General Questions

What changes were made for HEDIS 2016?

- RRU specification changes:
  - We removed the Use of Appropriate Medications for People With Asthma (ASM) measure from the Relative Resource Use for People With Asthma Quality Index. Refer to HEDIS 2016 Volume 2 Technical Specifications for details.
  - Eliminated regional peer groups (regional versions of the O/E) in the RRU calculations.
  - Eliminated the indexing of the O/E ratio.
  - Combined HMO and PPO data.
  - Used prior year expected performance (as opposed to current year).

What does “EXC” mean in Quality Compass?

EXC means “excluded” and indicates that there was not enough information to calculate the Quality Index. This can happen for a number of reasons; for example, there may be too many missing values (NAs, NRs or NBs) among the quality measures making up the Quality Index to calculate the result.

For the RRU Index Ratio, an EXC is displayed if the denominator is <200 for the condition or if the calculated indexed ratio is <0.33 or >3.00.

If a plan receives an EXC for the Quality Index, the corresponding RRU result will automatically display EXC.

What does “NR” mean in Quality Compass?

NR means “No Report” and indicates that a plan did not submit a valid RRU value or that the value did not pass audit.

How is the Quality Index calculated?

The Quality Index is calculated by averaging the rates of designated HEDIS Effectiveness of Care (EOC) quality measures for a specific condition. Refer to How NCQA Calculates a Quality Index, at www.ncqa.org/rru, for more information.

How is the Indexed Ratio calculated?*

The Indexed Ratio is calculated by dividing the plan’s observed-to-expected (O/E) ratio by the average national O/E ratio or the regional O/E ratio, adjusted by the plan’s peer group.

*Beginning with HEDIS 2016, NCQA will no longer report the indexed O/E ratio or regional expected results. If you have questions regarding either of these results, please contact the Information Products department through https://my.ncqa.org/.
How does the indexed ratio differ from the O/E ratio?

The Indexed Ratio compares a plan’s result to the mean performance of all health plans in a given product line. It is created by indexing all plan O/E ratio means to 1.0. This step allows NCQA to display plan performance in Quality Compass, despite inherent differences in plan population sizes and severity of condition.

The O/E ratio is determined for each RRU cost and service component using a plan-specific benchmark (expected) that lets a plan know how it is performing, compared with other plans in its immediate peer group.

What is the Total Medical Index?

The Total Medical index is an aggregate of the Inpatient Facility; Surgery and Procedure; Diagnostic Laboratory; Diagnostic Imaging; and Evaluation and Management (E&M) service categories. It is displayed on the scatterplots with the Quality Index.

Do expected total costs include all product types?

No. Expected total costs are collected and reported separately for each product type (line of business). For example, a commercial plan is compared with all commercial plans that submitted only RRU data. NCQA does not compare commercial plans to either Medicaid or Medicare plans.

Why don’t the Standard Pricing Tables reflect the actual values of services paid for?

Because of the significant variation in actual prices paid for health care services across the country, RRU measures rely on standardized instead of actual prices for each service to ensure that plan performance is compared by the relative resource volume, rather than by a total service cost that is unduly affected by market, region and other competitive factors.

Data Capture

Must a plan be approved, accredited or audited by NCQA before it may submit RRU data?

No. Although only audited data are accepted by NCQA and included in the RRU calculations, it is not necessary for a plan to be NCQA Accredited in order to submit data.

How should mental health inpatient services be handled in the RRU measures?

Mental health services (MHSA diagnosis codes) that can be mapped to a service on the Standard Pricing Tables should be included in both the cost and frequency reporting categories. Inpatient mental health stays should be included when counting services for inpatient frequency.

Do cost categories in RRU measures result from condition-specific discharges and pharmacy use, or from all inpatient discharges and medications, regardless of reason?

RRU measures look at all services for members with an identified condition and are not specific to diagnosis at time of discharge. Standardized prices are aggregated across services and members to compute overall resource use for each measure. For example, the RRU for People With Asthma (RAS) measure includes all services for which the plan has paid, or expects to pay, for the eligible population (i.e., members with persistent asthma during the measurement year).
If a plan receives multiple claims from different providers for the same service, should the service be counted multiple times? For example, if a member had one MRI performed and two different providers billed separately for the technical and professional components of the MRI, does that count as two MRIs?

No. When calculating service frequency, multiple claims for the same service should be counted only once. In your example, even though two claims were generated for the technical and professional components, only one MRI should be counted.

When calculating cost, include all claims submitted for services, even if there are separate claims for the same service.

If a plan cannot report an EOC measure, how is an RRU measure handled if the plan submits data?

If a plan cannot submit an EOC quality measure required in the RRU technical specifications, no RRU results will be reported in Quality Compass.

Should observation room stays be removed from the Total Service Frequency by Service Category reporting tables?

Yes. Only inpatient facility discharges and ED visits should be reported in the Total Service Frequency tables.

Should medical supplies (e.g., syringes) be excluded from pharmacy services in standard cost calculations?

Yes. Exclude medical supplies (e.g., syringes) from pharmacy standard cost calculations.

