NATIONAL QUALITY FORUM

Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item IM1.1 relates to sub criterion IM1).

Brief Measure Information

NQF #: 1560
De.2. **Measure Title:** Relative Resource Use for People with Asthma (RAS)
Co.1.1. **Measure Steward:** National Committee for Quality Assurance
De.3. **Brief Description of Measure:** The risk-adjusted relative resource use by health plan members with asthma during the measurement year.
IM2.1. **Developer Rationale:** The development and implementation of the RRU measurement set, when considered alongside relevant HEDIS quality of-care measures, advances us further down the path to obtaining information that supports value-based purchasing. For the first time, purchasers have a more complete picture of relative health plan value-performance. They can evaluate plans' relative quality and resource use, in comparison to other plans available to the employer, for a number of major chronic illnesses, in addition to specific premiums offered by the plans.
In terms of their overall role in defining cost and utilization, RRU measures provide an aggregate level of measurement within specific high-cost conditions but are reported nationally and within regions, overall and by service type (e.g., inpatient and outpatient E&M services) and across age/gender cohorts. This allows for identification of specific areas on which to focus improvement efforts. These measures are an important first step towards value-based purchasing.

De.1. **Measure Type:** Cost/Resource Use
S.5. **Data Source:** Claims
S.3. **Level of Analysis:** Health Plan, Integrated Delivery System, Other

IF Endorsement Maintenance – Original Endorsement Date: Apr 02, 2012 **Most Recent Endorsement Date:** Dec 29, 2014

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. **IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?**

Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.***

IM1. High Priority
IM1.1. Demonstrated High Priority Aspect of Healthcare
Affects large numbers

A leading cause of morbidity/mortality

High resource use

Patient/societal consequences of poor quality

Severity of illness

IM1.2. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in IM.1.3. Clinical Importance

Asthma is one of the most prevalent chronic diseases; becoming increasingly more commonplace over the past twenty years. Approximately 23.3 million Americans have asthma and it is responsible for over 3,000 deaths in the U.S. annually (American Lung Association, 2010). In 2006, 13.3 million clinical visits (hospital, outpatient, emergency department, and physician offices) were attributed to asthma (CDC, 2008). The incidence rate, and subsequently the number of asthma-related health visits, is expected to increase by an additional 100 million globally by 2025 (World Health Organization, 2007).

Financial Importance

Asthma accounts for over $20 billion spent on health care in the United States. Direct costs, including prescriptions, make up $15.6 billion of that total, and indirect costs, such as lost productivity, add an additional $5.1 billion (CDC, 2008). Inpatient hospitalization accounts for over 50 percent of overall asthma-related costs (Bahadori, 2009). In addition to the direct financial burden, asthma is also a leading cause of absenteeism and productivity, accounting for an estimated 14.2 million missed workdays for adults and over 14 million missed school days for children (Akinbami, 2009). Studies have shown that the indirect costs of asthma are becoming a growing financial burden on patients, and resulting in significant additional costs (Bahadori, 2009).

Appropriate medication management could potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits and missed work and school days) (Akinbami, 2009). The Asthma Regional Council supported this inference, stating that proper management could potentially save at least 25 percent of total asthma costs, or $5 billion, nationally by reducing health care costs (American Lung Association, 2009).

Another initiative, the Children's Health Fund's Childhood Asthma Initiative, examined patients enrolled in an asthma intervention program. Results illustrated that treatment that aligned with clinical guidelines reduced the severity of experienced symptoms experienced, as well as asthma-related events (e.g., hospitalizations, emergency room visits, etc.) (Columbia University, 2010). Additionally, subsequent savings attributed to improved clinical outcomes totaled to nearly $4.2 million or $4,525 per patient. This translated to a significant reduction in federally subsidized and private insurance-based costs for this population.

IM1.3. Citations for data demonstrating high priority provided in IM.1.2

Akinbami, LJ. The State of Childhood Asthma, United States, 1980–2007. Advance Data from Vital and Health Statistics. Revised February 16, 2009. Pediatrics 123 (Supplement); S131-45. Hyattsville, MD: National Center for Health Statistics. Available from: http://pediatrics.aappublications.org/cgi/content/full/123/Supplement_3/S131. (March 2010)

American Lung Association. Trends in Asthma Morbidity and Mortality. 2009.

Bahadori et al. Economic burden of asthma: a systematic review. BMJ 9(24): 1-16, 2009.

British Thoracic Society. British Guideline on the management of asthma. A national clinical guideline. Scotland: British Thoracic Society (BTS); 2009 June.

Centers for Disease Control and Prevention. Asthma: A Presentation of Asthma Management and Prevention. 2009. Available from: http://www.cdc.gov/asthma/speakit/default.htm. (September 2010)

Columbia University. Best Practice Asthma Program Saves the US Healthcare System More than $4500 a Year per Child. 2010. Available from: http://www.mailman.columbia.edu/news/best-practice-asthma-program-saves-us-healthcare-system-more-4500-year-child. (December 2010)

NHLBI/NAEPP (National Heart Lung and Blood Institute/National Asthma Education and Prevention Program). Measures of asthma assessment and monitoring: Expert panel report 3: guidelines for the diagnosis and management of asthma. Washington (DC): National Heart Lung and Blood Institute (NHLBI); 2007 Aug.

World Health Organization. Global surveillance, prevention and control of chronic respiratory diseases: a comprehensive approach. 2007.

IM2. Opportunity for Improvement

IM2.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in performance envisioned by use of this measure)

The development and implementation of the RRU measurement set, when considered alongside relevant HEDIS quality of-care measures, advances us further down the path to obtaining information that supports value-based purchasing. For the first time, purchasers have a more complete picture of relative health plan value-performance. They can evaluate plans' relative quality and resource use, in comparison to other plans available to the employer, for a number of major chronic illnesses, in addition to specific premiums offered by the plans.

In terms of their overall role in defining cost and utilization, RRU measures provide an aggregate level of measurement within specific high-cost conditions but are reported nationally and within regions, overall and by service type (e.g., inpatient and outpatient E&M services) and across age/gender cohorts. This allows for identification of specific areas on which to focus improvement efforts. These measures are an important first step towards value-based purchasing.

IM2.2. **Provide performance scores on the measure as specified** (current and over time) **at the specified level of analysis.** (This is required for endorsement maintenance. Include mean, stddev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include). **This information also will be used to address the subcriterion on improvement (U.2.1.) under Usability and Use.**
Annual analysis of RRU data collected by NCQA over the last seven years demonstrates substantial variation in health plan resource use from an overall perspective and with respect to specific service areas (e.g., procedure and surgery services or pharmacy services) and regions. Moreover, a substantial number of health plans can be identified as statistically significantly better or worse than average along both RRU and quality dimensions.

IM2.3. **If no or limited performance data on the measure as specified is reported in IM.2.2., then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**
National Committee for Quality Assurance (NCQA) HEDIS® 2013 Relative Resource Use (RRU) Annual Analytic Report. pp. 35-39, p.42.

