and surgery) and nonacute discharges and days. |
| ED Discharges | This category measures use of ED services.  Count each visit to an ED during the treatment period that does not result in an inpatient stay that was paid, or expected to be paid, by the organization, regardless of the intensity of care required during the stay or the length of stay. Count only one ED visit per date of service. Do not count visits to urgent care centers. Services for members admitted to the hospital from an ED visit are included in the Inpatient Facility category only.  Identify ED visits using either of the following:   * An ED visit (ED Value Set). * A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set). |

|  |  |
| --- | --- |
| Pharmacy Utilization | Use Table SPT—Pharm to identify the prescription categories for each drug dispensed in the treatment period.  Sum and report the number of prescriptions in each of the four categories in the Pharmacy—Total Service Frequency by Prescription Category table. |

Other Condition-Specific Categories

Use the information below and refer to the instructions in the *Guidelines for Relative Resource Use.*

|  |  |
| --- | --- |
| Cardiac Catheterization | Cardiac catheterization (Cardiac Catheterization Value Set). Report all cardiac catheterizations performed separately. Do not report a cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a PCI in the cardiac catheterization rate; report only the PCI.  Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG. |
| PCI | Percutaneous coronary intervention (PCI Value Set).Report all PCIs performed separately. Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG. |
| CABG | Coronary artery bypass graft (CABG Value Set). Coronary artery bypass graft. Report each CABG only once for each date of service per patient, regardless of the number of arteries involved or the number or types of grafts involved.  Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG. |
| Carotid Endarterectomy | Carotid endarterectomy (Carotid Endarterectomy Value Set). Report the number of carotid endarterectomies. |
| CAS Diagnostic Test | Carotid artery stenosis diagnostic test (CAS Tests Value Set). Report the number of CAS diagnostic tests. |
| Cardiac CT | Cardiac computed tomography (Cardiac CT Value Set). Report the number of cardiac CTs. |
| CAD Diagnostic Test Using EBCT/ Nuclear Imaging Stress Tests | Coronary artery disease diagnostic tests using EBCT and nuclear imaging stress tests (CAD Tests Value Set). Report the number of CAD diagnostic tests using EBCT and nuclear imaging stress tests. |

Data Elements for Reporting

Table RCA-A-1/2/3: Data Elements for Relative Resource Use for People   
With Cardiovascular Conditions

|  |  |
| --- | --- |
| Metadata ID | Metadata Specification Name |
| EligiblePopulation | Eligible Population |
| Exclusions | Exclusions |
| NameBrandOnlyCount | Pharmacy: Name Brand only (N1) |
| NameBrandGenericExistsCount | Pharmacy: Name Brand—Generic Exists (N2) |
| GenericOnlyCount | Pharmacy: Generic Only (G1) |
| GenericNameBrandExistsCount | Pharmacy: Generic—Name Brand Exists (G2) |

Table RCA-B-1/2/3: Data Elements for Relative Resource Use for People   
With Cardiovascular Conditions

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender | Age | Risk Group | Type | Metric Specification Name |
| Male | 18-44 | 1 | Cost | Inpatient Facility |
| Female | 45-54 | 2 | Cost | E&M Inpatient Services |
|  | 55-64 | 3 | Cost | E&M Outpatient Services |
|  | 65-75 | 4 | Cost | Surgery & Procedure Inpatient Services |
|  |  | 5 | Cost | Surgery & Procedure Outpatient Services |
|  |  | 6 | Cost | Imaging Services |
|  |  | 7 | Cost | Laboratory Services |
|  |  | 8 | Cost | Pharmacy |
|  |  | 9 | Count | Inpatient Facility: Acute Inpatient: Medical Days |
|  |  | 10 | Count | Inpatient Facility: Acute Inpatient: Medical Discharges |
|  |  | 11 | Count | Inpatient Facility: Acute Inpatient: Surgery Days |
|  |  | 12 | Count | Inpatient Facility: Acute Inpatient: Surgery Discharges |
|  |  | 13 | Count | Inpatient Facility: Nonacute: Days |
|  |  |  | Count | Inpatient Facility: Nonacute: Discharges |
|  |  |  | Count | ED Discharges |
|  |  |  | Count | Cardiac Catheterization |
|  |  |  | Count | PCI |
|  |  |  | Count | CABG |
|  |  |  | Count | Carotid Endarterectomy |
|  |  |  | Count | Carotid Artery Stenosis Diagnostic Test |
|  |  |  | Count | Cardiac Computed Tomography |
|  |  |  | Count | CAD Diagnostic Test Using EBCT/Nuclear Imaging Stress Test |
|  |  |  | Mem | Member Months Medical |
|  |  |  | Mem | Member Months Pharmacy |

