# Driving Quality, HEDIS® & Risk Adjustment Performance

2026 Provider Webinar

May 13, 2026

BlueCross BlueShield Kansas

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# Quality Based Reimbursement Program (QBRP)

# What is QBRP?

## Quality Based Reimbursement Programs Promote:

- Efficient Administration
- Improved Quality
- Better Patient Care and Outcomes

## BCBSKS QBRP Programs

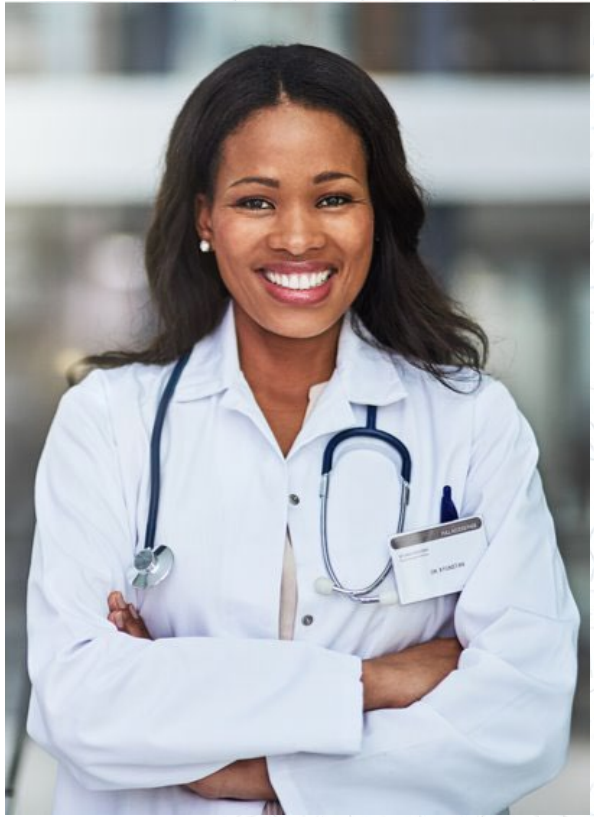
- Professional Providers (CMS-1500 billing)
- Institutional Facilities (Acute Care/PPS; Surgical; Critical Access and Rural Emergency Hospitals; Ambulatory Surgical Centers and Dialysis Facilities)
- Increased claims reimbursement

# Professional Provider QBRP

## QBRP Prerequisites and Groups

Claims data is used to determine qualifications for any applicable metric requiring data.

- Prerequisites
  - Receive Remittance Advice (RA) electronically
  - Submit claims electronically
  - Provider in good standing
- Group A
  - All eligible contracting professional providers
- Group B
  - Prescribing provider types (MD; DO; DPM; OD; PA; APRN; CRNA)
- Group C
  - Prescribing provider types as applicable to the measure and only to covered E&M codes



# 2026 Group A Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **Electronic Self-service (ES3)** | 2.0 (ES3) (96% or >) | Must use Availity portal or ANSI 270/271 & 276/277 transactions to electronically obtain patient eligibility, benefit and claims status information. Electronic access must meet one of the percentages at left compared to the provider's total number of queries to BCBSKS, regardless of the mode of inquiry to receive the corresponding incentive. Providers billing under a single tax ID number will have their inquiries combined for determining the applicable percent. | Semi-annual |
| **Provider Information Portal (PRT)** | 2.5 | Must verify and attest to provider information every 90 days according to the qualifying schedule. Each individual provider's information within a group must be verified. Verification must be completed in the BCBSKS provider information portal. Providers who do not attest every 90 days will be suppressed from the provider directory. | Every 90 days |
| **Electronic Provider Message Board (EPM)** | 1.0 | Must sign agreement to supply needed information for claim processing review/completion. Time frame for return of the requested information must be within the agreement time frame (15 days) through the provider message board portal. | Semi-annual |

# 2026 Group A Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **MiResource (MiR) (Behavior Health Providers only)** | 0.5 | This measure was discontinued March 31, 2026. | Semi-annual |
| **Certified Community Behavioral Health Clinic (CCBHC)** | 3.0 | Must provide signed documentation and certificate of approval from the Kansas Department for Aging and Disability Services to be eligible. A Certified Community Behavioral Health Clinic (CCBHC) is a specialized type of clinic focused on providing comprehensive mental health and substance use disorder services. These clinics are designed to improve access to care, regardless of diagnosis and insurance status. | Semi-annual |

# 2026 Group A Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **CPT II Codes (CAT2)** | 0.5 | CPT-II codes are supplemental procedure codes used to identify clinical components not associated with a relative value unit (RVU). These codes are often used to identify results of HbA1c tests; eye exams; blood pressure; medication reconciliation; cholesterol tests; and prenatal and postpartum visits, for example.<br><br>By providing these supplemental procedure codes on claims, there will be a decreased need for medical records while producing a more accurate HEDIS score for applicable measures.<br><br>The number of eligible CPT Category II codes submitted during the measurement period must be greater than or equal to 30 encounters to be eligible, calculated at the individual provider level. A complete list of QBRP eligible CPT-II codes can be found on pages 27-28 in the HEDIS Coding and Reference Guide for QBRP. | Semi-annual |

# 2026 Group A Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **ICD-10 SDoH Codes (ZZZ)** | 0.75 | Select ICD-10 Z codes can be used to help identify social determinants of health (SDoH), as well as 'history of' procedures or 'acquired absence of' codes used to support HEDIS. By providing these supplemental diagnoses codes on claims, social factors that impose barriers to a person's health and wellness can be identified, allowing appropriate resources to be allocated to better address the social needs of our members.<br><br>The number of eligible ICD-10 Z codes submitted during the measurement period must be greater than or equal to 30 encounters to be eligible, calculated at the individual provider level. A complete list of QBRP eligible ICD-10 Z codes can be found on pages 23-26 in the HEDIS Coding and Reference Guide for QBRP | Semi-annual |

# 2026 Group B Metrics Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **CCD or HIE HL7 use to State-approved HIOs.** Each provider must have a user ID and HL7 real-time connectivity to qualify. **The provider must send all five HL7 V2 feeds (a. - e.) OR CCD complete (f.) to receive any incentives** | | | |
| **a**-HIE HL7 V2 (ADT) Demographic, admissions, discharges, transfers | 3.0 | Must send all records for demographics, admissions, discharges and transfers. This includes office visits. | Semi-annual |
| **b**-HIE HL7 V2 (OPN via MDM) Progress notes | | Must send progress notes on all patient encounters. | Semi-annual |
| **c**-HIE HL7 V2 (ABS via ADT) Vitals, Diagnosis, Procedure coding | | Must send vitals, diagnosis and/or procedure coding on all patient encounters. | Semi-annual |
| **d**-HIE HL7 V2 (LAB via ORU) Lab reporting | | Must send all lab reports on all patient lab tests. | Semi-annual |
| **e**-HIE HL7 V2 (MED via RDE) Medication records | | Must send medication administration on all patient encounters. | Semi-annual |
| **f**-CCD complete/all data (KCCD) | | Must send complete and comprehensive Continuity of Care document (CCD HL7 V3) record, HL7 V2 ADT and HL7 V2 lab (ORU). | Semi-annual |