IM2.4. **Provide disparities data from the measure as specified** (current and over time) **by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) **This information also will be used to address the subcriterion on improvement (U.2.1.) under Usability and Use.**
The National Health Interview Survey (NHIS) data examined asthma prevalence among a range of subgroups from the late 1980s to 2006 (CDC, 2009). Results showed that asthma affects more children than adults, who consistently demonstrate lower prevalence and hospitalization rates (CDC, 2009). Over 7 million children under the age of 18 have asthma, placing it among the leading causes of hospitalization for children (American Lung Association, 2010). Asthma disproportionately affects a higher percentage of boys than girls (CDC, 2009). In addition, children of low-income families experience higher frequencies of urgent care visits, hospitalizations and mortality due to asthma when compared to the general public (CDC, 2009). In terms of racial/ethnic disparities, rates were highest for non-Hispanic African-American children (14.2 percent) and lowest for Asian children (7.1 percent), with the greatest amount of variability among Hispanic subgroups (CDC, 2009).
These findings are strengthened by a study highlighting disparities in the delivery of care when considering socioeconomic status and race/ethnicity. Data was collected using the Medical Expenditure Panel Survey (MEPS) (1996-2000), surveying 982 children with asthma younger than 18 years of age. The primary control variables associated with asthma-related service utilization were race/ethnicity, socioeconomic status, and health insurance status (Kim, 2009). Race/ethnicity subcategories included Hispanic, non-Hispanic black, non-Hispanic white and other racial groups; socioeconomic status subcategories included annual family income and mother's education; and insurance coverage subcategories included uninsured, public (both years of study), and private/public (both years of study). Private and public insurance subcategories were separated and analyzed in parallel, producing results similar to the original groupings.
The MEPS results showed that non-Hispanic African-American children utilized urgent care services more frequently than preventive care services (Kim, 2009). Additionally, children from low-income families were less likely to have prescriptions filled and/or receive annual primary health examinations (Kim, 2009). The study also examined insurance coverage, showing that children with insurance coverage utilized primary health care services for asthma more often (Kim, 2009).
In terms of the adult subgroup and race/ethnicity-based disparities, the NHIS data displayed that from the late 1980s to 2006, African-Americans have had a higher prevalence of asthma in comparison to Caucasians. In addition, non-Hispanic African-Americans have reported higher rates since 1997 when compared to both Hispanics and non-Hispanic Caucasians, who reported the lowest rates (CDC, 2009). African Americans are also more likely to be hospitalized or die as a result of asthma-based complications (CDC, 2009).
In comparing women versus men, the NHIS survey demonstrated that women have consistently outranked men in terms of the prevalence of asthma (CDC, 2009). This is corroborated by the hospital discharge rates per 10,000 population from 1980 to 2006, as well as mortality rates due to asthma, which have both been historically elevated for women versus men (CDC, 2009). Overall, mortality due to asthma has declined since 1999 for both men and women (CDC, 2009).

IM2.5. **If no or limited data on disparities from the measure as specified is reported in IM.2.4., then provide a summary of data**

from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

American Lung Association. Epidemiology & Statistics Unit, Research and Program Services. Asthma. 2010. Available from: http://www.lungusa.org/lung-disease/asthma/. (September 2010)
Centers for Disease Control and Prevention. Asthma: A Presentation of Asthma Management and Prevention. 2009. Available from: http://www.cdc.gov/asthma/speakit/default.htm. (September 2010)
Kim H, Kieckhefer GM, Greek AA, Joesch JM, Baydar N. Health care utilization by children with asthma. Prev Chronic Dis 2009;6(1). http://www.cdc.gov/pcd/issues/2009/jan/07_0199.htm. (October 2010)

IM3. **Measure Intent**

IM3.1. **Describe intent of the measure and its components/ Rationale (including any citations) for analyzing variation in resource use in this way.**

Relative Resource Use (RRU) measures are a standardized way to measure relative resource use as related to different types of health care services. When evaluated in conjunction with corresponding quality of care measures, they provide important information related to the efficiency or value of health care services. RRU measures have the following features:

- Focus on high-cost conditions for which there are corresponding HEDIS Effectiveness of Care measures
- Segment the effect of unit price and utilization variation
- Rely on an indirect standardization approach to risk adjustment originally developed from regression analysis

RRU measures report the organization's total resource use for defined diseases, by service category and by use of standardized price to relate service units for each eligible member, during each measure's treatment period. The organization does not report prices based on its contracts and fee schedules; rather it applies a standard price to each service, multiplies it by the number of units of service, and reports the resulting standard cost. For RRU measures that relate to chronic conditions (e.g., Relative Resource Use for People with Asthma), the treatment period is the 12-month measurement year. As contrasted with episode grouper based measures, Relative Resource Use is calculated for included services regardless of their relation (direct or indirect as defined by some algorithm or episode grouper) to the specific chronic condition.

When health plans select providers, negotiate price, design benefits or implement incentives, they use interventions to influence quality and moderate cost. When plans and other stakeholders can compare results with other health plans using the RRU measurement set based on national and regional benchmarks, they have a growing body of information with which to gauge their performance in categories such as clinical quality, patient experience and resource use-cost. Purchasers and plans can independently and collectively review and select appropriate, targeted interventions.

RRU measures indicate how a plan uses a set of key resources (e.g., physician visits, hospital stays) to care for its members with specific diseases, compared with the average for plans in the same region and adjusted for the set of diseases and case mix of plan members. RRU results make it possible to simultaneously evaluate both the quality of services and key elements that drive costs and premiums.

In the interest of transparency, NCQA has issued quality reports on individual measures and in aggregate ratings of quality—for example, in the State of Health Care Report and Consumer Reports Health Plan Rankings—that make it possible to compare plan performance with market averages. NCQA created additional disease-specific composites for use with the RRU measures. By reviewing a health plan's RRU and quality ratios together, purchasers and plans can engage in a balanced, data-driven dialogue about benefit design or the effectiveness of a wellness program or disease management program. Plan performance information can be supplemented with a detailed analysis of internal data by self-insured employers or by plans studying expenditures. These individual plan or purchaser data can provide a detailed look at specific criteria (e.g., age and disease, procedure-specific admissions).

Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. **Subject/Topic Area** *(check all the areas that apply):*
Respiratory, Respiratory : Asthma

De.6. **Non-Condition Specific** *(check all the areas that apply):*

De.7. **Care Setting** *(Select all the settings for which the measure is specified and tested):*
Inpatient/Hospital
Outpatient Services

S.1. **Measure-specific Web Page** *(Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)*
<WebPageURLExists nodeType="1">http://www.ncqa.org/RelativeResourceUseMeasuresRAS.aspx

S.2. **Type of resource use measure** *(Select the most relevant)*

S.3. **Level of Analysis** *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED):*
Health Plan, Integrated Delivery System, Other

S.4. **Target Population Category** *(Check all the populations for which the measure is specified and tested if any):*
Populations at Risk

S.5. **Data Source** *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
If other, please describe in S.5.1.
Claims

S.5.1. **Data Source or Collection Instrument** *(Identify the specific data source or data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.)*
NCQA collects HEDIS RRU data directly from Health Plan Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS).). RRU measures use NCQA's standardized prices and NCQA collects data with only the standardized prices applied. The list below summarizes the standard pricing tables (and table names) which organizations use to apply to each service captured for reporting RRU. 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.

