For the listening benefit of webinar attendees, we have muted all lines and will be starting our presentation shortly

- This helps prevent background noise (e.g. unmuted phones or phones put on hold) during the webinar
- This also means we are unable to hear you during the webinar
- Please submit your questions directly through the webinar platform only

How to submit questions:

- Open the chat feature at the top of your screen to type your question related to today's training webinar
- In the "Send to" field, select "Webinar Host"
- Once your question is typed in, hit the "Send" button to send it to the presenter
- We will address submitted questions at the end of the webinar

Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

Blue Advantage Diagnostic Accuracy / STARS

August 14, 2019

Webinar presenters:

Mia Bell

Katrina Bradford-Norflin, BS, CRC, CPC, COC, CPC-I

Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

HMO Louisiana, Inc. offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, incorporated as Louisiana Health Service & Indemnity Co., offers Blue Advantage (PPO). Both are independent licensees of the Blue Cross and Blue Shield Association.

Agenda

- Diagnostic Accuracy and Completion (DAC)
- Medicare Advantage STARS
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Part D Prescription Drug Measures

Upon completion of this presentation, you will:

- Understand the components of:
  - Medicare Advantage Risk Adjustment
  - Medicare Advantage STAR Rating System
- Learn Best Practices for DAC and Quality Care

Diagnostic Accuracy and Completion (DAC)

What is Diagnostic Accuracy and Completion (DAC)?

- The focus of ensuring the health status of a member is captured through accurate and complete documentation and coding
- Diagnosis data is then used to allocate resources to MA enrollees as well as provide patient-centric and collaborative support for their healthcare needs

What is Medicare Advantage (MA) Risk Adjustment?

- Centers for Medicare and Medicaid Services (CMS) model, allowing for a better prediction of health cost expenditures using the health status and demographics of MA enrollees
- Diagnosis data comes from claims and medical record documentation from the following provider types:
  - Hospital Inpatient Facilities
  - Hospital Outpatient Facilities
  - Physicians

Coding Guidelines and Documentation

- Diagnosis codes **must** be supported with medical record documentation noted by the treating, licensed provider during a face-to-face visit
- Documentation **must** be signed, credentialed and dated by the treating provider
- Documentation should include all conditions, including chronic and/or co-existing conditions that are considered during the visit and affect the provider's medical decision making
- All conditions should be coded to the highest level of specificity
- Do **not** code conditions that were previously treated and no longer exist as current conditions
- Personal/Family History of codes may be used as secondary codes if the historical condition or family history has an impact on current care or treatment

Coding Guidelines and Documentation

- Each page of the chart should include:
  - Two patient identifiers
    - Ex: Name and Date of Birth
  - Date of service and/or page numbers
    - If only the first page includes the date of service and there are multiple pages that follow, the pages should be numbered to show continuity and order of the date of service
- All chart entries should include:
  - Date of entry
  - Legible note/documentation without symbols or slang
  - Provider signature including credentials and date of signature

New!

Commonly Missed Coding Mistakes

- The most appropriate ICD-10-CM code not included with the narrative description of the diagnosis or symptoms within the medical chart
- No evidence of monitoring, evaluation, assessment/address and treatment included in the documentation
- Chronic medical conditions were not recorded as chronic
- Records did not include the highest level of specificity regarding symptoms and conditions
- Annual records were not kept for chronic conditions
- There was a failure to report the necessary manifestation code

New!

Commonly Missed Conditions

- Diabetes and manifestations
- Secondary cancers
- Drug/alcohol dependence
- Hemiplegia/paresis
- Amputation status
- Ostomy status
- Asymptomatic HIV infection status
- Renal dialysis status
- Ventilator dependence

Remember to Include:

- Diagnosis – be specific
- Condition status – stable, improving or worsening
- Treatment plan – medications prescribed, labs and imaging ordered and/or completed

Avoid the following verbiage: "rule out," "likely," "presumed," "probably," "suspicious for"

New!