# 2026 Group B Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **Registry Data (REG)** | 3.0 | Must send sufficient patient information to meet CMS quality measures to a CMS-approved registry. Electronic submission is preferred. Providers under a group qualify as a group. Must send report to BCBSKS demonstrating acceptance of submitting data and meeting registry requirements.* | Semi-annual |
| **Access Formulary Electronically (EEX)** | 0.75 | Must electronically access member benefit information for eligibility, formulary and medication history a minimum of 120 times per quarter. | Semi-annual |
| **Generic Utilization Rate (GUR)** | 0.75 | Minimum generic prescribing of 85% for all BCBSKS members with a prescription drug benefit. | Semi-annual |
| **Anesthesia Performed in a Health System with a Level 1 Trauma Center (ATC)** | 8.5 | Must be dedicated on-site 24 hours a day, seven days a week, 365 days a year to a Level 1 Trauma Center facility with a PICU and NICU and involved with teaching anesthesia residents. | Semi-annual |

*applies only to anesthesia; pathology; radiology; urology; chiropractic; optometry; ophthalmology; rheumatology; pulmonary; gastroenterology and otolaryngology.

# 2026 Group B Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **Breast Cancer Screening (BCS)** | 1.0 | Percentage of women 50-74 years of age (52-74 as of the end of the measurement period) who had a mammogram anytime in the past two years. Must be greater than or equal to 75% to meet the metric, calculated at the provider group level having at least five attributed/eligible patients for breast cancer screening. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. *Note: OB/GYN and Geriatrician providers can qualify as well.* | Semi-annual |
| **Cervical Cancer Screening (CCS)** | 1.5 | Percentage of women 21-64 years of age who were screened for cervical cancer. Must be greater than or equal to 75% to meet the metric, calculated at the provider group level having at least five attributed/ eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. | Semi-annual |
| **Colorectal Cancer Screening (COL)** | 1.0 | Percentage of adults 45-75 years of age (46-75 as of Dec. 31 of the measurement year) who had appropriate screening for colorectal cancer. Members with multiple screenings will be counted only once as appropriately screened. Must be greater than or equal to 60% to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. | Semi-annual |

# 2026 Group B Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **Low-Back Pain (LBP)** | 1.0 | Percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis. The percentage is reported as an inverted rate; therefore, a higher reported rate indicates appropriate treatment of low back pain. Must be greater than or equal to 90% to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.<br><br>*Note: Member is attributed to the provider associated with the earliest date of service for an eligible encounter with principal diagnosis of low back pain. Chiropractors are eligible.* | Semi-annual |
| **Well-Child visits (W30A)** 6 or more visits in first 15 months | 1.0 | Percentage of members 0-15 months who had six or more well-child visits with a PCP during the first 15 months of life. Must be greater than or equal to 80% to meet the metric, calculated at the provider group level having at least 5 attributed/eligible patients. Individual providers in the group must have a least one attributed/eligible patient to receive incentive. | Semi-annual |
| **Well-Child visits (W30B)** 2 or more visits during months 15-30 | 1.0 | Percentage of members 15-30 months of age who had two or more well-child visits with a PCP between 15-30 months of life. Must be greater than or equal to 80% to meet the metric, calculated at the provider group level having at least 5 attributed/eligible patients. Individual providers in the group must have a least one attributed/eligible patient to receive incentive. | Semi-annual |

# 2026 Group B Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **Well-Child visits (WCV)** 1 or more visits for members 3-21 years of age | 1.0 | Percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year. Must be greater than or equal to 50% to meet the metric, calculated at the provider group level having at least 5 attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. | Semi-annual |
| **Statin Therapy for Patients with Cardiovascular Disease (SPC)** | 1.0 | Percentage of males 21-75 years of age and females 40-75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. Must be greater than or equal to 80% to meet the metric, calculated at the provider group level having at least five attributed eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive | Semi-annual |
| **Statin Therapy for Patients with Diabetes (SPD)** | 1.0 | Percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one statin medication of any intensity during the measurement year. Must be greater than or equal to 65% to meet the metric, calculated at the provider group level having at least five attributed eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. | Semi-annual |

# 2026 Group C Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **Statin Therapy for Patients with Diabetes (SPD)** | 1.0 | Percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one statin medication of any intensity during the measurement year. Must be greater than or equal to 65% to meet the metric, calculated at the provider group level having at least five attributed eligible patients. Individual providers in the group must have at least one attributed/ eligible patient to receive incentive. | Semi-annual |
| **Eye Exams for Patients with Diabetes (EED)** | 1.0 | Percentage of members 18-75 years of age as of the end of the measurement year with diabetes (type 1 or type 2) who had an eligible screening or monitoring for diabetic retinal disease as identified by administrative data. Must be greater than or equal to 50% to meet the metric, calculated at the provider group level having at least five attributed eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive | Semi-annual |

# 2026 Group C Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **Avoidance of Antibiotic Treatment in Members with Acute Bronchitis (AAB)** | 1.5 | Percentage of members 3 months of age and older with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed an antibiotic prescription. Must be greater than or equal to 50% to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.* | Semi-annual |
| **Appropriate Testing for Members with Pharyngitis (CWP)** | 1.5 | Percentage of members 3 years of age and older who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e. appropriate testing). Must be greater than or equal to 70% to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.* | Semi-annual |
| **Appropriate Treatment for Members with Upper Respiratory Infection (URI)** | 1.5 | Percentage of members 3 months of age and older who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription. Must be greater than or equal to 80% to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.* | Semi-annual |

**Note: The member is attributed to the provider associated with the earliest date of service for an eligible encounter with a principal diagnosis of acute bronchitis/pharyngitis/URI, regardless of specialty.*

# 2026 Group C Metrics

## Professional Provider QBRP

| Metric | % | Description | Qualifying Period |
|---|---|---|---|
| **Follow-up After Hospitalization for Mental Illness (FUH)** | 0.5 | Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of a selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health provider within 7 days after discharge. Must be greater than or equal to 70% to meet the metric, calculated at the provider group level having at least five attributed eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.* | Semi-annual |

*Note: The member is attributed to the provider associated with the earliest date of service of an eligible encounter with a principal diagnosis of mental illness or intentional self-harm, regardless of the specialty*