S.5.2. **Data Source or Collection Instrument Reference** *(available at measure-specific Web page URL identified in S.1 OR in the file attached here) (Save file as: S_5_2_DataSourceReference)*
2013_RRU_Analytic_Report.pdf

S.6. **Data Dictionary or Code Table** *(Please provide a web page URL or attachment if exceeds 2 pages. NQF strongly prefers URLs. Attach documents only if they are not available on a web page.)*

Data Dictionary:

URL:

Please supply the username and password:

Attachment:

Code Table:

URL: http://www.ncqa.org/RelativeResourceUseMeasuresRAS.aspx

Please supply the username and password: Value Set link can be found in the Denominator Exclusion Details section and is attached to this form.

Attachment: 1560_RAS_Value_Sets.xlsx

Construction Logic

S.7.1. **Brief Description of Construction Logic**

If applicable, summarize the general approach or methodology to the measure construction. This is most relevant to measures that are part of or rely on the execution of a measure system or applies to multiple measures.

The measure reports total standard costs for all included services for which the organization has paid or expects to pay for the eligible population during a pre-specified measurement year. The eligible population for RAS includes all health plan members between the ages of 5-64 years with persistent asthma that were continuously enrolled for a two year period (the measurement year and the year prior). Total standard costs are assigned to each service the member received during the measurement year by matching codes for services rendered to codes listed in the NCQA Standardized Price Tables (SPTs). Standard costs are calculated and reported for the following service categories:

- Inpatient Facility
- Surgery and Procedure (inpatient and outpatient service categories)
- E&M (inpatient and outpatient service categories)
- Diagnostic Laboratory Services
- Diagnostic Imaging Services
- Pharmacy, Ambulatory

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. Organizations capture each eligible member's services rendered during the treatment period, reports these data to NCQA which then generates a service frequency report for the following:

1. Total Inpatient Facility: Discharges, Days, ALOS
2. Total Acute Inpatient: Discharges, Days, ALOS
1. Total Acute Medicine: ALOS
2. Total Acute Surgery: ALOS
3. Total Nonacute: Discharges, ALOS
4. ED Discharges
5. Pharmacy Utilization
6. Generic Utilization, given the existence of a generic option
7. Generic Substitution Rate
8. Overall Generic Utilization

S.7.2. **Construction Logic** *(Detail logic steps used to cluster, group or assign claims beyond those associated with the measure's clinical logic.)*

An organization counts all services listed in the Standardized Price Tables rendered to members in the eligible population during the measurement year. The unit prices are calculated to 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. Standard prices support consistent comparisons of "weighted utilization" across all members, organizations and geographic areas and protect individual proprietary pricing and fee schedules.

First the eligible population is defined using the clinical and eligibility criteria outlined in Section S8.2 and below:
Step 1: Identify members or patients eligible within the specified clinical condition. Members must meet the following eligibility criteria to be included in the data set for reporting RRU measures:

- For Commercial: 5–85 years of age as of December 31 of the measurement year
- For Medicaid: 5-64 years of age as of December 31 of the measurement year
- For Medicare: 18-85 years of age as of December 31 of the measurement year
- They must be continuously enrolled throughout the measurement year and the year prior to the measurement year.
- They may not have more than one gap in enrollment (of up to 45 days) anytime 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).
- They must have medical and pharmacy benefits for the measurement year

Exclusion criteria are then applied to the eligible population as detailed in Section S.9.1. Member months are then calculated for each measure's eligible population after all exclusion criteria has been applied to the eligible population data set using the following steps:

Step 1: Determine member months using a pre-specified day (e.g., the 15th or the last day of the month), determined according to 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. Organizations may count any month in which members were enrolled retrospectively and the organization received a retroactive capitation payment.

Step 2: Use the member's age on the last day of the treatment period to determine the age group where member months will be counted.

Step 3: Attribute all member months to the product line in which the member is enrolled on the last day of the treatment period. (Pharmacy member months are the number of months during the treatment period when the member is covered by a pharmacy benefit. Calculate pharmacy member months with the same method described in steps 1–3).

In order to calculate outpatient procedures and services, organizations count the number of specified services the organization paid for, or expects to pay for, during the treatment period. The organization is responsible for reporting all services under the member's age and product on the last day of the treatment period.
In order to calculate inpatient services, organizations categorize member services into services for pricing and services for frequency:
1) In services for standard pricing, each organization identifies all 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. Include all services billed for any inpatient facility, E&M; surgery and procedure, and pharmacy service. Include multiple billings that have the same date of service in the member/patient record.
2) To determine frequency of services, each organization identifies all inpatient utilization and reports by discharge date (rather than admission date) using the member's age and product on the last day of the treatment period. Include all discharges that occurred during the treatment period. For inpatient discharges, ED visits and condition-specific frequencies, count discharges, not the frequency of procedure codes billed. Transfers between institutions are treated as separate admissions especially when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services. Only one admission is counted when the transfer takes place within the same service category but to a different level of care.

When calculating inpatient services length of stay, organizations should use the following formula to report length of stay (LOS).
LOS = discharge date – admit date – denied days
LOS includes all paid days from admission up to discharge except 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. 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. If the inpatient stay falls completely within the treatment period, the total number of paid days is used as the per diem multiplier. If the inpatient stay does not fall completely inside the treatment period, or all days are not paid for or expected to be paid for, only the days within the treatment period (including the last day in the treatment period) that are paid for or expected to be paid for, are counted to compute the per diem multiplier.

Step 4-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 Standardized Price Tables).
Sum and report the total standard cost for the eligible population in each service category by member cohort.

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. Organizations capture each eligible member's services rendered during the treatment period for the following utilization categories.
- Total Inpatient Facility: Discharges, Days and ALOS
- Acute Inpatient: Discharges, Days, ALOS
- Acute Medicine: Discharges, Days, ALOS
- Acute Surgery: Discharges, Days, ALOS

• Nonacute: Discharges, Days, ALOS
• ED Discharges
• Pharmacy Utilization:

Step 5: For each of the RRU reporting services categories, if a member's standard cost exceeds the set cap amount (http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/2016SPTUsageAgreement/2016SupportingTables.aspx), only the total standard cost, including the truncated amount taken from the NCQA Member Cost Cap Amounts table, is reported. Members are not excluded from the data set when the capped amount is reached.

Service Category Cap Amount
Inpatient Facility $75,000
E&M – Outpatient $2,500
E&M – Inpatient $2,500
Surgery – Outpatient $7,500
Surgery – Inpatient $15,000
Pharmacy - $15,000
Laboratory - $4,000
Imaging - $4,000

S.7.2a. **CONSTRUCTION LOGIC ATTACHMENT or URL:** If needed, attach supplemental documentation (Save file as: S_7_2_Construction_Logic). All fields of the submission form that are supplemented within the attachment must include a summary of important information included in the attachment and its intended purpose, including any references to page numbers, tables, text, etc.