Table RCA-C-1/2/3: Data Elements for Relative Resource Use for People With   
Cardiovascular Conditions

|  |
| --- |
| Data Element |
| Eligible Population |
| Exclusions |
| Eligible Population per 1,000 MY Medical |
| Eligible Population per 1,000 MY Pharmacy |
| Name Brand Only Count (N1) |
| Name Brand Generic Exists Count (N2) |
| Generic Only Count (G1) |
| Generic Name Brand Exists Count (G2) |
| Total Prescriptions (N1+N2+G1+G2) |
| Generic Utilization Rate [(G1 + G2)/(N2+G1+G2)] |
| Generic Substitution Rate [(G2)/(N2+G2)] |
| Overall Generic Utilization [(G1+G2)/(N1+N2+G1+G2)] |
| Inpatient Facility PMPM |
| E&M Inpatient Services PMPM |
| E&M Outpatient Services PMPM |
| Surgery & Procedure Inpatient Services PMPM |
| Surgery & Procedure Outpatient Services PMPM |
| Imaging Services PMPM |
| Laboratory Services PMPM |
| Pharmacy PMPM |
| Inpatient Facility: Acute Inpatient: Medical Days per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Medical Discharges per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Surgery Days per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Surgery Discharges per 1,000 MY |
| Inpatient Facility: Nonacute Days per 1,000 MY |
| Inpatient Facility: Nonacute Discharges per 1,000 MY |
| Inpatient Facility Acute Medical ALOS |
| Inpatient Facility Acute Surgery ALOS |
| Inpatient Facility Nonacute ALOS |
| Total Inpatient Facility Acute ALOS |
| Total Inpatient Facility ALOS |
| ED Discharges per 1,000 MY Medical |
| Cardiac Catheterization per 1,000 MY Medical |
| PCI per 1,000 MY Medical |
| CABG per 1,000 MY Medical |
| Carotid Endarterectomy per 1,000 MY Medical |
| Carotid Artery Stenosis Diagnostic Test per 1,000 MY Medical |
| Cardiac Computed Tomography per 1,000 MY Medical |
| CAD Diagnostic Test Using EBCT/Nuclear Imaging Stress Tests per 1,000 MY Medical |

**Note:** This table indicates the calculated fields that NCQA provides for the age-gender-risk totals.

## [Relative Resource Use for People With Hypertension (RHY)](#TOC)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

The relative resource use by members with hypertension during the measurement year.

Eligible Population

**Note:** Organizations must report the quality measure (CBP) when reporting RHY.

|  |  |
| --- | --- |
| Product line | Commercial, Medicaid, Medicare(report each product line separately). |
| Ages | 18–85 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year.  To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage  (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/ diagnosis | Members are identified as hypertensive if they had at least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), acute inpatient encounters (Acute Inpatient Value Set) or ED visits (ED Value Set), on different dates of service during the measurement year, with any diagnosis of hypertension (Essential Hypertension Value Set). Visit type need not be the same for the two encounters. |

Exclusions *(optional)*

* Members with evidence of ESRD (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or before December 31 of the measurement year.

**Note:** The required exclusion criterion is limited to ESRD or kidney transplant during the measurement year. Some members who meet the optional exclusion criteria for ESRD might not meet the required exclusion criteria.

* Members with any diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

Exclusions *(required)*

Refer to *Required Exclusions* in the *Guidelines for Relative Resource Use.*

*Note*

* *If any CBP optional exclusion included in both CBP and RHY is applied to the CBP measure, apply that same optional exclusion to the RHY measure.*
* *If any CBP optional exclusion included in both CBP and RHY is not applied to the CBP measure, do not apply that optional exclusion to the RHY measure.*
* *Because RHY is administrative-only, do not exclude members from this measure based on exclusions found during chart review for the CBP measure. They must be included in RHY, whether or not they were excluded during chart review for CBP.*

Categorization of Eligible Population

|  |  |
| --- | --- |
| Major clinical category | Hypertension. |
| Risk Group | Refer to *RRU Risk Adjustment* in the *Guidelines for Relative Resource Use.* |