# Institutional QBRP

- Voluntary program
- Provides incentives for providers to enhance quality and safety, and to reward providers for superior quality outcomes and cost efficiency.
- Focus is on quality, but not necessarily tied to HEDIS

## Reporting Periods & Submission Timelines

### Period 1

- Quality data submitted **November 5, 2025**
- Earned incentives took effect **January 1, 2026**
- Data reflects discharges from **January 1 – June 30, 2025**

### Period 2

- Quality data submitted **May 5, 2026**
- If updated measures were not received by this date, a reimbursement reduction begins **July 1, 2026**
- Data reflects discharges from **July 1 – December 31, 2025**

# Implementation of Clinical Data Submissions

***Aligned expectations across CAH and PPS Hospitals***

## Clinical Data Exchange (HL7 / CCD)

| Data Submission Requirement | CAH Measure | PPS Measure | What's Required |
|---|---|---|---|
| HL7 or CCD Connectivity | QM4 | QM6 | Hospitals must submit either:<br>• HL7 v2 (HL7 Bundle)<br>***or***<br>• HL7 v3 (CCD Bundle) |
| HL7 v2 – HL7 Bundle | QM4 | QM6 | All five feeds required:<br>ADT; MDM; ABS via ADT; ORU (Labs); ORM (MAR) |
| HL7 v3 – CCD Bundle | QM4 | QM6 | CCD + ADT + ORU (Labs) |
| Incentive Earned When | QM4 | QM6 | Required feeds are actively submitting to the state-approved HIO (KHIN) |

# Shared QBRP Clinical Quality & Safety Measures

***Aligned across CAH and PPS Hospitals***

## Clinical Quality, Patient Safety and Data Exchange

| Measure Area | CAH Measure ID | PPS Measure ID | Measure Name |
|---|---|---|---|
| Medication Safety | QM1 | QM1 | Adverse Drug Events |
| Infection Prevention | QM2 | QM2 | Clostridioides Difficile (C. diff) |
| Infection Prevention | QM3 | QM4 | Catheter-Associated UTI (CAUTI) |
| Data Interoperability | QM4 | QM6 | Clinical Data Submission (HL7 or CCD) |
| Antibiotic Safety | QM5 | QM13 | Antimicrobial Stewardship |
| Hand Hygiene | QM6 | QM7 | Hand Hygiene Adherence |
| Utilization | QM7 | QM8 | Unplanned All-Cause 30-Day Readmissions |
| Patient Safety | QM15 | QM15 | Falls with Injury |
| Sepsis Care | QM14 | QM14 | Severe Sepsis / Septic Shock 3-Hour Bundle |

# Shared Patient Engagement & Health Equity Measures

***Aligned expectorations for patient-centered care***

## Patient Experience, Engagement & Equity

| Measure Area | CAH Measure ID | PPS Measure ID | Measure Name |
|---|---|---|---|
| Patient Engagement | QM9 | QM9 | Patient & Family Engagement (PFE) Bundle |
| Health Equity Leadership | QM10 | QM10 | Hospital Commitment to Health Equity |
| Social Needs Screening | QM11 | QM11 | Screening for Social Determinants of Health |
| Equity Outcomes | QM12 | QM12 | SDOH Screening – Positive Rate |
| CMS Star Rating ≥ 3 | — | QM20–QM22 | CMS Star Rating *(PPS only)* |

# HEDIS 101

# What is HEDIS?

The Healthcare Effectiveness Data and Information Set (HEDIS) is a National Committee for Quality Assurance (NCQA) performance measurement/improvement tool.

## HEDIS Measures

**Around 90 HEDIS measures across 6 dimensions of care and service:**

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems

# Important HEDIS Elements to Know

## Measurement Year vs. Reporting Year

**Measurement Year (MY)**

- 12-month timeframe when services are rendered
- Jan. 1 through Dec. 31, generally
- Data is reported in the reporting year

**Reporting Year (RY)**

- Timeframe when data is collected and reported
- Service dates are typically from the prior measurement year
- In some cases, services may go back more than one year

## Denominator and Numerator

**Measure Denominator**

- Members who qualify for a measure
- Based on NCQA technical specifications

**Measure Numerator**

- Members who meet compliance criteria
- Based on NCQA technical specifications for appropriate care or service

# Important Elements to Know

## Required Exclusion

- Certain members are removed from the denominator
- Exclusions are based on:
  - Diagnosis
  - Procedures
  - Claim, encounter or pharmacy data

## HEDIS Benchmarks

- National, regional or state performance targets and comparative data
- Developed by the NCQA
- Used to compare results to industry averages for quality measures
- Key benchmarks are found in NCQA's Quality Compass

# Collecting and Reporting HEDIS Data

## Reporting Methods

**Administrative**

- Use the total eligible population for the denominator.
- Medical, pharmacy and encounter claims count toward the numerator.
- Approved supplemental data may be used for the numerator in some cases.

**Hybrid**

- Uses a random sample of 411 members from a health plan's total eligible population for the denominator.
- Numerator includes medical and pharmacy claims, encounters and medical record data.
- Auditor-approved supplemental data may be used for the numerator.

# Supplemental Data

Standardized process in which clinical data is collected by health plans for purposes of HEDIS improvement.

Supplemental clinical data is additional data beyond claims data.

# Electronic Clinical Data Systems (ECDS)

## What is ECDS?

- Allows use of multiple data sources
- Provides a more complete picture of care quality
- Used to support eligible HEDIS ECDS reporting

| ECDS Eligible Data Sources |
| --- |
| Administrative claims |
| Member eligibility files |
| Electronic health records (EHRs) |
| Clinical registries |
| Health information exchanges |
| Administrative claims systems |
| Disease/case management registries |

# Value-Based Program 101

# What is a Value-Based Program?

A health care payment model that rewards the quality of care, not volume of services performed. It focuses on:

- Better patient health outcomes
- Improved patient experience
- Lower overall health care costs

# BCBSKS Value-Based Program

## How it Works

**Uses 15 HEDIS measures to evaluate primary care quality**

- Many align with the Quality-Based Reimbursement Program (QBRP)

**Clinics receive monthly performance reports that:**

- Identify care gaps
- Track incentive performance
- Summarize overall clinic results

**Members are assigned to providers monthly to**:

- Clarify care responsibility
- Support focused, high-quality, cost-effective care