Commonly Missed Conditions

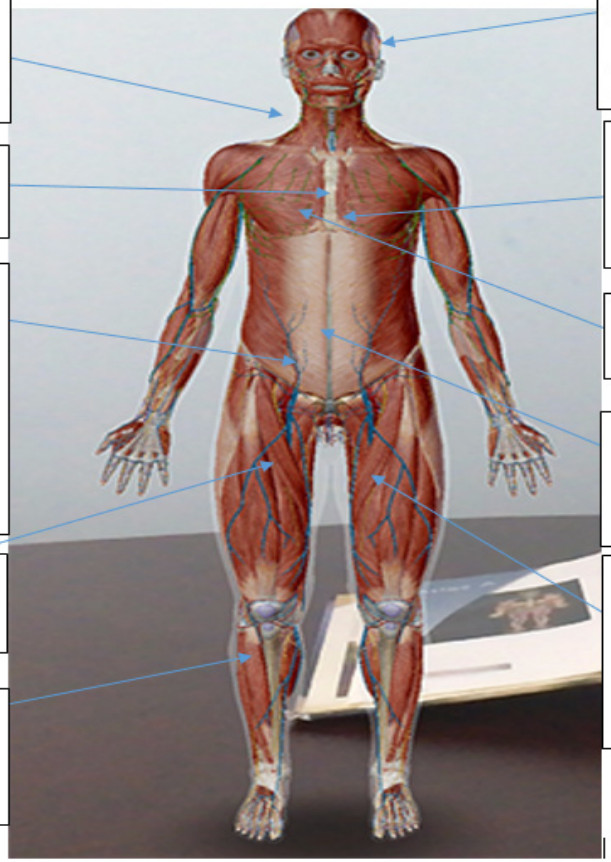
1. HCC108-Vascular Disease
- a. **I70.0**: Aortic atherosclerosis
- b. **I71.4/I71.2**: Aortic aneurysm: abdominal/thoracic
- c. **I73.9**:Peripheral vascular disease
- d. **I82.509**:Chronic DVT of lower extremity

2. HCC85-Congestive Heart Failure
- **a. I42.9:** Cardiomyopathy, unspecified
- **b. I50.20/I50.30**: Systolic/Diastolic heart failure

3. HCC18-Diabetes with Chronic Complications
- **a. E11.22:** DM 2 w/CKD
- **b. E11.311/E11.319:** DM 2 w/retinopathy w or w/o macular edema
- **c. E11.40:** DM 2 w/ diabetic neuropathy
- **d. E11.51:** DM 2, w/ diabetic peripheral vascular disease
- **e. E11.65:** DM 2, poorly controlled
- **f. E10.65:** DM1, poorly controlled
- **g. E11.351/E11.359:** DM 2 w/ proliferative retinopathy w or w/o macular edema
- **h. E10.351/E10.359**: DM 1, w/ proliferative retinopathy w or w/o macular edema

4. HCC19-Diabetes without Complications
- **a. E10.9:** Type 1 DM w/o complications
- **b. E11.9:** Type 2 DM w/o complications

5. HCC96-Specified Heart Arrhythmias
- **a. I48.91/I48.92:** Atrial fibrillation/Atrial flutter
- **b. I47.1:** Supraventricular tachycardia or paroxysmal atrial tachycardia



6. HCC58-Major Depressive, Bipolar, and Paranoid Disorders
- a. **F32.0-F33.9**: Major depressive disorders
- b. **F31.9/F20.9**:Bipolar disorder/Schizophrenia

HCC55-Drug/Alcohol Dependence
- c. **F10.20/F11.20**:Alchol dependence/Opioid dependence

7. HCC111-Chronic Obstructive Pulmonary Disease
- **a. J42:** Chronic bronchitis
- **b. J44.9/J43.9:** COPD/Emphysema
- **c. J41.0:** Smoker's cough