URL:

Please supply the username and password:

Attachment:

S.7.3. **Concurrency of clinical events, measure redundancy or overlap, disease interactions** *(Detail the method used for identifying concurrent clinical events, how to manage them, and provide the rationale for this methodology.)*
We do not provide specifications for concurrency of clinical events.

The NCQA RRU measures account for all health plan members who meet the disease specific criteria. All events or encounters for the predefined population that occur during the measurement year are captured by the measure cost or frequency of service categories.

S.7.4. **Complementary services** *(Detail how complementary services have been linked to the measure and provide rationale for this methodology.)*
We do not provide specifications for linking complementary services.

The NCQA RRU measurement approach accounts for all health plan members who meet the disease specific criteria. All events or encounters for the predefined population that occur during the measurement year are collected separately across all service categories, and standard costs and service frequencies are aggregated across services and members to compute the overall resource use for that member for that year. Including all events for a member, whether or not it can be attributed to a specific chronic condition captures a true snapshot of the resources required to treat a health plan member with a chronic condition.

S.7.5. **Clinical hierarchies** *(Detail the hierarchy of codes or condition groups used and provide rationale for this methodology.)*

The RRU-HCC risk adjustment divides qualified service diagnoses into 184 condition categories which are subject to hierarchy logic, assigning each a ranking group and an HCC group using tables provided by NCQA. The approach captures the combined effect of multiple unrelated conditions; however some diseases (e.g. diabetes, vascular disease) have multiple HCCs to differentiate disease severity and identify rankings (hierarchy) so that a member/patient's highest ranked HCC for a given disease will cancel out lower ranked HCCs for the same disease. See Section S.9.1 for the specific steps required to assign HCCs and rankings. Members/patients are assigned to a demographic cohort, each of which is defined by a range of severity as estimated by HCC-RRU. A weight is calculated for each identified HCC for the member/patient and summed to provide a summarized total risk score, which is then assigned to a predetermined risk cohort for reporting.

S.7.6. **Missing Data** *(Detail steps associated with missing data and provide rationale for this methodology (e.g., any statistical techniques to impute missing data)*

We do not provide measure specifications or guidelines for missing data :

NCQA requires reportable observed data in order to calculate RRU results. All measures must have a final, audited result submitted to NCQA. All plans that do not have any blanked-out utilization numbers are included in the calculation of the raw observed-to-expected ratio. When normalizing the ratios to develop an index, if any raw ratio = 0 (zero), or a plan has submitted a $0.00 cost for its given member months, that ratio is discarded.

S.7.7. **Resource Use Service Categories (Units) (Select all categories that apply)**

Inpatient services: Evaluation and management

Inpatient services: Procedures and surgeries

Inpatient services: Imaging and diagnostic

Inpatient services: Lab services

Inpatient services: Admissions/discharges

Ambulatory services: Outpatient facility services

Ambulatory services: Emergency Department

Ambulatory services: Pharmacy

Ambulatory services: Evaluation and management

Ambulatory services: Procedures and surgeries

Ambulatory services: Imaging and diagnostic

Ambulatory services: Lab services

S.7.8. **Identification of Resource Use Service Categories (Units)**

(For each of the resource use service categories selected above, provide the rationale for their selection and detail the method or algorithms to identify resource units, including codes, logic and definitions.)

Standard Costs are reported for the following categories:

- Inpatient facility: this category reports standard prices for inpatient facility services assigned to each stay and based on the standard per diem price. Organizations use the length of stay and ICD-9-CM/ICD-10-CM Diagnosis codes to assign the appropriate standard price.

- E&M: Standard prices for E&M services 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 services are summarized and collected separately from outpatient services.

- Surgery and Procedures: Standard prices for 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 surgery and procedure services are summarized and collected separately from outpatient services.

- Diagnostic Lab and Imaging: 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 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. Both the standard price per metric quantity and the standard price per days supply are included in the SPT provided on the NCQA Web site

(http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/2016SPTUsageAgreement/2016SupportingTables.aspx).

Service Frequency is reported for the following categories:
- 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.

If days from the stay are counted in the cost calculation, the stay should also be counted in the inpatient frequency calculation. For nonacute discharges, days and ALOS, include care from any institution that provides nonacute care in hospice, nursing homes, rehabilitation, SNFs, transitional care and respite.

- ED Visits: 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, 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) OR A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).
(See corresponding Excel file for the ED Value Set, ED Procedure Code Value Set, and the ED POS Value Set)

- Pharmacy Utilization: Use Table SPT-Pharm (http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/2016SPTUsageAgreement/2016SupportingTables.aspx) 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.

S.7.8a. **If needed, provide supplemental resource use service category specifications in either URL (preferred) or as an attachment (Save file as S.7.8a_RU_Service_Categories):**
URL:
http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/2016SPTUsageAgreement/2016SupportingTables.aspx

Please supply the username and password:

Attachment:

Clinical Logic

S.8.1. **Brief Description of Clinical Logic** (Briefly describe your clinical logic approach including clinical topic area, whether or not your account for comorbid and interactions, clinical hierarchies, clinical severity levels and concurrency of clinical events.)
This measure addresses the resource use of members identified as having asthma. Both encounter and pharmacy data are used to identify members for inclusion in the eligible population, and the results are adjusted to account for age, gender, and HCC-RRU risk classifications that predict cost variability (Refer to Attachment S8_RAS_Clinical Logic for additional information).

S.8.2. **Clinical Logic** *(Detail any clustering and the assignment of codes, including the grouping methodology, the assignment algorithm, and relevant codes for these methodologies.)*
Members are identified for the eligible population of the measure in two ways: by an encounter with a diagnosis; or by multiple asthma medication events. An organization must use both methods to identify the eligible population, but a member only needs to be identified by one to be included in the measure. The following steps are employed in order to identify the eligible population for measurement:

Step 1: Health Plan members are identified as having persistent asthma by meeting 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 principle diagnosis of asthma (Asthma Value Set), or
• At least one acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of asthma (Asthma Value Set)), or
• 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 types

need not be the same for the four encounters, or
• At least four asthma medication dispensing events (Table MMA_A)

(See the corresponding Excel file for value sets referenced above)

Table MMA-A: Asthma Medications
Antiasthmatic combinations: dyphylline-guaifenesin, guaifenesin-theophylline

Antibody inhibitor: omalizumab

Inhaled steroid combinations: budesonide-formoterol, fluticasone-salmeterol, Mometasone-formoterol

Inhaled corticosteroids: beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone CFC free, mometasone

Leukotriene modifiers: montelukast, zafirlukast, zileuton

Mast cell stabilizers: cromolyn

Methylxanthines: aminophylline, dyphylline, theophylline

Short-acting, inhaled beta-2 agonists: albuterol, levalbuterol, pirbuterol

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).