**Performance compared to national benchmarks – NCQA Quality Compass**

- Incentives begin at the 50$^{th}$ percentile on a measure

# Value-Based Program HEDIS Measures

| HEDIS Measue | Priority |
|---|---|
| Breast Cancer Screening (BCS) | Required, High |
| Cervical Cancer Screening (CCS) | Required, High |
| Colorectal Cancer Screening (COL) | Required, High |
| Eye Exam Diabetes (EED) | High |
| Statin Therapy for Patients with Diabetes-Statin (SPD-Statin) | High |
| Statin Therapy for Patients with Cardiovascular Disease-Statin (SPC-Statin) | High |
| Well-Child Visits in the First 30 Months of Life – First 15 Months (W30-a) | High |
| Well-Child Visits in the First 30 Months of Life – 15 Months to 30 Months (W30-b) | High |
| Child and Adolescent Well-Care Visits (WCV) | High |
| Blood Pressure Control for Patients with Diabetes (BPD) | Other |
| Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) | Other |
| Use of Imaging Studies for Low Back Pain (LBP) | Other |
| Appropriate Treatment for Upper Respiratory Infection (URI) | Other |
| Asthma Medication Ratio (AMR)* retiring in 2026, will be replaced. | Other |
| Appropriate Testing for Pharyngitis (CWP) | Other |

# Priority HEDIS Measures

# Breast Cancer Screening (BCS-E)

## BCS-E Definition

Percentage of members ages 40-74 who were recommended for routine breast cancer screening and had a mammogram within the required timeframe – completed on or by Oct. 1, two years prior to the MY through Dec. 31 of the MY.

## Required Exclusions

- Hospice care
- Deceased members
- Members with sex assigned as male at birth
- History of bilateral mastectomy
  - Includes documented unilateral procedures resulting in bilateral removal
- Gender-affirming chest surgery with diagnosis of gender dysphoria

# BCS-E Best Practices & Tips

- Educate patients on the importance of routine screening.
- Reminders that breast cancer often has no early symptoms.
- Follow screening frequency recommendations:
  - At least every 24 months for women ages 40-74
- Support scheduling during visits or referrals.
- Document history of bilateral mastectomy annually.

# Cervical Cancer Screening (CCS-E)

**CCS-E Definition:** Percentage of members ages 21-64 who received recommended cervical cancer screening using one of the following:

- Cervical cytology (ages 21-64)
- Cervical cytology/HR-HPV co-testing (ages 30-64)
- High-risk HPV (hrHPV) testing alone (ages 30-64

## Required Exclusions

- Hospice care
- Deceased members
- Members with sex assigned as male at birth
- Hysterectomy with no residual cervix
    - Cervical agenesis or acquired absence of cervix

# CCS-E Best Practices & Tips

- Offer cervical cancer screening in-office when possible or support scheduling with accessible in-network providers.
- Provide screening reminders at appointment scheduling.
- Be mindful of patient concerns or trauma-related barriers.
- Help members schedule routine screening.
- Document and code hysterectomy history when applicable.
- Submit applicable procedure codes.

# Annual Documentation of Hysterectomy for CCS-E

## Question to NCQA

Concerning the following criteria: Persons with a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix; Hysterectomy with no residual cervix or cervical agenesis or acquired absence of cervix any time during the person's history through the last day of the measurement period;

Does the PCP have to be the one documenting annually or can clinical staff, such as MA, scribe, or RN document the info?

## Answer from NCQA

"In scenarios where a patient is annually self-reporting their medical history (e.g., previous hysterectomy), the expectation is that this information is being collected by that patient's PCP or a specialist in the course of taking a medical history and documented in the patient's medical record.

It would not be appropriate for this information to only be documented by a medical assistant without involvement of a PCP (or specialist) during the collection and documentation in that patient's chart. The information sharing and review of that information should involve a PCP (or specialist). Please note: This is specific to scenarios where patients are self-reporting their medical history."

## Interpretation

It is appropriate to include documentation when the PCP (or specialist) has signed off on a note where the patient's history has been obtained from the patient or reviewed with the patient by clinical staff. However, it is not sufficient for clinical staff to do an independent review of the patient's medical record and report a history of hysterectomy.

# Cervical Cancer Screening (CCS-E) CPT/CPT II Codes

| Cervical Cytology | High-Risk HPV Test | Exclusion Codes |
| --- | --- | --- |
| 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175 | 87624, 87625, 87626, 0502U | 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135 |

# Colorectal Cancer Screening (COL-E)

## COL-E Definition

Percentage of members ages 45-75 who had an appropriate colorectal cancer screening.

## Required Exclusions

- Hospice care
- Deceased members
- Members with colorectal cancer or a total colectomy
- Members 66 and older with:
  - Frailty and advanced illness
  - Both criteria must be met to qualify for exclusion

# COL-E Best Practices & Tips

- Discuss non-invasive screening options for patients who refuse colonoscopy.
  - Keep KIT kits readily available during visits.

- For telehealth, phone or e-visits, ask if the patient is willing to complete an in-home FIT-DNA test.

- Educate patients on the importance of early detection:

- Colorectal cancer often can be prevented by removing growths before they turn into cancer.

- Discuss the benefits and risks of screening options and make a plan that supports the best health outcomes.

# Colorectal Cancer Screening (COL-E) Coding

| Time Frame | Test or Procedure | Coding Information |
|---|---|---|
| Measurement year to 9 years prior | Colonoscopy | CPT 44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398 |
| | | HCPCS G0105, G0121 |
| | | SNOMED 8180007, 12350003, 25732003, 73761001, 174158000, 174185007, 235150006, 302052009, 367535003, 443998000, 444783004, 446521004, 446745002, 447021001, 709421007, 710293001, 711307001, 789778002, 1209098000, 48021000087103, 48031000087101, 174173004, 174179000, 609197007, 771568007, 1217313001, 1304042004, 1304043009, 1304044003, 1304045002, 1304049008, 1304050008 |
| Measurement year to 4 years prior | Flexible sigmoidoscopy | CPT 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350 |
| | | HCPCS G0104 |
| | CT colonography | CPT 74261, 74262, 74263 |
| | | LOINC 60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3 |
| | | SNOMED 418714002 |
| Measurement year to 2 years prior | Stool DNA (sDNA) with FIT Test | CPT 81528 (specific to the Cologuard® FIT-DNA test), 0464U |
| | | LOINC 77353-1, 77354-9 |
| | | SNOMED 708699002 |
| Measurement year | iFOBT, gFOBT, FIT | CPT 82270, 82274 |
| | | HCPCS G0328 |
| | | LOINC 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6, 104738-0 |
| | | SNOMED 104435004, 441579003, 442067009, 442516004, 442554004, 442563002, 59614000, 167667006, 389076003, 71711000112103 |

# BCBSKS Case Management

## HEDIS Measures

# EDU – Emergency Room Utilization

## What do we know?

- ER misuse leads to fragmented care, worse outcomes and higher costs
- Most misuse is not patient irresponsibility
- Access, education and system gaps drive ER use
- Providers have strongest ability to influence patients
- Primary care access and communication are most effective points of intervention

# Emergency Department Utilization (EDU)

## Inclusions and Exclusions

| EDU Notable Procedure/Diagnosis Codes | |
|---|---|
| Include CPT/Rev Codes | 99281-99285 and 10004-69990 in the ED POS; 045X and 0981 Revenue Codes |
| Exclusions for Mental and Behavioral Disorders | Nearly 800 diagnosis codes (ICD-10-CM Chapter 9) |
| Exclusions for Psychiatry and ECT encounters | 90791-90899 |

# Common Examples of Misuse:

- Non-urgent conditions (URI, back pain, med refills)
- Chronic condition flares manageable outpatient
- After-hours visits driven by access issues

# What isn't misuse:

- True emergencies
- Patient uncertainty when education was never provided; no other option was clear

“If a patient didn’t know another option existed, the ER made sense.”