8. HCC88-Coronary Artery Disease
- **a. I25.119:** CAD w/ angina pectoris

9. HCC22-Nutrition
- **a. E66.01:** Morbid obesity

HCC21-Protein Calorie Malnutrition
- **b. R64:** Cachexia

10. HCC8-Metastatic Cancer
- **a. C77.0-C77.9:** Metastasis to lymph nodes

HCC48-Coagulation Defects
- **b. D69.6:** Thrombocytopenia

HCC47-Disorder of Immunity
- **c. D70.9:** Neutropenia

Best Practices for Documentation

- Be Specific!
  - Acute vs Chronic Conditions
- Status codes should be documented at least once per year
  - Example: Paraplegia Status, Transplant Status, Amputation Status
- Use the words "due to"
  - Example: Neuropathy "due to" diabetes
- When possible, link medications to conditions
  - Example: "Diabetes – stable, well-controlled on insulin"

- Evaluate MA enrollees at least once per year for an annual wellness visit
- Document any conditions being monitored, assessed, evaluated and treated to ensure the medical record displays an accurate clinical picture

Monitor

Evaluate

Assess

Treat

Remember:

- If it is not documented, it cannot be coded
- ICD codes are not sufficient documentation

Medicare Advantage Stars

Medicare Advantage STAR Rating System

- Initially published by CMS in 2008 to help beneficiaries choose a high-quality health plan
- Rates the performance of Medicare Advantage plans using one to five stars
- Primary goal is improving health outcomes of beneficiaries in an efficient, patient-centered and high-quality manner
- Provides beneficiaries with a true reflection of the plan's quality by encompassing multiple dimensions of high-quality care
- Since 2012, CMS has tied revenue and incentives to star ratings
- Continuously evolving

STAR Rating Calculations

STAR Ratings are used to encourage improvements in Medicare quality by measuring these five broad categories:

Category
Outcomes
Intermediate Outcomes
Patient Experience & Complaints
Access
Process

STAR Rating Data Sources

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys
- Health Outcomes Survey (HOS)
- Plan Performance Reporting Sources
    - Complaints Tracking Module (CTM)
    - Compliance Activity Module (CAM)
    - Independent Review Entity (IRE)
    - Call Center
- Part D Prescription Drug Measures

STAR Measures and Data Sources

HEDIS Measures

- Adult BMI Assessment
- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling Blood Pressure
- Diabetes Care - Blood Sugar Controlled
- Diabetes Care - Eye Exam
- Diabetes Care - Kidney Disease Monitoring
- Medication Reconciliation Post-Discharge
- Osteoporosis Management in Women who had a Fracture
- Statin Therapy for Patients with Cardiovascular Disease
- Rheumatoid Arthritis Management
- Plan All-Cause Readmissions

STAR Measures and Data Sources

CAHPS Survey

- Annual Flu Vaccine
- Getting Needed Care
- Getting Care Quickly
- Customer Service
- Overall Rating of Health Care Quality
- Overall Rating of Plan
- Care Coordination

HOS Survey

- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health
- Improving Bladder Control
- Reducing the Risk of Falling

STAR Measures and Data Sources

Plan Performance Measures

- Complaints about the Health Plan
- MA enrollees Choosing to Leave the Plan
- Beneficiary Access and Performance Problems
- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions
- Call Center – Foreign Language Interpreter and TTY
- Appeals Auto-forward and Appeals Upheld

Part D Prescription Drug Measures

- MPF Price Accuracy
- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS antagonists)
- Medication Adherence for Cholesterol (Statins)
- Statin Use in Persons with Diabetes (SUPD)
- Medication Therapy Management (MTM)

Healthcare Effectiveness Data and Information Set (HEDIS®)

Adult BMI Assessment (ABA)

- Percentage of MA enrollees with an outpatient visit who had their BMI calculated and recorded in their medical record during the measurement year or year prior

- Eligible Population: MA enrollees 18-74 years of age

- Optional Exclusion: MA enrollees with a diagnosis of pregnancy during the measurement year or year prior