Standard Cost Calculations

The organization reports total standard costs of all services for which the organization has paid or expects to pay for the eligible population during the treatment period. Total standard costs are assigned by matching codes for services rendered to codes listed in the NCQA SPTs (the tables will be posted to NCQA’s Web site by November 2, 2015).

|  |  |  |
| --- | --- | --- |
| Apply standard price | SPTs categorize services as follows:   * Inpatient Facility. * E&M. * Inpatient Services. * Outpatient Services. * Laboratory Services. | * Surgery and Procedure. * Inpatient Services. * Outpatient Services. * Imaging Services. * Pharmacy. |
| Count all services listed in the SPTs rendered to members in the eligible population during the treatment period. Refer to the *Calculating Standard Cost* instructions in the *Guidelines for Relative Resource Use* for steps on categorizing services and linking service data to the NCQA SPTs. | |
| Calculate total cost | Sum the total standard cost for each eligible member. For each service category, if a member’s standard cost exceeds the service category cap amount, report the total standard cost specified in the NCQA Cost Cap Amounts table (released with the SPTs).  Sum and report the total standard cost for the eligible population in each service category by member cohort. | |

Service Frequency Calculations

|  |  |
| --- | --- |
| Total service frequency | Service frequency counts are reported for all services for which the organization has paid or expects to pay for the eligible population during the treatment period. The measure captures each eligible member’s services rendered during the treatment period for the following service categories.   * Acute Medicine: Discharges, Days. * Acute Surgery: Discharges, Days. * Nonacute: Discharges, Days. * ED Discharges. * Pharmacy Utilization. * Name brand only (N1). * Name brand—Generic exists (N2). * Generic only (G1). * Generic name—Name brand exists (G2).   Refer to the instructions in the *Guidelines for Relative Resource Use.* The Pharmacy Utilization categories are included in Table SPT—Pharm. |
| Inpatient Facility | This category measures the number of acute and nonacute inpatient facility discharges and days, regardless of diagnosis. Count each discharge once. Include data from any institution that provides acute or long-term/specialty nonacute care.  Refer to the *Guidelines for Relative Resource Use* to identify acute inpatient (including medicine and surgery) and nonacute discharges and days. |
| ED Discharges | This category measures use of ED services.  Count each visit to an ED during the treatment period that does not result in an inpatient stay that was paid, or expected to be paid, by the organization, regardless of the intensity of care required during the stay or the length of stay. Count only one ED visit per date of service. Do not count visits to urgent care centers. Services for members admitted to the hospital from an ED visit are included in the *Inpatient Facility* category only.  Identify ED visits using either of the following:   * An ED visit (ED Value Set). * A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set). |
| Pharmacy Utilization | Use Table SPT—Pharm to identify the prescription categories for each drug dispensed in the treatment period.  Sum and report the number of prescriptions in each of the four categories in the Pharmacy—Total Service Frequency by Prescription Category table. |

Data Elements for Reporting

Table RHY-A-1/2/3: Data Elements for Relative Resource Use for People   
With Hypertension

|  |  |
| --- | --- |
| Metadata ID | Metadata Specification Name |
| EligiblePopulation | Eligible Population |
| Exclusions | Exclusions |
| NameBrandOnlyCount | Pharmacy: Name Brand only (N1) |
| NameBrandGenericExistsCount | Pharmacy: Name Brand—Generic Exists (N2) |
| GenericOnlyCount | Pharmacy: Generic Only (G1) |
| GenericNameBrandExistsCount | Pharmacy: Generic—Name Brand Exists (G2) |

Table RHY-B-1/2/3: Data Elements for Relative Resource Use for People   
With Hypertension

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender | Age | Risk Group | Type | Metric Specification Name |
| Male | 18-44 | 1 | Cost | Inpatient Facility |
| Female | 45-54 | 2 | Cost | E&M Inpatient Services |
|  | 55-64 | 3 | Cost | E&M Outpatient Services |
|  | 65-85 | 4 | Cost | Surgery & Procedure Inpatient Services |
|  |  | 5 | Cost | Surgery & Procedure Outpatient Services |
|  |  | 6 | Cost | Imaging Services |
|  |  | 7 | Cost | Laboratory Services |
|  |  | 8 | Cost | Pharmacy |
|  |  | 9 | Count | Inpatient Facility: Acute Inpatient: Medical Days |
|  |  | 10 | Count | Inpatient Facility: Acute Inpatient: Medical Discharges |
|  |  | 11 | Count | Inpatient Facility: Acute Inpatient: Surgery Days |
|  |  | 12 | Count | Inpatient Facility: Acute Inpatient: Surgery Discharges |
|  |  | 13 | Count | Inpatient Facility: Nonacute: Days |
|  |  |  | Count | Inpatient Facility: Nonacute: Discharges |
|  |  |  | Count | ED Discharges |
|  |  |  | Mem | Member Months Medical |
|  |  |  | Mem | Member Months Pharmacy |