# Why Patients Choose the ER

## Common drivers

- Can’t get a same-day appointment
- Symptoms worsen after hours
- Unsure what’s “serious enough”
- Previously told to “go to the ER if it gets worse”
- Transportation or social barriers

## Root causes providers can influence

### Access barriers

- Long wait times for appointments
- Limited same-day or after-hours options
- Transportation challenges

### Education gaps – what patients don’t know

- When to call vs. when to go
- What urgent care can appropriately treat
- How to reach the care team after hours

### Care transitions

- Poor follow-up after hospital or ER discharge
- No clear plan for “what to do next time”

# Normalize calling & provide after-hours guidance

## Start with access & reassurance

- Do you have a nurse line or walk-in clinic?
- Encourage patients to call first
- Reassure patients they are not “bothering” anyone

## What to do on nights & weekends

- Clearly explain after-hours options or nurse-line information
- Include instructions in AVS and portal messages
- During chronic care visits, reinforce who/when to call and where/when to go

## Use after-hours & urgent care strategically

**Clearly explain**

- When urgent care is appropriate
- What conditions *must* go to the ER

**Clarify differences**

- ER: Life-threatening emergencies
- Urgent care: Same-day, non-life-threating
- PCP: Continuity and chronic care

## Reinforce with tools

- Provide written or portal-based resources

Patients remember **where** to go better than what to do. They remember **places** better than symptoms.

# Focus on High-risk Patients

## Target populations

- Frequent ER utilizers
- Chronic diseases (COPD, CHF, diabetes, asthma)
- Behavioral health or substance use disorders

## Action steps

- Proactive follow-ups
- Care management referrals
- Clear escalation plans

## Tighten follow-up for high-risk patients

### Effective tactics

- Schedule follow-ups *before* they leave the visit
- Post-ER check-in calls within 48 -72 hours

#### Patients don't know

- Schedule PCP follow-up within 7 days
- Post-ER outreach within 48 – 72 hours
- Clarify what should prompt a call vs. ER return
- Goal = Break the repeat-visit cycle

- Care management referrals

# BCBSKS Disease Management

## HEDIS Measures

# GSD – Glycemic Status Assessment for Patients with Diabetes

## What counts

- Most recent HbA1c result
- Ongoing monitoring of glycemic control

## Why it matters

- Poor control increases risk of ER visits, hospitalizations and complications
- Regular A1c monitoring allows earlier intervention

## What providers can do

- Order an HbA1c at least annually
- Close gaps for overdue labs
- Document results clearly

## Focus on patients with

- Prior elevated HbA1c
- Missed visits or labs
- Multiple chronic conditions

## Key message

Refer to BCBSKS Disease Management and Wellness Diabetes Program for member education

# CBP – Controlling High Blood Pressure

## What counts

- Most recent BP reading <140/90
- Eligible outpatient visit reading
- Re-check and document elevated readings

## Key message

- Refer to BCBSKS Disease Management and Wellness HTN Program for member education

# AAB – Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

## Measure assessment

- Episode-based HEDIS measure (patients three months and older)
- Acute bronchitis/bronchiolitis episodes that do NOT result in an antibiotic being dispensed
- Reported as an inverted rate (higher = better care)

## Scope of encounters

- Outpatient, urgent care, ER, telephone and telehealth
- Episode date = date of service
- Intake period: July 1 (prior year) – June 30 (measurement year)

## Why this matters:

- Illness is most often viral
- Antibiotics generally do not improve outcomes
- Reduces adverse effects and antimicrobial resistance

# Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

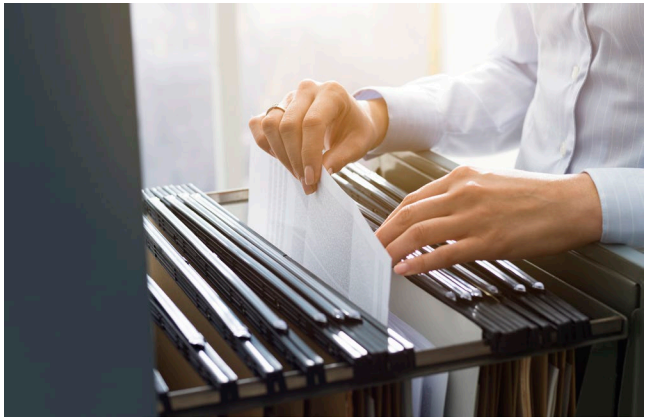
(AAB) Inclusions and Exclusions

| AAB Notable ICD-10-CM Diagnosis Codes | |
|---|---|
| Include (“triggering”) codes | J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9, J21.0, J21.1, J21.8, J21.9 |
| Exclusions for Comorbid Conditions | >1600 diagnosis codes |
| Exclusions for Competing Diagnsois | >800 diagnosis codes |

# When Episodes Count & How Documentation Affects AAB

## When episode counts against performance

- Diagnosis of acute bronchitis or bronchiolitis is submitted AND
- Antibiotic dispensed within three days of episode date AND
- No qualifying exclusion applies



## Common exclusions when clinically appropriate & coded

**Competing bacterial diagnosis**

- Acute pharyngitis or tonsillitis
- Acute sinusitis
- Otitis media
- Pneumonia

**High-risk comorbid conditions**

- COPD or emphysema
- Malignancy
- HIV
- Immune system disorders

**Visits resulting in inpatient admissions**

# AAB – Additional Considerations

## Episode counting

- One eligible episode per 31-day period is counted
- A member may count multiple times per year for separate episodes with antibiotic fills

## What does NOT exclude an episode

- Asthma
- Diabetes
- Tobacco use
- Fever or cough alone

## Why documentation matters

- Ensures episodes are classified correctly
- Supports appropriate antibiotic stewardship