Adult BMI Assessment (ABA)

Compliant Values and Data Sources

- Claims
  - ICD diagnosis codes:
    - BMI Value (Z68.1 thru Z68.45) or
    - BMI percentile (Z68.51 thru Z68.54)
- Medical Record Review
  - Age ≥ 20: Documentation of the weight and BMI value from the same date of service
  - Age <20: Documentation of the height, weight and BMI percentile from the same date of service

Best Practices

- Measurement and documentation of height, weight and BMI on every office visit
- Use BMI ICD codes on claims when possible

Breast Cancer Screening (BCS)

- Percentage of women who had a mammogram on or between October 1 two years prior to the measurement year, and December 31 of the measurement year
    - Ex: 2018 Timeframe: October 1, 2016 – December 31, 2019

- Eligible population: Women enrollees 52-74 years of age
- Optional exclusion: MA enrollees with a history of a bilateral mastectomy

Breast Cancer Screening (BCS)

Compliant Values and Data Sources

- Claims
  - CPT® and HCPCS codes for any type of mammography testing (screening, diagnostic, film, digital or digital breast tomosynthesis)
  - Bilateral/right & left mastectomy codes from claims also identify MA enrollees meeting exclusion criteria

Best Practices

- Educate female MA enrollees about the importance of early detection and encourage testing
- Standing order or EMR reminders as completion due date approaches
- When applicable, use ICD status code for history of bilateral mastectomy on claim

Colorectal Cancer Screening (COL)

- Percentage of MA enrollees who had a colorectal cancer screening
- Eligible population:
  MA enrollees 50-75 years of age
- Optional exclusion:
  MA enrollees with a history of a total colectomy or colorectal cancer diagnosis

Colorectal Cancer Screening (COL)

Compliant Procedures and Timeframes

- Colonoscopy
  - Measurement year or nine years prior
  - Ex: January 1, 2010 – December 31, 2019
- Flexible Sigmoidoscopy or CT Colonography
  - Measurement year or four years prior
  - Ex: January 1, 2015 – December 31, 2019
- FIT – DNA Test (Cologuard)
  - Measurement year or two years prior
  - Ex: January 1, 2017 – December 31, 2019
- Fecal Occult Blood Test
  - During the measurement year
  - Ex: January 1, 2019 – December 31, 2019

Colorectal Cancer Screening (COL)

Compliant Values and Data Sources

- Claims Data
  - CPT, HCPCS, ICD Proc codes, Rev Codes
- Medical Record Review
  - Ensure medical record documentation includes:
    - Date and name of procedure or lab test performed
    - Date of colorectal cancer diagnosis, if member meets exclusion criteria
    - Patient reported information is acceptable if the type of screening and date is documented by the provider

Best Practices

- Educate patients on the various options for colorectal cancer screenings, especially those opposed to a colonoscopy
- If screening was performed by an outside provider, attempt to obtain operative report, pathology report and/or lab values for the member's record
- Document patient reported dates and submit history of ICD codes when applicable

Controlling Blood Pressure (CBP)

- Percentage of MA enrollees with hypertension (HTN) whose blood pressure was adequately controlled during the measurement year as evidenced by a blood pressure reading less than 140/90

- Eligible Population: MA enrollees 18-85 years of age with a diagnosis of HTN on two different dates of service during the measurement year or the year prior

    - One of the two visits may be a telephone visit, an online assessment or a telehealth visit

- Optional Exclusions: MA enrollees with a pregnancy diagnosis or non-acute inpatient admission during the measurement year or MA enrollees with a history of ESRD, kidney transplant or dialysis

Controlling Blood Pressure (CBP)

Compliant Values and Data Sources

- Claims Data
  - CPT-Cat-II codes for both systolic and diastolic values on the same date of service
- Medical Record Review
  - Most recent BP reading during the year, including readings from remote monitoring devices that are digitally stored and transmitted to the provider
    - Systolic <140
    - Diastolic <90