Table RHY-C-1/2/3: Data Elements for Relative Resource Use for People   
With Hypertension

|  |
| --- |
| Data Element |
| Eligible Population |
| Exclusions |
| Eligible Population per 1,000 MY Medical |
| Eligible Population per 1,000 MY Pharmacy |
| Name Brand Only Count (N1) |
| Name Brand Generic Exists Count (N2) |
| Generic Only Count (G1) |
| Generic Name Brand Exists Count (G2) |
| Total Prescriptions (N1+N2+G1+G2) |
| Generic Utilization Rate [(G1 + G2)/(N2+G1+G2)] |
| Generic Substitution Rate [(G2)/(N2+G2)] |
| Overall Generic Utilization [(G1+G2)/(N1+N2+G1+G2)] |
| Inpatient Facility PMPM |
| E&M Inpatient Services PMPM |
| E&M Outpatient Services PMPM |
| Surgery & Procedure Inpatient Services PMPM |
| Surgery & Procedure Outpatient Services PMPM |
| Imaging Services PMPM |
| Laboratory Services PMPM |
| Pharmacy PMPM |
| Inpatient Facility: Acute Inpatient: Medical Days per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Medical Discharges per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Surgery Days per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Surgery Discharges per 1,000 MY |
| Inpatient Facility: Nonacute Days per 1,000 MY |
| Inpatient Facility: Nonacute Discharges per 1,000 MY |
| Inpatient Facility Acute Medical ALOS |
| Inpatient Facility Acute Surgery ALOS |
| Inpatient Facility Nonacute ALOS |
| Total Inpatient Facility Acute ALOS |
| Total Inpatient Facility ALOS |
| ED Discharges per 1,000 MY Medical |

**Note:** This table indicates the calculated fields that NCQA provides for the age-gender-risk totals.

## [Relative Resource Use for People With COPD (RCO)](#TOC)

Summary of Changes to HEDIS 2016

* No changes to this measure.

Description

The relative resource use by members with COPD during the measurement year.

Eligible Population

**Note:** Organizations must report the quality measures (SPR and PCE) when reporting RCO.

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 42 years or older by December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/ diagnosis | Members who had any diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set) during the measurement year. |

Exclusions *(required)*

Refer to *Required Exclusions* in the *Guidelines for Relative Resource Use.*

Categorization of Eligible Population

|  |  |
| --- | --- |
| Major clinical condition | COPD. |
| Risk group | Refer to *RRU Risk Adjustment* in the *Guidelines for Relative Resource Use.* |

Standard Cost Calculations

The organization reports total standard costs of all services for which the organization has paid or expects to pay for the eligible population during the treatment period. Costs are assigned by matching codes for services rendered to codes listed in the NCQA SPTs (the tables will be posted to NCQA’s Web site by November 2, 2015).

|  |  |  |
| --- | --- | --- |
| Apply standard price | SPTs categorize services as follows.   * Inpatient Facility. * E&M. * Inpatient Services. * Outpatient Services. * Laboratory Services. | * Surgery and Procedure. * Inpatient Services. * Outpatient Services. * Imaging Services. * Pharmacy. |
| Count all services listed in the SPTs rendered to members in the eligible population during the treatment period. Refer to the *Calculating Standard Cost* instructions in the *Guidelines for Relative Resource Use* for steps on categorizing services and linking service data to NCQA’s SPTs. | |
| Calculate total cost | Sum the total standard cost for each eligible member. For each service category, if a member’s standard cost exceeds the service category cap amount, report the total standard cost specified in the NCQA Cost Cap Amounts table (released with the SPTs).  Sum and report the total standard cost for the eligible population in each service category by member cohort. | |