## Symptomatic management options

- Rest and hydration
- NSAIDs or acetaminophen
- Cough suppressants
- Short-acting bronchodilators when wheezing or bronchospasm is present

# LBP – Imaging for Low Back Pain

## Measure assesses

- Adults ages 18-50 with a primary diagnosis of low back pain
- Evaluates avoidance of imaging (X-ray, CT, MRI)
- Imaging within the first 28 days counts against HEDIS performance, unless exclusions apply

## Why it matters

- Most acute low back pain is nonspecific and self-limited
- Early imaging does not improve clinical outcomes
- Unnecessary imaging may lead to the following:
  - Incidental findings
  - Additional testing or procedures
  - Increased cost and patient anxiety

## Imaging IS appropriate – HEDIS exclusions include

- Cancer
- Significant trauma
- Infection
- Neurologic impairment
- Recent lumbar surgery
- Severe or progressive symptoms with clinical justification

## Providers can

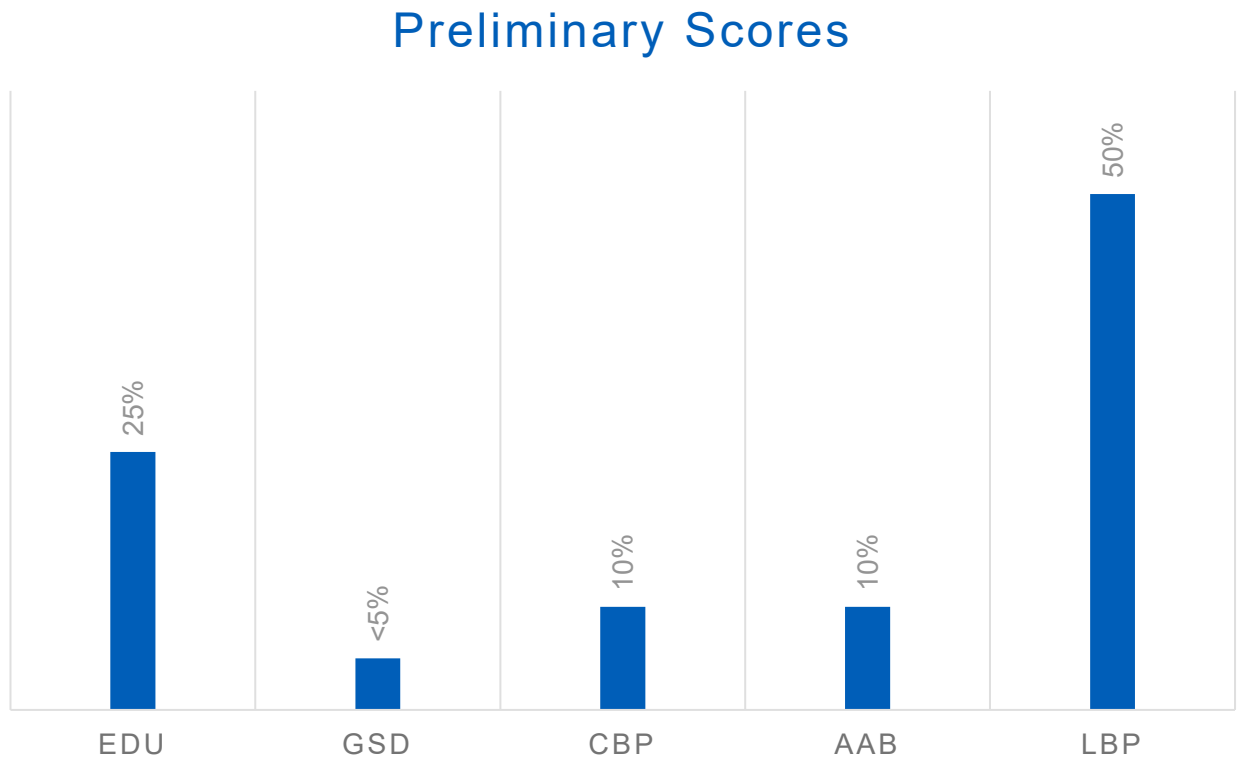
- Set expectations for improvement within four to six weeks
- Encourage conservative management first
- Clearly document red flags or exclusions when present
- Reinforce evidence-based, high-value care

# Use of Imaging Studies for Low Back Pain (LBP)

## Inclusions and Exclusions

| LBP Notable Procedure/Diagnosis Codes | |
|---|---|
| Include CPT &<br>ICD-10-CM codes | 72020-72158, 72200-72220<br>>90 dx codes for uncomplicated low back pain |
| Exclusions for ICD-10CM for which imaging is clinically appropriate | Nearly 1200 diagnosis codes |

# Measurement Scores – as of 02/25



# BCBSKS Available Resources

Provider FEP Toolkits

- Cover Page (PDF)
- Poster (PDF)
- Coaching Sheet (PDF)
- Prescription Pad (PDF)
- Blood Pressure Quick Reference Guide (PDF)
- Lower Back Pain Quick Reference Guide (PDF)
- Managing High Blood Pressure Brochure (PDF)

Provider Referral Form (PDF) for disease and wellness management programs

Disease and wellness management programs handout

# Break

# Pharmacy: Medicare Outreach Programs

**Tony Knutson, PharmD, BCPS**

5/13/2026

BlueCross BlueShield Kansas

# Statin Therapy for Patients with Cardiovascular Disease (SPC)

# Statin Therapy
## for Patients with Cardiovascular Disease (SPC)

### What is the measure?

- Males ages 21-75 and females ages 40-75 – identified by event or diagnosis as having clinical atherosclerotic cardiovascular disease (ASCVD) *and*
- Dispensed at least one high-intensity or moderate-intensity statin medication *and*
- Were at least 80% adherent for the remainder of the measurement year[1]

### Why is it important?

ACC/AHA guidelines recommend moderate or high-intensity statin for adults with established clinical ASCVD[2]

### How can you impact?

Must be prescribed a moderate or high-intensity statin to meet measure

| Category | Medication |
|---|---|
| High-intensity | • Atorvastatin 40-80mg<br>• Amlodipine-atorvastatin 40-80mg<br>• Rosuvastatin 20-40 mg<br>• Ezetimibe-simvastatin 80 mg<br>• Simvastatin 80 mg |
| Moderate-intensity | • Atorvastatin 10-20 mg<br>• Amlodipine-atorvastatin 10-20 mg<br>• Rosuvastatin 5-10 mg<br>• Simvastatin 20-40 mg<br>• Ezetimibe-simvastatin 20-40 mg<br>• Pravastatin 40-80 mg<br>• Lovastatin 40 mg<br>• Fluvastatin 40-80 mg<br>• Pitavastatin 1-4 mg |