Note: Patient reported results to the provider from a remote monitoring device are not acceptable

Best Practices

- If the patient's initial reading is elevated, obtain a second reading toward the end of the visit and record both in the medical record
- Medical record documentation indicating onset of HTN, current treatment plan and other providers or specialists are involved in the patient's management of HTN
- When applicable, utilize CPT-Cat-II codes on claims

Comprehensive Diabetes Care

- MA enrollees with diabetes are measured for compliance in each of the following areas:
  - **Blood Sugar Controlled**
    - Most recent HbA1c is less than or equal to 9% in 2019
  - **Eye Exam**
    - A retinal or dilated eye exam in 2019 OR 2018 that was negative for retinopathy OR a history of bilateral eye enucleation in any year
  - **Kidney Disease Monitoring**
    - Received medical attention for nephropathy in 2019
- Eligible population: MA enrollees ages 18-75 with diabetes (Type 1 or Type 2)
- Optional exclusion: MA enrollees who have only had a diagnosis of gestational diabetes or steroid induced diabetes during the measurement year or prior year

Diabetes Care – Blood Sugar Controlled

Compliant Values and Data Sources

- Claims Data
  - CPT-Cat-II codes
- Medical Record Review
  - Documentation of the most recent A1C test date and result

Best Practices

- Educate diabetic MA enrollees on importance of glucose control and A1C testing
- When possible, utilize CPT-Cat-II codes on claims

Diabetes Care – Eye Exam

Compliant Values and Data Sources

- Claims Data
  - CPT and HCPCS codes indicating an eye exam was performed
  - CPT-Cat-II codes include the results of the exam
- Medical Record Review
  - Date of eye exam, provider name/specialty and results
  - Patient reported information is acceptable if the date and results are clearly documented in the record

Best Practices

- Educate diabetic MA enrollees on importance of annual eye exams
- When possible, utilize CPT-Cat-II codes on claims
- If exam was performed by an outside provider, attempt to obtain the report for the member's record
- Use documentation such as "last eye exam in June 2018 with no retinopathy" instead of "eye exam up to date" or "eye exam current"
- If exact date is unknown, document the nearest month and year of known test

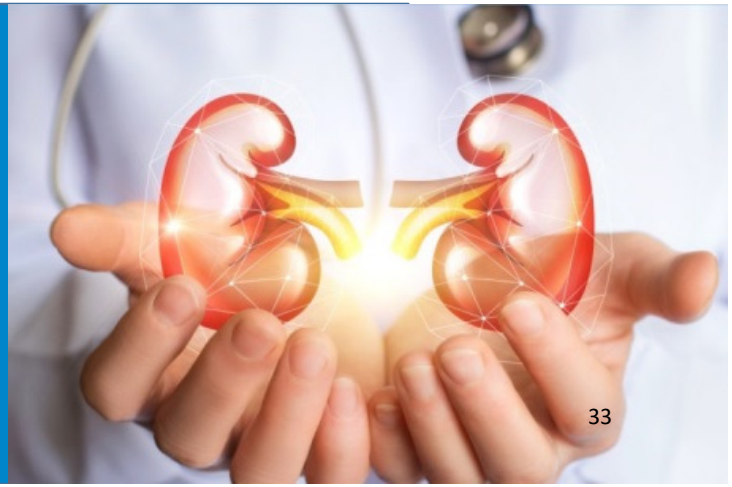
Diabetes Care – Kidney Disease Monitoring

Compliant Values and Data Sources

- One of the following during the year via claims data or medical record review:
  - Urine protein test
  - Evidence of stage 4 chronic kidney disease, ESRD or a kidney transplant
  - Treatment for nephropathy or evidence of ACE/ARB therapy
  - Visit with a nephrologist
  - An ACE inhibitor or ARB dispensing event

Best Practices

- When possible, utilize CPT-Cat-II codes for urine protein test, treatment for nephropathy, ACE/ARB therapy
- Documentation of lab results, referrals to specialists, prescribed medications