Service Frequency Calculations

|  |  |
| --- | --- |
| Total service frequency | Service frequency counts are reported for all services in the treatment period. The measure captures each eligible member’s services rendered during the treatment period for the following service categories.   * Acute Medicine: Discharges, Days. * Acute Surgery: Discharges, Days. * Nonacute: Discharges, Days. * ED Discharges. * Pharmacy Utilization. * Name brand only (N1). * Name brand—Generic exists (N2). * Generic only (G1). * Generic name—Name brand exists (G2).   Refer to the instructions in the *Guidelines for Relative Resource Use.* The pharmacy utilization categories are included in Table SPT—Pharm. |

|  |  |
| --- | --- |
| Inpatient Facility | This category measures the number of acute and nonacute inpatient facility discharges, days and ALOS, regardless of diagnosis. Count each discharge once. Include data from any institution that provides acute or long-term/specialty nonacute care.  Refer to the *Guidelines for Relative Resource Use* to identify acute inpatient (including medicine and surgery) and nonacute discharges and days. |
| ED Discharges | This category measures use of ED services.  Count each visit to an ED during the treatment period that does not result in an inpatient stay that was paid, or expected to be paid, by the organization, regardless of the intensity of care required during the stay or the length of stay. Count only one ED visit per date of service. Do not count visits to urgent care centers. Services for members admitted to the hospital from an ED visit are included in the Inpatient Facility category only.  Identify ED visits using either of the following:   * An ED visit (ED Value Set). * A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set). |
| Pharmacy Utilization | Use Table SPT—Pharm to identify the prescription categories for each drug dispensed in the treatment period.  Sum and report the number of prescriptions in each of the four categories in the Pharmacy—Total Service Frequency by Prescription Category table. |

Data Elements for Reporting

Table RCO-A-1/2/3: Data Elements for Relative Resource Use for People   
With COPD

|  |  |
| --- | --- |
| Metadata ID | Metadata Specification Name |
| EligiblePopulation | Eligible Population |
| Exclusions | Exclusions |
| NameBrandOnlyCount | Pharmacy: Name Brand only (N1) |
| NameBrandGenericExistsCount | Pharmacy: Name Brand—Generic Exists (N2) |
| GenericOnlyCount | Pharmacy: Generic Only (G1) |
| GenericNameBrandExistsCount | Pharmacy: Generic—Name Brand Exists (G2) |

Table RCO-B-1/2/3: Data Elements for Relative Resource Use for People  
With COPD

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender | Age | Risk Group | Type | Metric Specification Name |
| Male | 42-44 | 1 | Cost | Inpatient Facility |
| Female | 45-64 | 2 | Cost | E&M Inpatient Services |
|  | 65-74 | 3 | Cost | E&M Outpatient Services |
|  | 75+ | 4 | Cost | Surgery & Procedure Inpatient Services |
|  |  | 5 | Cost | Surgery & Procedure Outpatient Services |
|  |  | 6 | Cost | Imaging Services |
|  |  | 7 | Cost | Laboratory Services |
|  |  | 8 | Cost | Pharmacy |
|  |  | 9 | Count | Inpatient Facility: Acute Inpatient: Medical Days |
|  |  | 10 | Count | Inpatient Facility: Acute Inpatient: Medical Discharges |
|  |  | 11 | Count | Inpatient Facility: Acute Inpatient: Surgery Days |
|  |  | 12 | Count | Inpatient Facility: Acute Inpatient: Surgery Discharges |
|  |  | 13 | Count | Inpatient Facility: Nonacute: Days |
|  |  |  | Count | Inpatient Facility: Nonacute: Discharges |
|  |  |  | Count | ED Discharges |
|  |  |  | Mem | Member Months Medical |
|  |  |  | Mem | Member Months Pharmacy |