# SPC Exclusions

To exclude patients unable to tolerate a statin, a claim with appropriate ICD-10 dose MUST be submitted ANNUALLY

| Exclusion Codes for SPC | |
|---|---|
| **Condition** | **ICD-10-CM Code** |
| Myalgia | M79.10–M79.12, M79.18 |
| Myositis | M60.839–M60.9 |
| Myopathy | G72.0, G72.2, G72.9 |
| Rhabdomyolysis | M62.82 |
| Cirrhosis | K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81 |
| ESRD | N18.5, N18.6, Z99.2 |

# Statin Use in Persons with Diabetes (SUPD)

# Statin Use
## in Persons with Diabetes (SUPD)

### What is the measure?

Patients with diabetes age 40-75 who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement year[1]

### Why is it important?

- All patients with diabetes are at higher risk of developing ASCVD[3]
- Cardiovascular disease (CVD) is major cause of morbidity and mortality in diabetes and, in turn, a contributor of high cost for diabetes management[3]
- ADA and ACC/AHA guidelines recommend moderate to high intensity statins first line for patients with diabetes aged 40-75 for prevention of cardiovascular disease[2,3]
- Benefit of statin use in diabetes: primary and secondary prevention of CVD (~20%) and decreased mortality (~9%) [4]

# Statin Use in Persons with Diabetes (SUPD)

## New for 2026

**Exclusion criteria change:** Members who have at least one prescription claim during the measurement period using their Part D benefits for either a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (Repatha or Praluent) OR bempedoic acid (Nexletol or Nexlizet) and do not have a statin fill or other exclusion

## How can you impact?

- Prescribe statins to patients with diabetes when clinically appropriate
  - Consider statin even with normal cholesterol levels for primary prevention
  - Continue to discuss benefits of statins with patients

- For patients experiencing adverse effects or intolerance, consider decreased dose/frequency and/or a more hydrophilic statin: rosuvastatin or pravastatin

# SUPD Exclusions

To exclude patients unable to tolerate a statin, a claim with appropriate ICD-10 dose MUST be submitted ANNUALLY

| Exclusion codes for SUPD | |
|---|---|
| **Condition** | **ICD-10-CM Code** |
| **Cirrhosis:** | |
| Alcoholic cirrhosis of liver without ascites | K70.30 |
| Cirrhosis of liver with ascites | K70.31 |
| Toxic liver disease with fibrosis and cirrhosis of liver | K71.7 |
| Primary biliary cirrhosis | K74.3 |
| Secondary biliary cirrhosis | K74.4 |
| Biliary cirrhosis, unspecified | K74.5 |
| Unspecified cirrhosis of liver | K74.60 |
| Other cirrhosis of liver | K74.69 |

| Exclusion codes for SUPD | |
|---|---|
| **Condition** | **ICD-10-CM Code** |
| **End Stage Renal Disease/Dialysis:** | |
| Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease | I12.0 |
| Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease or end stage renal disease | I13.11 |
| Hypertensive heart and chronic kidney disease with heart failure, with stage 5 chronic kidney disease or end stage renal disease | I13.2 |
| Chronic kidney disease, stage 5 | N18.5 |
| End stage renal disease | N18.6 |
| Renal failure, unspecified | N19 |
| Patient's noncompliance with renal dialysis | Z91.15 |
| Dependence on renal dialysis | Z99.2 |

# SUPD Exclusions, continued

| Exclusion codes for SUPD | |
|---|---|
| **Condition** | **ICD-10-CM Code** |
| **Rhabdomyolysis/myopathy/myositis*:** | |
| Drug-induced myopathy | G72.0 |
| Other specified myopathies | G72.89 |
| Myopathy, unspecified | G72.9 |
| Other myositis, unspecified site | M60.80 |
| Other myositis, unspecified shoulder | M60.819 |
| Other myositis, unspecified upper arm | M60.829 |
| Other myositis, unspecified forearm | M60.839 |
| Other myositis, unspecified hand | M60.849 |
| Other myositis, unspecified thigh | M60.859 |
| Other myositis, unspecified lower leg | M60.869 |
| Other myositis, unspecified ankle and foot | M60.879 |
| Myositis, unspecified | M60.9 |
| Rhabdomyolysis | M62.82 |

| Exclusion codes for SUPD | |
|---|---|
| **Condition** | **ICD-10-CM Code** |
| **Pregnancy and/or Lactation** | Numerous > 1k |
| **Polycystic Ovarian Syndrome** | E28.2 |
| **Pre-diabetes** | R73.03 |
| **Other abnormal blood glucose** | R73.09 |

*The condition the code refers to does not necessarily need to occur in the same year the code was billed. The member's medical chart should reflect 'history of.' These codes are intended to close Star measure gaps and do not apply to payment or reimbursement. Only the codes listed above will exclude the member from the SUPD measure.

# Concurrent Use of Opioids and Benzodiazepines (COB)

# Concurrent Use of Opioids and Benzodiazepines (COB)

## What is the measure?

Percentage of individuals 18 years of age or older with concurrent use of prescription opioids and benzodiazepines. Concurrent use is defined as overlapping days' supply for at least 30 cumulative days during the measurement period. A lower rate indicates better performance[1]

## How can you impact?

- Avoid initial combination of opioid and benzodiazepine medications
- Continue long-term co-prescribing only when necessary and monitor for potential abuse
- If new prescriptions are necessary, limit dose and duration
- Taper long-standing medications gradually and discontinue when possible
- Provide rescue medication (naloxone) to high-risk patients and caregivers
- Patients are excluded if they receive hospice services during the measurement year, have a cancer or sickle cell disease diagnosis

## Drugs that impact the measure:

| Drug Class | Medication | | |
|---|---|---|---|
| Opioids | • Benzhydrocodone<br>• Buprenorphine<br>• Butorphanol<br>• Codeine<br>• Dihydrocodeine<br>• Fentanyl | • Hydrocodone<br>• Hydromorphone<br>• Levorphanol<br>• Meperidine<br>• Methadone<br>• Morphine | • Opium<br>• Oxycodone<br>• Oxymorphone<br>• Pentazocine<br>• Tapentadol<br>• Tramadol |
| Benzodiazepines | • Alprazolam<br>• Chlordiazepoxide<br>• Clobazam<br>• Clonazepam<br>• Clorazepate | • Diazepam<br>• Estazolam<br>• Flurazepam<br>• Lorazepam<br>• Midazolam | • Oxazepam<br>• Quazepam<br>• Temazepam<br>• Triazolam |

# Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

# Poly-ACH

## What is the measure?

Percentage of individuals 65 years of age or older with concurrent use of two or more unique anticholinergic medications.