Medication Reconciliation Post Discharge

- Percentage of discharges for MA enrollees 18 years of age and older for whom medications were reviewed and reconciled on the date of discharge or 30 days after
- Event/Diagnosis: discharged from acute or non-acute inpatient care between January 1 and December 1 of the measurement year (2019)

Medication Reconciliation Post Discharge

Compliant Values and Data Sources

- Claims Data
  - CPT-Cat-II on the date of discharge or 30 days after
- Medical Record Review
  - Medication reconciliation conducted by a prescriber, clinical pharmacist or registered nurse on the date of discharge or 30 days after
  - Documentation should indicate that the reconciling provider reviewed both the current medication list and the discharge medication list on the same date of service

Osteoporosis Management in Women who had a Fracture

- Percentage of female MA enrollees who had a fracture and received either a bone mineral density (BMD) test or osteoporosis prescription in the 6 months after
- Eligible Population: female MA enrollees 67-85 years of age
- Event/Diagnosis: fracture between July 1, 2018 and June 30, 2019

  (Does not include fractures of finger, toe, face or skull)
- Required Exclusions:
  - MA enrollees who had a BMD test during the 24 months before the fracture
  - MA enrollees who received osteoporosis medication therapy 12 months before the fracture

Osteoporosis Management in Women who had a Fracture

Compliant Values and Data Sources

- Claims Data
  - The member received one of the following on or within 180 days (six months) of the fracture:
    - Bone Mineral Density (BMD) Test
      - Identified with CPT, HCPCS and ICD-PCS codes from claims data
    - Osteoporosis Medications
      - Identified with HCPCS injection codes and pharmacy data

Best Practices

- Encourage MA enrollees to have a BMD test after a fracture
- If prescribing an osteoporosis medication, follow up with member to ensure prescription was filled AND taken
- Ensure correct diagnosis coding of fractures on claims

Statin Therapy for Patients with Cardiovascular Disease

- Percentage of MA enrollees who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year
- Eligible Population: Males 21-75 years of age and females 40-75 years of age with ASCVD, which is considered as having one of the following:
  - MI-discharged from an inpatient setting with an MI during the year
  - CABG, PCI or other revascularization procedure during the year
  - Ischemic vascular disease (IVD) in the past 2 years
- Required Exclusions:
  - Pregnancy, in vitro fertilization or prescription for clomiphene during the measurement year
  - Conditions and symptoms that indicate statin intolerance such as muscular pain and diseases, Cirrhosis or ESRD

Statin Therapy for Patients with Cardiovascular Disease

Compliant Values and Data Sources

- At least one dispensing event noted by pharmacy claims for a high-intensity or moderate-intensity statin medication during the measurement year (2019)

Best Practices

- Educate MA enrollees on the importance of medication adherence
- If MA enrollees meet exclusion criteria, ensure accurate diagnostic coding is submitted on the claim and supported with adequate documentation in the medical record
- Follow up with member to ensure prescription fill and adherence

Statin Therapy for Patients with Diabetes

- Percentage of those who received at least one statin medication of any intensity during the measurement year (2019)

- Eligible Population: MA enrollees 40-75 years of age who were dispensed insulin or hypoglycemics/antihyperglycemics OR with a diagnosis of diabetes during the measurement year or the year prior (2018)

- Required Exclusions: MA enrollees with astherosclerotic cardiovascular disease (ASCVD) as noted in the statin therapy for patients with cardiovascular disease measure, pregnancy, in vitro fertilization, prescription for clomiphene or conditions that indicate statin intolerance such as muscular pain and diseases, cirrhosis or ESRD

Rheumatoid Arthritis Management

- Percentage of MA enrollees with rheumatoid arthritis (RA) who were dispensed at least one prescription for a disease-modifying anti-rheumatic drug (DMARD)
- Eligible Population: MA enrollees ages 18 years and older who had a rheumatoid arthritis diagnosis on two different dates of service on or between January 1 and November 30 of the measurement year
- Optional Exclusions:
  - A history of HIV
  - Female MA enrollees with a pregnancy during the measurement year