Table RCO-C-1/2/3: Data Elements for Relative Resource Use for People With COPD

|  |
| --- |
| Data Element |
| Eligible Population |
| Exclusions |
| Eligible Population per 1,000 MY Medical |
| Eligible Population per 1,000 MY Pharmacy |
| Name Brand Only Count (N1) |
| Name Brand Generic Exists Count (N2) |
| Generic Only Count (G1) |
| Generic Name Brand Exists Count (G2) |
| Total Prescriptions (N1+N2+G1+G2) |
| Generic Utilization Rate [(G1 + G2)/(N2+G1+G2)] |
| Generic Substitution Rate [(G2)/(N2+G2)] |
| Overall Generic Utilization [(G1+G2)/(N1+N2+G1+G2)] |
| Inpatient Facility PMPM |
| E&M Inpatient Services PMPM |
| E&M Outpatient Services PMPM |
| Surgery & Procedure Inpatient Services PMPM |
| Surgery & Procedure Outpatient Services PMPM |
| Imaging Services PMPM |
| Laboratory Services PMPM |
| Pharmacy PMPM |
| Inpatient Facility: Acute Inpatient: Medical Days per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Medical Discharges per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Surgery Days per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Surgery Discharges per 1,000 MY |
| Inpatient Facility: Nonacute Days per 1,000 MY |
| Inpatient Facility: Nonacute Discharges per 1,000 MY |
| Inpatient Facility Acute Medical ALOS |
| Inpatient Facility Acute Surgery ALOS |
| Inpatient Facility Nonacute ALOS |
| Total Inpatient Facility Acute ALOS |
| Total Inpatient Facility ALOS |
| ED Discharges per 1,000 MY Medical |

**Note:** This table indicates the calculated fields that NCQA provides for the age-gender-risk totals.

## [Relative Resource Use for People With Asthma (RAS)](#TOC)

Summary of Changes to HEDIS 2016

* Expanded age range up to 85 years for the commercial product line.
* Added the Medicare product line.
* Removed the reference to the retired ASM measure in the eligible population Note.
* Replaced all references of Table ASM-C with “Table MMA-A" in step 1.
* Revised and renamed the reporting tables.

Description

The relative resource use by members with persistent asthma during the measurement year.

Definitions

|  |  |
| --- | --- |
| Oral medication dispensing event | One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date when the prescription is filled.  Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.   * *Two prescriptions* for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each). * *Two prescriptions* for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each). * *Two prescriptions* for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days). * *Two prescriptions* for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days). |
| Inhaler dispensing event | All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.  Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.  Use the *Drug ID* field in the NDC list to determine if the medications are the same or different. |

|  |  |
| --- | --- |
| **Injection dispensing event** | Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.  Allocate the dispensing events to the appropriate year based on the date when the prescription was filled. |

Eligible Population

**Note:** Organizations must report the quality measures (MMA and AMR) when reporting RAS.

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | *For commercial,* ages 5–85 as of December 31 of the measurement year.  *For Medicaid,* ages 5–64 as of December 31 of the measurement year.  *For Medicare,* ages 18–85 as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year and the year prior to the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment year. |
| Anchor date | December 31 of the measurement year. |
| Benefits | Medical. Pharmacy during the measurement year. |
| Event/ diagnosis | Follow the steps below to identify the eligible population for the measure. |
| *Step 1* | Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across years.   * At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set). * At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set). * At least four outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set), on different dates of service, with any diagnosis of Asthma (Asthma Value Set) ***and*** at least two asthma medication dispensing events (Table MMA-A). Visit type need not be the same for the four encounters. * At least four asthma medication dispensing events (Table MMA-A). |
| *Step 2* | A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year). |

Exclusions *(required)*

* Exclude members who had any diagnosis from any of the following value sets, any time during the member’s history through December 31 of the measurement year:
* Emphysema Value Set.
* Other Emphysema Value Set.
* COPD Value Set.
* Obstructive Chronic Bronchitis Value Set.
* Chronic Respiratory Conditions Due To Fumes/Vapors Value Set.
* Cystic Fibrosis Value Set.
* Acute Respiratory Failure Value Set.
* Refer to *Required Exclusions* in the *Guidelines for Relative Resource Use* for additional required exclusions*.*

Categorization of Eligible Population

|  |  |
| --- | --- |
| Major clinical condition | Asthma. |
| Risk group | Refer to *RRU Risk Adjustment* in the *Guidelines for Relative Resource Use.* |

Standard Cost Calculations

The organization reports total standard costs of all services for which the organization has paid or expects to pay for the eligible population during the treatment period. Total standard costs are assigned by matching codes for services rendered to codes listed in the NCQA SPTs (the tables will be posted to NCQA’s Web site by November 2, 2015).

|  |  |  |
| --- | --- | --- |
| Apply standard price | SPTs categorize services as follows:   * Inpatient Facility. * E&M. * Inpatient Services. * Outpatient Services. * Laboratory Services. | * Surgery and Procedure. * Inpatient Services. * Outpatient Services. * Imaging Services. * Pharmacy. |
| Count all services listed in the SPTs rendered to members in the eligible population during the treatment period. Refer to the *Calculating Standard Cost* instructions in the *Guidelines for Relative Resource Use* for steps on categorizing services and linking service data to the NCQA SPTs. | |
| Calculate total cost | Sum the total standard cost for each eligible member. For each service category, if a member’s standard cost exceeds the service category cap amount, report the total standard cost specified in the NCQA Cost Cap Amounts table (released with the SPTs).  Sum and report the total standard cost for the eligible population in each service category by member cohort. | |