S.8.3. **Evidence to Support Clinical Logic Described in S.8.2** *Describe the rationale, citing evidence to support the grouping of clinical conditions in the measurement population(s) and the intent of the measure (as described in IM3)*

S.8.3a. **CLINICAL LOGIC ATTACHMENT or URL: If needed, attach supplemental documentation (Save file as: S_8_3a_Clinical_Logic). All fields of the submission form that are supplemented within the attachment must include a summary of important information included in the attachment and its intended purpose, including any references to page numbers, tables, text, etc.**
URL:

Please supply the username and password:

Attachment: S_8_3a_RAS_Clincal_Logic.pdf

S.8.4. **Measure Trigger and End mechanisms** *(Detail the measure's trigger and end mechanisms and provide rationale for this methodology)*
The measure captures total annual resource use measured from January 1st to December 31st of the measurement year.

S.8.5. **Clinical severity levels** *(Detail the method used for assigning severity level and provide rationale for this methodology)*

The methodology for calculating risk via HCC and the mapping of that estimated risk to HCC-RRU risk categories accounts for clinical severity as well as other interactions that have been shown to be significant predictors of health care costs. Refer to Section S.9.1 for a more complete description of the steps for risk adjustment that account for comorbidities and other disease interactions.

S.8.6. **Comorbid and interactions** *(Detail the treatment of co-morbidities and disease interactions and provide rationale for this methodology.)*

NCQA utilizes a risk adjustment model based on components of the CMS-HCC risk adjustment methodology that accounts for variable risk classifications due to comorbidities and other disease interactions. For each condition, members are assigned to a clinical cohort category that provides a more specific classification of the condition and has been shown to be a predictor of healthcare costs.

A member/patient's age, gender, and HCC-RRU category all determine their risk score (cohort). Refer to section S10.1 for a more complete description of the steps for risk adjustment that account for comorbidities and other disease interactions.

Adjustments for Comparability

S.9.1. **Inclusion and Exclusion Criteria** *Detail initial inclusion/exclusion criteria and data preparation steps (related to clinical exclusions, claim-line or other data quality, data validation, e.g. truncation or removal of low or high dollar claim, exclusion of ESRD patients)*

:

Inclusion Criteria

To identify the eligible population, include all services whether or not the organization paid for (or expects to pay for) the services (i.e., include denied claims).

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. Organizations and providers that use proprietary codes, Level II or state-specific Level III HCPCS codes must map to the industry standard code and remove codes that are not included in the NCQA Standardized Price Tables (SPTs).

The reporting organization has several options when determining payment for claims: a) Cover the full amount; b) Pay only a portion of the fee (e.g., 80 percent); c) Not pay anything because the member must cover the entire amount to meet a deductible; d) Not pay anything because the service is covered as part of a PMPM payment; or e) Deny the service.

Count the service if:
1) The organization pays the full amount or a portion of the amount (e.g., 80 percent)
1) The member paid for the cost of a service that is part of their benefit offering (e.g., to meet a deductible), or
2) The service was covered under a PMPM payment.

Do not count the service if:
1) The organization denied the service for any reason unless the member paid for the cost of a service that is part of the benefit offering (e.g., to meet a deductible)
2) The claim for the service was rejected because it was missing information or was invalid for some other reason.

Exclusion Criteria

Members with one or more of the following clinical conditions anytime during the member's history through December 31 of the measurement year are excluded from the RAS measurement data set.
1) Emphysema (Emphysema Value Set; Other Emphysema Value Set)

2) COPD (COPD Value Set)

3) Obstructive Chronic Bronchitis (Obstructive Chronis Bronchitis Value Set)

4) Chronic Respiratory Conditions (Chronic Respiratory Conditions Due to Fumes/Vapors Value Set)

5) Cystic Fibrosis (Cystic Fibrosis Value Set)

6) Acute Respiratory Failure (Acute Respiratory Failure Value Set)

7) ESRD. Exclude members with ESRD (ESRD Value Set) during the measurement year.

8) Kidney Transplant. Exclude members with kidney transplant (Kidney Transplant Value Set) during the measurement year.

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

1) Active cancer. Exclude members who had at least one face-to-face encounter, in any setting, with any diagnosis of cancer (Malignant Neoplasms Value Set; Other Neoplasms Value Set) in conjunction with any treatment code (Cancer Treatment Value Set), during the measurement year.

2) HIV/AIDS. Exclude 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).

3) Organ Transplant (other than kidney). Organ transplant (other than kidney) (Organ Transplant Other Than Kidney Value Set) during the measurement year.

See corresponding Excel file for value sets referenced above.

S.9.2. **Risk Adjustment Type** (Select type)
Stratification by risk category/subgroup
If other:

S.9.3. **Statistical risk model method and variables** *(Name the statistical method - e.g., logistic regression and list all the risk factor variables.)*
The current risk model utilized by NCQA is based on components of the CMS-HCC risk adjustment methodology and accounts for age, gender, and HHC-RRU risk classifications that predict cost variability. For each condition, members are assigned to a clinical cohort category that provides a more specific classification of the condition. For example, a member with Type 1 or Type 2 diabetes is assigned to one of 64 HCC-RRU risk categories based on diagnosis codes that are identified in claims for each member in the prior year. A members age, gender, and HCC category determines their risk score (cohort). NCQA then calculates the average per-member per-month (PMPM) cost for each cohort then weights that cost by the total member months within each cohort. Each plan will have its own weight for each cohort since case-mix varies across plans. These weighted cohort PMPMs are then summed across all cohorts to arrive at a PMPM that would be expected if the "average" plan had the same case-mix as the plan in question. The ratio of the observed to expected PMPM utilization indicates the degree to which a plan deviates from expected performance. This is known as indirect standardization.

Health plans submit the member month and summarized standardized cost separately for each member cohort, and NCQA calculates expected per member per month (PMPM) results. Thus, each health plan's RRU results are adjusted based on its mix of members.

The following steps assign each member a risk score and HCC-RRU risk reporting category for RRU measurement. Steps are implemented after the eligible population is identified:
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 (http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/2016SPTUsageAgreement/2016SupportingTables.aspx).

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.

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.

Step 4: For each ranking group, select only the highest ranking HCC using the "Rank" column (1 is the highest rank possible). Drop all other HCCs in each ranking group and if necessary, de-duplicate the HCC list.
For example, for member 1, the following HCCs would be listed:
• HCC-RRU-5
• HCC-RRU-15
Note: One CC-RRU can map to multiple HCC-RRUs; each HCC-RRU can have one or more CC-RRUs.

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

Step 6: Identify Demographic HCC-RRUs.
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.

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.

Step 9: Use the table below to assign the member to a risk group based on risk score.
Category Lower Score Range Upper Score Range

For example, a patient with a total HCC risk score of 1.2300 is assigned to Risk Group 5. Report all patient months and cost information for this patient in this risk group, within the appropriate age and gender stratifications.

1: 0.000-0.249
2: 0.250-0.499
3: 0.500-0.749
4: 0.750-0.999
5: 1.000-1.249
6: 1.250-1.499
7: 1.500-1.999
8: 2.000-2.499

9: 2.500-2.999
10: 3.000-3.999
11: 4.000-4.999
12: 5.000-5.999
13: 6.000-6.999 over

See corresponding Excel document for the above value sets.