If Inpatient Facility services are not available, should we disregard that category and only report E&M, Surgery—Outpatient and Pharmacy services?

Plans should make every attempt to obtain inpatient facility services data. If these data are not reported to NCQA, no results will be displayed in Quality Compass, nor will the Total Medical Index be calculated. Plans will only receive the individual category information provided to NCQA in the IDSS report.

Are there special rules for disabled or dual-eligible subpopulations in RRU measures?

No. Disabled and dual-eligibles are treated the same as the general population in RRU measures.

Are members who were excluded from the Comprehensive Diabetes Care measure through the chart review process also excluded from the RRU Diabetes measure; for example, if it is determined that a member is not diabetic (or is excluded for another reason)?

No. Do not exclude members based on medical record chart review findings in this measure.

How are services handled for members who are insured on a capitation basis? Are services incurred by these members (reported as encounters, not as paid claims) included in the measure?

Yes. Count capitated encounters, just as you do for other HEDIS Utilization measures. Pay particular attention to data completeness to determine the measure’s reportability.
How are services that are carved out or delegated via a per member, per month fee (e.g., behavioral healthcare) reported for the RRU measures?

If a service is carved out, data completeness is the only consideration. If the service is delegated by the plan, encounter data should be obtained from the delegated entity and included in cost and frequency estimations.

What does “dominant medical condition” mean? Is it the principal diagnosis, or is it any diagnosis on a claim?

The “dominant medical condition” refers to one or more of the following conditions: active cancer, organ transplant, ESRD, HIV/AIDS. Because of the disproportionally high-cost resources required to treat these conditions, members with one or more of the conditions are excluded from RRU calculations. The dominant medical condition is not the same thing as the principal diagnosis.

If a member has two different E&M codes on the same day, should only one be counted, or both?

Count both E&M codes and assign the standardized price for each service. When you count frequency of services, count each unique service once.

Using RRU Results

How do investments in health promotion and wellness programs affect RRU results for a plan that focuses resources on these types of activities?

RRU measures focus on chronic conditions. Wellness and health promotion interventions are not captured directly in the measure cost calculation, although it is reasonable to expect that successful wellness programs would have a positive effect on resource use, especially for the high-cost Inpatient and Surgical Service categories.

RRU methods are not sensitive enough to account for additional care for secondary health issues addressed because of high quality.

The current risk adjustment protocol considers the number of different diagnoses in the medical record, for assigning members to an appropriate comparison (severity) group for measurement of resource use and quality.

How does NCQA address the problem that outpatient-intensive plans may be unfairly targeted as inefficient because of increased resource use in that environment?

Although plans that use more outpatient services will probably have higher costs in the outpatient E&M and Surgery areas, they are also likely to have lower inpatient and total medical costs (additional outpatient services that keep people out of the hospital, which would reflect in the inpatient cost categories and the total medical cost). For this reason, plans that have higher outpatient costs are not labeled "inefficient.”

It is important to look at results in total, not only at a single result in isolation.

How do we account for a wide variation in associated costs because of plans that have a disproportionate number of members with multiple comorbidities?
The RRU specifications feature an HCC-RRU risk adjustment model that accounts for potential differential severity among chronic disease populations in different health plans.

Do RRU results allow researchers to calculate a chronic disease cost saving per patient, per year? For example, reducing HbA1c by only 1% results in $1,205 saved per patient, per year.

No. RRU measures are not intended to report dollar savings per patient, per year. NCQA produces an annual State of Health Care Quality Report that provides the national mean average and the 10th and 90th percentiles for the current year, as well as previous years’ national averages, for selected measures.

**Viewing RRU Results**

How do we access and view RRU data?

**Commercial:**
- Log in to Quality Compass. The License page gives the option to select the RRU + Quality Index (Commercial) license. For HEDIS 2015 results, there are two RRU + Quality Index licenses - one for HMO plans, the other for PPO plans.

*Note: If you have purchased a license for Quality Compass: Commercial data, you have complimentary access to RRU + Quality Index data.*

**Medicaid and Medicare:**
- Medicare and Medicaid RRU + Quality Index data are available in separate downloadable files.
- Existing Quality Compass: Medicaid or Medicare customers can access these files via the “Standard Downloads” section of Quality Compass.

Why does the RRU + Quality Index (Commercial) license contain fewer submissions than are reported in the Commercial license?

Not every plan that reports HEDIS measure data to NCQA also provides RRU information. Quality Compass includes all plan RRU data that meet public reporting requirements.

What plans can we see by clicking “View Graph” on the scatter plot graph?

The scatter plot graph displays the plan you selected (represented by a red dot) and the other plans in the same HHS region (represented by gray dots).

Why are some plans represented on the graph as a diamond?

Plan results from 0.33–0.49 and from 1.51–3.00 are displayed as a diamond-shaped pattern at the appropriate (upper or lower) limit of the graph, meaning that the actual value for the plan falls outside the plot’s constant value range of 0.5–1.5.

- A red diamond represents the health plan selected for viewing.
- A gray diamond represents other plans in the same HHS region.