Service Frequency Calculations

|  |  |
| --- | --- |
| Total service frequency | Service frequency counts are reported for all services for which the organization has paid or expects to pay for the eligible population during the treatment period. the measure captures each eligible member’s services rendered during the treatment period for the following service categories:   * Acute Medicine: Discharges, Days. * Acute Surgery: Discharges, Days. * Nonacute: Discharges, Days. * ED Discharges. * Pharmacy Utilization: * Name brand only (N1). * Name brand—Generic exists (N2). * Generic only (G1). * Generic name—Name brand exists (G2).   Refer to the instructions in the *Guidelines for Relative Resource Use.* The *Pharmacy Utilization* categories are included in Table SPT—Pharm. |
| Inpatient Facility | This category measures the number of acute and nonacute inpatient facility discharges and days, regardless of diagnosis. Count each discharge once. Include data from any institution that provides acute or long-term/specialty nonacute care.  Refer to *Guidelines for Relative Resource Use* to identify acute inpatient (including medicine and surgery) and nonacute discharges and days. |
| ED Discharges | This category measures use of ED services.  Count each visit to an ED during the treatment period that does not result in an inpatient stay that was paid, or expected to be paid, by the organization, regardless of the intensity of care required during the stay or the length of stay. Count only one ED visit per date of service. Do not count visits to urgent care centers. Services for members admitted to the hospital from an ED visit are included in the Inpatient Facility category only.  Identify ED visits using either of the following:   * An ED visit (ED Value Set). * A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set). |
| Pharmacy Utilization | Use Table SPT-Pharm to identify the prescription categories for each drug dispensed in the treatment period.  Sum and report the number of prescriptions within each of the four categories in the Pharmacy—Total Service Frequency by Prescription Category table. |

Data Elements for Reporting

Table RAS-A-1/2/3: Data Elements for Relative Resource Use for People   
With Asthma

|  |  |
| --- | --- |
| Metadata ID | Metadata Specification Name |
| EligiblePopulation | Eligible Population |
| Exclusions | Exclusions |
| NameBrandOnlyCount | Pharmacy: Name Brand only (N1) |
| NameBrandGenericExistsCount | Pharmacy: Name Brand—Generic Exists (N2) |
| GenericOnlyCount | Pharmacy: Generic Only (G1) |
| GenericNameBrandExistsCount | Pharmacy: Generic—Name Brand Exists (G2) |

Table RAS-B-1: Data Elements for Relative Resource Use for People   
With Asthma

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender | Age | Risk Group | Type | Metric Specification Name |
| Male | 5-17 | 1 | Cost | Inpatient Facility |
| Female | 18-44 | 2 | Cost | E&M Inpatient Services |
|  | 45-54 | 3 | Cost | E&M Outpatient Services |
|  | 55-64 | 4 | Cost | Surgery & Procedure Inpatient Services |
|  |  | 5 | Cost | Surgery & Procedure Outpatient Services |
|  |  | 6 | Cost | Imaging Services |
|  |  | 7 | Cost | Laboratory Services |
|  |  | 8 | Cost | Pharmacy |
|  |  | 9 | Count | Inpatient Facility: Acute Inpatient: Medical Days |
|  |  | 10 | Count | Inpatient Facility: Acute Inpatient: Medical Discharges |
|  |  | 11 | Count | Inpatient Facility: Acute Inpatient: Surgery Days |
|  |  | 12 | Count | Inpatient Facility: Acute Inpatient: Surgery Discharges |
|  |  | 13 | Count | Inpatient Facility: Nonacute: Days |
|  |  |  | Count | Inpatient Facility: Nonacute: Discharges |
|  |  |  | Count | ED Discharges |
|  |  |  | Mem | Member Months Medical |
|  |  |  | Mem | Member Months Pharmacy |