S.9.4. **Detailed Risk Model Specifications** *available at measure-specific Web page URL identified in S.1 OR in attached data dictionary/code list Excel or csv file.*
Attachment
SA_Reliability_Validity-Testing-635350812611373298-635986554043399777.pdf

S.9.5. **Stratification Details/Variables** *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets)*
NCQA collects resource measures at the plan level and summarizes across reporting cohorts along the following dimensions:
1. Product line (3 levels): commercial, Medicaid, and Medicare;
2. Reporting type (2 levels): HMO and PPO;
3. Area level (2 levels): national and region;
4. Resource use or utilization (11 levels): inpatient facility, procedure and surgery (inpatient and outpatient), evaluation and management (inpatient and outpatient), laboratory services, imaging services, ambulatory pharmacy, inpatient discharges, emergency department discharges.
Although the HCC-RRU risk adjustment accounts for confounding variables such as age and gender, in order to assist organizations in using their results to identify opportunities to improve, NCQA reports RRU results using the HCC-RRU cohorts as reporting strata by age and gender cohorts. Reporting the measure results by these strata increases the ability of the reporting organizations to target areas for improvement without having to reverse engineer their measure results.

S.9.6. **Costing method**
Detail the costing method including the source of cost information, steps to capture, apply or estimate cost information, and provide rationale for this methodology.
Standardized pricing
RRU measures use NCQA's standardized prices. The organization does not report prices based on its contracts and fee schedules, rather it applies a standard price to each service, multiplies it by the number of units of service and reports the resulting standard cost. Using this approach protects proprietary fee schedules and contracts while supporting equitable measure comparison across organizations and across regions without requiring adjustment for levels of service payment. Each year, NCQA updates RRU SPTs that catalog a unit price for each type of health service necessary to report the measure. The SPTs allow health plans to match resource use in various service categories to a standardized cost structure, thus translating utilization to relative resource use. The standard pricing approach is based on the following sources of data:
- Relative values from the Medicare Fee Schedule (Resource-Based Relative Value Scale, or RBRVS)
- Pharmacy prices published by First Bank Data
- Inpatient prices based on a model that uses a broad set of averages, representing different local, regional and national health plans across the country.

A plan maps a standard price to each service, multiplies it by the number of units of service and reports the resulting standard cost. It then calculates total standard costs for eligible members across different areas of clinical care and aggregates standard costs across services and members to compute the overall relative resource use.
All RRU measures report the standard cost 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

Calculating Standard Cost

The organization applies the SPTs to all services in each service category using the following steps.

Step 1: Identify eligible members for each major clinical condition and assign them into the appropriate HCC-RRU risk category (See Section S.9.1).

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, standard price includes room and board and ancillary services)
- E&M (inpatient visits, and outpatient visits including office visits, consultations and other services)
- Surgery and Procedure (inpatient and outpatient procedures)
- Pharmacy (ambulatory prescriptions included in a member's pharmacy benefit)

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 below to calculate standard cost.

Step 4: For each major clinical condition, aggregate or sum each eligible member's total standard cost for each service category.

Step 5: Aggregate and report the total standard cost at the member cohort level.

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 (http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014/HEDIS2014PCRAndRRUSupportiveTables.aspx). Do not exclude members who exceed the capped amount. Methods used to identify the unit of service and assign standard unit prices vary by service category. The steps required for calculating each category are described below.

Calculating Total Standard Cost: Inpatient Facility

Step 1: Identify all inpatient stays that occurred during the treatment period. Include stays that may have started before the treatment period or ended after the close of the treatment period. Define a single, 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 +	G

Step 4: Determine the LOS per diem multiplier. If the inpatient stay falls within the treatment period, use the total number of paid for or expected-to-be-paid-for days as the per diem multiplier. If the inpatient stay does not fall inside the treatment period, or if all days are not paid for or expected to be paid for, 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. For frequency reporting of inpatient stays, acute and nonacute stays will be reported separately. 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 (http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014/HEDIS2014PCRAndRRUSupportiveTables.aspx) 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 eligible 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 it 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 non-surgical 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.
Calculating Total Standard Cost: E&M
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.
(http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014/HEDIS2014PCRAndRRUSupportiveTables.aspx)
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.
Calculating Total Standard Cost: Surgery and Procedure
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 table. Use only the applicable modifiers below to combine with procedure codes.

- 26 = Professional Component
- 50 = Bilateral Service
- 51 = Multiple Surgery
- 52 = Reduced Service
- 54 = Surgical Care Only
- 55 = Post-Surgical Care Only
- 56 = Pre-Op Surgical Care Only
- 62 = Two Surgeons
- 78 = Return to Operating Room
- 80–82 = Assistant at Surgery
- TC = Technical Component

If a procedure code is billed with a nonapplicable modifier, set the modifier to blank. 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. 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, 51or 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 (http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014/HEDIS2014PCRAndRRUSupportiveTables.aspx).
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. Note: • Surgeries must be correctly classified as inpatient or outpatient because the overhead charges for inpatient surgeries are included in the Inpatient Facility Cost category. The overhead for outpatient surgeries are 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, those costs should not be counted 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, the claim or encounter for these services should not be included in the total cost.
Calculating Total Standard Cost: Laboratory Services

Step 1: Identify all lab services that occurred during the treatment period. The valid lab codes used to select these services are listed in Table SPT-LAB.
Step 2: Match each lab service to the codes in Table SPT-LAB and assign the standard price to the service.
Step 3: Multiply the standard price by the number of units associated with the lab service. Most services have one unit.
Step 4: Sum the standard prices across the lab services to calculate the total cost. Include all units of service on a claim line.
Calculating Total Standard Cost: Imaging Services
Step 1: Identify all Imaging services that occurred during the treatment period. The valid imaging codes used to select these services are listed in Table SPT-IMG.
Step 2: Match each imaging service to the codes in Table SPT-IMG and assign the standard price to the imaging service.
Step 3: Multiply the standard price by the number of units associated with the imaging service. Most services have one unit.
Step 4 Sum the standard prices across the imaging services to calculate the total cost. Include all units of service on a claim line.
Calculating Total Standard Cost and Frequency: Pharmacy Services
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, the organization should use the standard unit price per day in the NCQA table. An organization that uses proprietary or regional codes should map them to standard NDC codes.
Step 3: Download Table SPT-Pharm from the NCQA Web site (http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014/HEDIS2014PCRAndRRUSupportiveTables.aspx). The table contains:

- The NDC code
- A standard unit price per metric quantity
- A standard unit price per day.
- Prescription category

o Name brand only (N1) Generic only (G1)
o Name brand—Generic exists (N2) Generic name—Name brand exists (G2)

Step 4: Match each NDC code to the appropriate row in Table SPT-Pharm.
Step 5: Aggregate and report service frequencies within each prescription category at the total level by organization for pharmacy prescription utilization.
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.
SA_Standardized_Price_Implementation-635350761264040422.pdf

S.10. Type of score*(Select the most relevant):*
Frequency Distribution
Rate/Proportion
Ratio
Weighted score/composite scale
Attachment
If other:
Attachment: S10_RAS_Sample_Score_Report.pdf