Compliant Values and Data Sources

- Claims Data:
  - HCPCS injection codes
  - Pharmacy claims

Best Practices

- Evaluate all MA enrollees with RA to determine if DMARD therapy is appropriate

Plan All-Cause Readmissions

- Percentage of MA enrollees discharged from an acute inpatient hospital stay who had an unplanned acute readmission within 30 days
- Eligible Population: MA enrollees 18 years or older as of the date of discharge
- Event/Diagnosis: an acute inpatient discharge on or between January 1 and December 1 in the measurement year (2019)
- Required Exclusions:
  - Member died during the admission
  - Principal diagnosis of pregnancy or condition originating in the prenatal period
  - Planned hospital stays for chemotherapy, rehab, organ transplants or other planned procedures without a principal acute diagnosis condition

Plan All-Cause Readmissions

- Compliant Values and Data Source:
  - At least one acute readmission for any diagnosis within 30 days of the initial admission discharge date
  - Identified through claims data
- Lower rate is better
- Observed/expected ratio is used for STAR assignment
- Best Practices
  - Follow-up with patients post discharge

Transitions of Care - TRC

- First year "display measure"
- The percentage of hospital discharges who had each of the following during the measurement year
    - Four rates are reported:
        - Notification of Inpatient Admission
        - Receipt of Discharge Information
        - Patient Engagement After Inpatient Discharge
        - Medication Reconciliation Post-Discharge
- Eligible Population: MA enrollees 18 years of age and older who were discharged from an inpatient setting
- All four rates are reported using one record from the member's PCP or ongoing provider
    - Shared EMRs vs single provider record

Transitions of Care - TRC

- Notification of Inpatient Admission: Documentation of receipt of notification of inpatient admission on the day of admission or the following day
- Receipt of Discharge Information: Documentation of receipt of discharge information on the day of discharge or the following day
- Patient Engagement After Inpatient Discharge: Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge
- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)

Part D Prescription Drug Measures

Medication Adherence Measures

- Using pharmacy claims, each category measures the percentage of MA enrollees who fill their prescriptions often enough to cover 80% or more of the time they are supposed to be taking their medication
- Eligible Population: Part D beneficiaries 18 years or older with at least two prescriptions filled on different dates of service with the first fill at least 91 days before the end of the enrollment period

Medication Adherence for Cholesterol Medications

- Cholesterol medications included: Statin Drugs

Medication Adherence for Diabetes Medications

- Diabetes medications included: Biguanides, sulfonylureas, thiazolidinediones, DPP-IV inhibitors, incretin mimetic drugs, meglitinides or SGLT2 inhibitors
- MA enrollees who take insulin or have ESRD are not included

Medication Adherence for Hypertension (RAS Antagonists)

- Hypertension medications included: ACE Inhibitors, ARBs or a direct renin inhibitor
- MA enrollees who were prescribed sacubitril/valsartan or with ESRD during the measurement year are not included

Medication Measures

Best Practices

- Educate MA enrollees about their medication
  - Benefits
  - Side effects
  - Expected results
  - Other options
- If MA enrollees meet exclusion criteria, ensure accurate diagnostic coding is submitted claims and supported with documentation in the medical record
- Follow up with the member to ensure the prescription was filled and to address adherence, side effects and other questions

Resources

CMS-HCC:

- Announcements/Final Call Letter
  - www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html
- Risk Adjustment Training
  - www.csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Risk%20Adjustment%20Processing%20System~Training?open&expand=1&navmenu=Risk^Adjustment^Processing^System||
- Stars Technical Notes
  - www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html
- HEDIS Measure Specification
  - www.ncqa.org/hedis-quality-measurement/hedis-measures

If you have additional questions after this webinar,
please email provider.relations@bcbsla.com.