Table RAS-B-2: Data Elements for Relative Resource Use for People   
With Asthma

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender | Age | Risk Group | Type | Metric Specification Name |
| Male | 5-17 | 1 | Cost | Inpatient Facility |
| Female | 18-44 | 2 | Cost | E&M Inpatient Services |
|  | 45-54 | 3 | Cost | E&M Outpatient Services |
|  | 55-64 | 4 | Cost | Surgery & Procedure Inpatient Services |
|  | 65-85 | 5 | Cost | Surgery & Procedure Outpatient Services |
|  |  | 6 | Cost | Imaging Services |
|  |  | 7 | Cost | Laboratory Services |
|  |  | 8 | Cost | Pharmacy |
|  |  | 9 | Count | Inpatient Facility: Acute Inpatient: Medical Days |
|  |  | 10 | Count | Inpatient Facility: Acute Inpatient: Medical Discharges |
|  |  | 11 | Count | Inpatient Facility: Acute Inpatient: Surgery Days |
|  |  | 12 | Count | Inpatient Facility: Acute Inpatient: Surgery Discharges |
|  |  | 13 | Count | Inpatient Facility: Nonacute: Days |
|  |  |  | Count | Inpatient Facility: Nonacute: Discharges |
|  |  |  | Count | ED Discharges |
|  |  |  | Mem | Member Months Medical |
|  |  |  | Mem | Member Months Pharmacy |

Table RAS-B-3: Data Elements for Relative Resource Use for People   
With Asthma

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender | Age | Risk Group | Type | Metric Specification Name |
| Male | 18-44 | 1 | Cost | Inpatient Facility |
| Female | 45-54 | 2 | Cost | E&M Inpatient Services |
|  | 55-64 | 3 | Cost | E&M Outpatient Services |
|  | 65-85 | 4 | Cost | Surgery & Procedure Inpatient Services |
|  |  | 5 | Cost | Surgery & Procedure Outpatient Services |
|  |  | 6 | Cost | Imaging Services |
|  |  | 7 | Cost | Laboratory Services |
|  |  | 8 | Cost | Pharmacy |
|  |  | 9 | Count | Inpatient Facility: Acute Inpatient: Medical Days |
|  |  | 10 | Count | Inpatient Facility: Acute Inpatient: Medical Discharges |
|  |  | 11 | Count | Inpatient Facility: Acute Inpatient: Surgery Days |
|  |  | 12 | Count | Inpatient Facility: Acute Inpatient: Surgery Discharges |
|  |  | 13 | Count | Inpatient Facility: Nonacute: Days |
|  |  |  | Count | Inpatient Facility: Nonacute: Discharges |
|  |  |  | Count | ED Discharges |
|  |  |  | Mem | Member Months Medical |
|  |  |  | Mem | Member Months Pharmacy |

Table RAS-C-1/2/3: Data Elements for Relative Resource Use for People   
With Asthma

|  |
| --- |
| Data Element |
| Eligible Population |
| Exclusions |
| Eligible Population per 1,000 MY Medical |
| Eligible Population per 1,000 MY Pharmacy |
| Name Brand Only Count (N1) |
| Name Brand Generic Exists Count (N2) |
| Generic Only Count (G1) |
| Generic Name Brand Exists Count (G2) |
| Total Prescriptions (N1+N2+G1+G2) |
| Generic Utilization Rate [(G1 + G2)/(N2+G1+G2)] |
| Generic Substitution Rate [(G2)/(N2+G2)] |
| Overall Generic Utilization [(G1+G2)/(N1+N2+G1+G2)] |
| Inpatient Facility PMPM |
| E&M Inpatient Services PMPM |
| E&M Outpatient Services PMPM |
| Surgery & Procedure Inpatient Services PMPM |
| Surgery & Procedure Outpatient Services PMPM |
| Imaging Services PMPM |
| Laboratory Services PMPM |
| Pharmacy PMPM |
| Inpatient Facility: Acute Inpatient: Medical Days per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Medical Discharges per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Surgery Days per 1,000 MY |
| Inpatient Facility: Acute Inpatient: Surgery Discharges per 1,000 MY |
| Inpatient Facility: Nonacute Days per 1,000 MY |
| Inpatient Facility: Nonacute Discharges per 1,000 MY |
| Inpatient Facility Acute Medical ALOS |
| Inpatient Facility Acute Surgery ALOS |
| Inpatient Facility Nonacute ALOS |
| Total Inpatient Facility Acute ALOS |
| Total Inpatient Facility ALOS |
| ED Discharges per 1,000 MY Medical |

**Note:** This table indicates the calculated fields that NCQA provides for the age-gender-risk totals.