S.11. Interpretation of Score *(Classifies interpretation of a ratio score(s) according to whether higher or lower resource use amounts is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score, etc.)*
The measure performance is normalized to a mean each year based on total submissions from health plans. Performance for each plan is compared to a normalized mean for each cohort within each category and is not trendable over time due to adjustments in both the number and types of plans that are submitting as well as adjustments to the standardized prices that are updated on an annual basis.
RRU measures indicate how a plan uses a set of key resources (e.g., physician visits, hospital stays) to care for its members with specified diseases, compared with the average for plans in the same region and adjusted for the set of diseases and case mix of plan members. When used in tandem with quality measures, RRU results make it possible to simultaneously evaluate the quality of services and key elements that drive costs and premiums. As described in detail in Sections S13.1 and S13.3, a ratio of observed-to-expected resource use is calculated for each clinical condition for each plan which is then indexed to a mean of 1.0 to allow for

equitable comparisons between plan peer groups. When considering RRUs for members/patients with asthma, an RRU index ratio result of 1.00 indicates that a health plan used the same level of resources to treat its population of patients with asthma as the average of all plans for a similar (case mix-adjusted) group of members/patients with asthma. An index ratio of 1.12 indicates that a health plan used 12 percent more resources than their national or regional (depending on which benchmark is being used) peer average. An index ratio of 0.73 indicates that a plan used 27 percent fewer resources than the average of all plans for a similar (case mix-adjusted) group of members/patients.

S.12. **Detail Score Estimation** *(Detail steps to estimate measure score.)*

A ratio of observed-to-expected resource use is calculated for each clinical condition for each plan. The observed value is the actual summarized use data that health plans submit to NCQA for each measure's eligible population. NCQA calculates the expected value for each plan—the resources the plan would be expected to use if it performed at the average level of use for all other plans that submitted data, considering case mix differences between plans. NCQA then calculates an observed to expected ratio and reports it for each plan's national and regional peer group

The definitions below provide the rationale behind the type of score and how each are reported:

Observed (O): A plan's resource use, calculated using units of resources used (inpatient days) converted to dollar terms using the SPT and reported to NCQA. Summarized data are displayed as PMPM dollars for the four RRU service categories and as per 1,000 member years for the service frequency categories.

Expected (E): A plan's resource use assuming that the plan performed like an "average" plan with the same case-mix. NCQA provides these values to the plans.

O/E ratio: A plan's observed (reported) RRU values divided by its expected RRU values.

Indexed O/E ratio: The O/E ratio adjusted such that the mean of the O/E ratios for all plans equals 1.0

NCQA estimates and reports both the national peer group O/E results and the indexed plan type/regional peer group O/E results. An indexed ratio result of 1.00 indicates that one plan's level of resource use is the same as the average of all plans' level of resource use. This calculation creates a method for purchasers to examine the differences in plan resource use for a specific condition.

Reporting Guidelines

This section is optional and will be available for users of the measure as guidance for implementation and reporting.

S.13.1. **Describe discriminating results approach**

Detail methods for discriminating differences (reporting with descriptive statistics--e.g., distribution, confidence intervals).

IDSS report information gives health plans an opportunity to identify areas where resource use is too high (O/E >1.0) or offers a benchmark of best performance. NCQA concurrently publishes an organization's RRU ratio, indexed ratio, and quality index ratios for both the national and regional peer groups.

The O/E ratio for each plan can indicate if that plan's O/E is different from 1 or not. These include confidence interval (CI) calculations for the national Total Medical and Total Pharmacy service categories. The O/E ratio for each plan can indicate if that plan's O/E is different from 1 or not.

Service category-specific confidence intervals for a given plan are calculated using the following.

95% Confidence Limit=O/E ratio ± 1.96 ×SE

where:

"SE" is the standard error

1.96 is the standard normal deviate that corresponds to a 95% confidence limit

The standard error (SE) that NCQA uses in the calculation of the plan confidence limits is derived through a bootstrap approach resulting in 100 simulations drawing from plans covering 44 market areas (Ingenix Impact Benchmark Database). These simulations result in plans with pre-specified eligible populations (30, 50, 100, 200, 400, 1000, and 2500). The standard error across simulations of O/E ratios for each eligible population size is the estimated standard error for the O/E ratio. For a given plan, the standard error chosen for the calculation of its confidence limit is the estimate corresponding to the nearest match on eligible population size (highest bootstrap sample size that an observed eligible population exceeds).

S.13.2. **Detail attribution approach**

Detail the attribution rules used for attributing resources/costs to providers (e.g., a proportion of total measure cost or frequency of

visits during the measure's measurement period) and provide rationale for this methodology.
Using administrative claims data submitted by all organizations, NCQA estimates the expected RRU amounts for each clinical condition for each organization. RRU index amounts are based on the ratio of observed to expected amounts. 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. Relative resource use is calculated at the plan-level and no attribution of resource use is made below this level. Attribution of resource use to a particular NCQA submission is based on the product line and reporting type of the plan that the member was enrolled in as of the end of the measure year.

S.13.3. **Identify and define peer group**

Identify the peer group and detail how peer group is identified and provide rationale for this methodology.
There are multiple concepts of a "peer group" for the RRU measures. NCQA collects resource measures at the plan level and summarizes across reporting cohorts along the following dimensions:

1) Product line (3 levels): commercial, Medicaid, and Medicare;
2) Reporting type (2 levels): HMO and PPO;
3) Area level (2 levels): national and region;
4) Resource use or utilization (11 levels): inpatient facility, procedure and surgery (inpatient and outpatient), evaluation and management (inpatient and outpatient), laboratory services, imaging services, ambulatory pharmacy, inpatient discharges, emergency department discharges.

In the context of calculation of RRU ratios for risk adjustment purposes, NCQA uses indirect standardization to define a "case-mix peer group" for each plan relative to a hypothetical plan (with the same case-mix). The national average of PMPM resource use for each cohort is used to calculate this "case-mix peer-group." Conceptually speaking, the "case-mix peer group" represents what we might expect resource use to look like from the "average" plan if it had the same case-mix as the observed plan. Mathematically, this expected resource use is the national mean PMPM resource use for each cohort (weighted by the cohort's member months in an individual plan) summed up over all of the cohorts in the plan for each service category (e.g. Inpatient facility, Inpatient E&M, etc.). Resource use can be summed across service categories to get grand totals such as "Total Medical." At this point, there are estimates of both observed and expected resource use.
In order to determine how different a plan is from its own hypothetical "case-mix peer-group" (i.e. how different observed resource use is from expected resource use) the observed and expected total costs are expressed as an observed to expected (O/E) ratio. If a plan used 10% fewer resources than expected, it would have an O/E ratio of 0.9. Conversely, a plan that used 10% more resources than expected, the O/E ratio would be 1.1.
These O/E ratios are subsequently indexed to facilitate comparisons of efficiency by region and by reporting type (e.g. HMO/PPO), with the "indexed peer group" defined by the average O/E ratio for all plans in the same region and of the same reporting type. The difference between the "case-mix peer group" and the "indexed peer group" is that the former is an intermediate step of risk-adjustment and the latter is a means for making comparisons within a plan type and within a region more straightforward.
After calculating the indexed O/E ratios, NCQA provides organizations with their relative resource index score 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 for a given region and plan type.
- A score >1.00 indicates that the observed amounts for standard costs or utilization are greater than the expected amounts for a given region and plan type.
- A score <1.00 indicates that the observed amounts for standard costs or utilization are lower than the expected amounts for a given region and plan type.

S.13.4. **Sample size**

Detail the sample size requirements for reporting measure results.
Organizations submit all patients who meet the eligible population criteria for asthma to NCQA; however we do not publicly report any organization whose eligible population (n) is <200
The sample size of 200 is based on a bootstrap sampling approach in which the standard errors of each plan's O/E ratios for Total Medical and Total Pharmacy were calculated from 100 simulations. In these simulations, plans were drawn from 44 market areas with pre-specified eligible populations of 30, 50, 100, 200, 400, 1000, and 2500. Across the RRU conditions, the decrease in the average standard error (estimated over the 100 simulations) with increasing sample size begins to flatten out at a sample of size close to 200, indicating reliable estimates of the O/E ratios can be obtained for plans with as few as 200 cases of the chronic disease.

S.13.5. **Define benchmarking and comparative estimates**

Detail steps to produce benchmarking and comparative estimates and provide rationale for this methodology.
A ratio of observed-to-expected resource use is calculated for each clinical condition for each plan cohort each reporting year based on total submissions of RRU data to NCQA. The observed value is the actual summarized use data that health plans submit to NCQA for each measure's eligible population. NCQA calculates the expected value, or the resources the plan would be expected to use if it performed at the average level of use for all other plans that submitted data with consideration of case mix differences between plans (See Section S13.3).
Upon obtaining these values, NCQA calculates an observed-to-expected ratio and reports it for each plan's national and regional peer group. If a plan reported that its level of resource use for all patients with asthma was identical to the average of all plans and the plan had a case mix of patients that was identical to the average for all plans, the observed and expected values would be the same and the O/E ratio would be 1.0.
If the plan used more resources for members/patients with asthma than the average of all plans but had the same (average) case mix, the actual reported RRU (observed) would be higher than expected and the O/E ratio would be >1.0.
Generally, NCQA calculates the index ratio, which compares a plan's resource use to the average performance of all health plans in a specific product line. NCQA does not set benchmarks or thresholds for the O/E or indexed ratios (other than the outlier exclusion for publically reporting O/E ratios > 3 and < 0.33).

Validity – See attached Measure Testing Submission Form

SA.1. Attach measure testing form
1560_RAS_MeasTesting_v1.2-635350772379357293-636096456055929471.pdf

Feasibility

F.1. **Byproduct of Care Processes**
For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

F.1.1. **Data Elements Generated as Byproduct of Care Processes.**
Generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition
Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)
If other:

F.2. **Electronic Sources**
The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

F.2.1. **To what extent are the specified data elements available electronically in defined fields** (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)
ALL data elements are in defined fields in a combination of electronic sources

F.2.1a. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

F.2.2. **If this is an eMeasure,** provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

F.3. **Data Collection Strategy**
Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

F.3.1. **Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**
NA – measure currently is in use

F.3.2. **Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, and algorithm)?**

F.3.3. **If there are any fees associated with the use of this measure as specified, attach the fee schedule here. (Save file as: F3_3_FeeSchedule)**

Usability and Use

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making.

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.
U.1.1. **Current and Planned Use**

Specific Plan for Use	Current Use (for current use provide URL)
	Public Reporting Health Plan Ranking http://reportcard.ncqa.org/plan/external/plansearch.aspx Annual State of Health Care Quality: http://www.ncqa.org/tabid/836/Default.aspx

U.1.2. **For each CURRENT use, checked above, provide:**
- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

STATE OF HEALTH CARE ANNUAL REPORT: This measure is publically reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2012 the report included measures on 11.5 million Medicare Advantage beneficiaries in 455 Medicare Advantage health plans, 99.4 million members in 404 commercial health plans, and 14.3 million Medicaid beneficiaries in 136 plans across 50 states.

U.1.3. **If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons?** (*e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?*)

U.1.4. **If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)

U.2.1. **Progress on Improvement. (Not required for initial endorsement unless available.) Performance results on this measure (current and over time) should be provided in IM.2.2 and IM.2.4.**

Discuss:

- **Purpose Progress (trends in performance results)**
- **Geographic area and number and percentage of accountable entities and patients included**

The measure performance is normalized to a mean each year based on total submissions from health plans. Performance for each plan is compared to a normalized mean for each cohort within each category and is non-trendable over time due to adjustments in both the number and types of plans that are submitting as well as adjustments to the standardized prices that are updated on an annual basis. Based on feedback from key stakeholders (including the NQF Steering Committee); NCQA has been exploring options for adapting component RRU results for the purposes of assessing individual plan performance over time.

U.2.2. **If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

U.3.1. **Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO´s ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

1) information practices and control procedures
2) sampling methods and procedures
3) data integrity
4) compliance with HEDIS specifications
5) analytic file production
6) reporting and documentation

In addition to the HEDIS Audit, NCQA provides a system to allow “real-time” feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the measure.

Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

H.1. **Relation to Other NQF-endorsed Measures**

If there are related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

H.1.1. **List of related or competing measures (selected from NQF-endorsed measures)**

H.1.2. **If related or competing measures are not NQF endorsed please indicate measure title and steward.**

H.2. Harmonization

H.2.1. **If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**
Are the measure specifications completely harmonized?

H.2.2. **If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**

H.3. **Competing Measure(s)**

H.3.1. **If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**
Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Contact Information

Co.1 **Measure Steward (Intellectual Property Owner):** National Committee for Quality Assurance
Co.2 **Point of Contact:** Bob, Rehm, nqf@ncqa.org, 202-955-1728-
Co.3 **Measure Developer if different from Measure Steward:** National Committee for Quality Assurance
Co.4 **Point of Contact:** Jill Marie, Farrell, farrell@ncqa.org, 202-955-1785-

Additional Information

Ad.1 **Workgroup/Expert Panel involved in measure development**
List the workgroup/panel members' names and organizations.
Describe the members' role in measure development.
The Efficiency Measurement Advisory panel (EMAP) has guided NCQA staff through most of the measure development process. They EMAP provide methodological expertise as well as feedback from their respective organizations experiences in programming the measures. Specific members of the panel have created large research datasets (under contract with NCQA) in which NCQA tests measure concept s and refinements to the measure specifications prior to public release.

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Michael DeLorenzo
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Dan Dunn, PhD
Ingenix
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Timothy Zeddies, PhD, MHSA (Chair)
HMC Informatics/Reporting
Ranyan Lu
United Health Network
Bob Kelly
Thomson Reuters

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 **Year the measure was first released:** 2007

Ad.3 **Month and Year of most recent revision:** 01, 2013

Ad.4 **What is your frequency for review/update of this measure?** annually

Ad.5 **When is the next scheduled review/update for this measure?** 01, 2014

Ad.6 **Copyright statement:** NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

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Ad.7 **Disclaimers:**

Ad.8 **Additional Information/Comments:**