Concurrent use is defined as overlapping days' supply for at least 30 cumulative days during the measurement period. A lower rate indicates better performance[1]

## How can you impact?

- Avoid initial combination by offering alternative approaches
- If new prescriptions are needed, limit the dose and duration
- Taper long-standing medications gradually and, whenever possible, discontinue
- Continue long-term co-prescribing only when necessary and monitor closely
- Patients are excluded if they receive hospice services during the measurement year

# Poly-ACH

## Drugs that impact the measure:

| Drug class | Medication |
|---|---|
| Antispasmodics | • Atropine (excludes ophthamic)<br>• Dicyclomine<br>• Clidinium-chlordiazopoxide<br>• Homatropine (excludes ophthalmic)<br>• Hyoscyamine<br>• Scopolamine (excludes ophthalmic) |
| Antiemetics | • Prochlorperazine<br>• Promethazine |
| Antihistamines | • Brompheniramine<br>• Chlorpheniramine<br>• Cyproheptadine<br>• Dimenhydinate<br>• Diphendydramine (oral)<br>• Doxylamine<br>• Hydroxyzine<br>• Meclizine<br>• Triprolidine |
| Antiparkinsonian Agents | • Benztropine<br>• Trihexyphenidyl |
| Skeletal muscle relaxants | • Cyclobenzaprine<br>• Orphenadrine |
| Antidepressants | • Amitriptyline<br>• Amoxapine<br>• Clomipramine<br>• Desipramine<br>• Doxepin (>6 mg/day)<br>• Imipramine<br>• Nortriptyline<br>• Paroxetine |
| Antimuscarinic (urinary incontence) | • Darifenacin<br>• Festoterodine<br>• Flavoxate<br>• Oxybutynin<br>• Solifenacin<br>• Tolterodine<br>• Trospium |
| Antipsychotics | • Chlorpromazine<br>• Clozapine<br>• Olanzapine<br>• Perphenazine |

# Adherence: Diabetes, Hypertension and Cholesterol

# Adherence

## What is the measure?

Patients ages 18 and older with prescription for diabetes, hypertension or cholesterol medications who fill often enough to cover 80 percent or more of the time they are supposed to be taking medication, monitored by percent of days covered (PDC)[1]

Medications covered:

- Diabetes: Non-insulin diabetes medications
- Hypertension: ACE-inhibitors, Angiotensin receptor blockers (ARBs) and Direct Renin inhibitors (Aliskiren)
- Cholesterol: Statins

## Why is it important?

Studies demonstrate improved outcomes for patients who are adherent to these medications[5]

# Tips for Measuring Success

1. Ensure patients fill through prescription drug benefit
    - Claims filled through discount programs and medication samples don’t count
    - Gap closure is dependent on pharmacy claims
2. Emphasize benefits of taking AND risks of not taking medications (benefits should outweigh risks)
3. 100-day supplies improve medication adherence, decrease trips to the pharmacy and maximize plan benefits
4. Write prescriptions for 100 or 90-day supply AND with refills when tolerating and stable on regimen
5. Schedule follow-up visit within 30 days when prescribing new medications to assess effectiveness and tolerability
6. Write new prescriptions when dose changes are made to prevent medication stockpiling and inadvertent measure non-compliance
7. Encourage patients to utilize auto-fill programs and reminder tools (med box, calendar, alarm, etc.)
8. At each visit ask patients open-ended questions about medication habits:
    - Side effects
    - How many doses missed
    - Financial barriers
    - Issues preventing refill of prescriptions

# Why 100 and 90-day Supplies? Why Preferred Retail and Mail Order?

1. Reducing member cost
    - Drug cost is often a concern for patients
    - 100 and 90-day supplies for tier 1 and tier 2 drugs are $0 copay at preferred retail and mail order
2. Convenience
    - Less trips to the pharmacy
    - Easier to sync medication fills
3. Improved adherence

| Preferred Retail Pharmacies: |
| --- |
| Kroger (Dillons) |
| Walgreens |
| Walmart |
| Select Independents |

| Preferred Mail Order Pharmacy: |
| --- |
| Amazon |

# How Does Blue Cross and Blue Shield of Kansas Help?

# Member Outreach

1. Adherence calls
    - Phone call to patient to discuss possible barriers to adherence
    - Encourage patient to fill prescription regularly

2. Performance Network
    - Partner with local pharmacies to assist in closing gaps

3. Guided Health and Lettering campaigns
    - Identify specific patients that have open gaps
    - Sent via direct provider notification, fax or letter
    - Targeted patient interventions for appropriate coding or prescribing

4. Medication Therapy Management (MTM) Program

5. Health system and provider group partnerships
    - Current pilot program in Topeka
    - Consideration for other partnerships

# Medicare Advantage Incentives

# Financial Incentives for Meeting Measure Goals

| Incentive Payout | Measure(s) |
|---|---|
| **Quality Performance Measures** | |
| $300 | Annual Wellness Visit |
| **Effectiveness of Care HEDIS Measures** | |
| $100 | Medication Adherence – Cholesterol*, Medication Adherence – Diabetes*, Medication Adherence – Hypertension* |
| $100 | Breast Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patients with Diabetes, Glycemic Status Assessment for Patients with Diabetes, Kidney Health Evaluation for Patients with Diabetes, Statin Therapy for Patients with Cardiovascular Disease, Statin Use in Persons with Diabetes, Transitions of Care – Medication Reconciliation, Transitions of Care – Patient Engagement |
| $200 | Controlling Blood Pressure |

* Maximum potential Blue MA Star Ratings Incentive of $1,500 per member.

# Medication Therapy Management (MTM) Program

# Medication Therapy Management (MTM)

## How do patients qualify?

Must meet certain criteria. CMS recently expanded the qualifications criteria to target more patients.

- Disease state
- Medication
- Financial

Automatic enrollment when criteria met

## How can you help?

Encourage those qualifying to participate

### 2026 Qualifications

1. Have **three or more** of the following conditions:
   - Chronic Heart Failure (CHF)
   - Diabetes
   - Hypertension
   - Dyslipidemia
   - Mental health disorders – depression, schizophrenia, bipolar disorders and chronic/disabling mental health conditions
   - Respiratory disease – COPD/Asthma
   - Alzheimer's disease
   - End-stage renal disease (ESRD)
   - Bone disease, arthritis – osteoporosis, osteoarthritis and rheumatoid arthritis
   - Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)

   **AND**
2. Take eight or more prescription drugs covered by Medicare Part D

   **AND**
3. Expect to spend $1,276 or more on prescription drugs covered by Medicare Part D in 2026

   **AND/OR**
4. Have an active coverage limitation for an opioid or frequently abused prescription drug, as a result of a Drug Management Program

# Medication Therapy Management (MTM)

## What we offer?

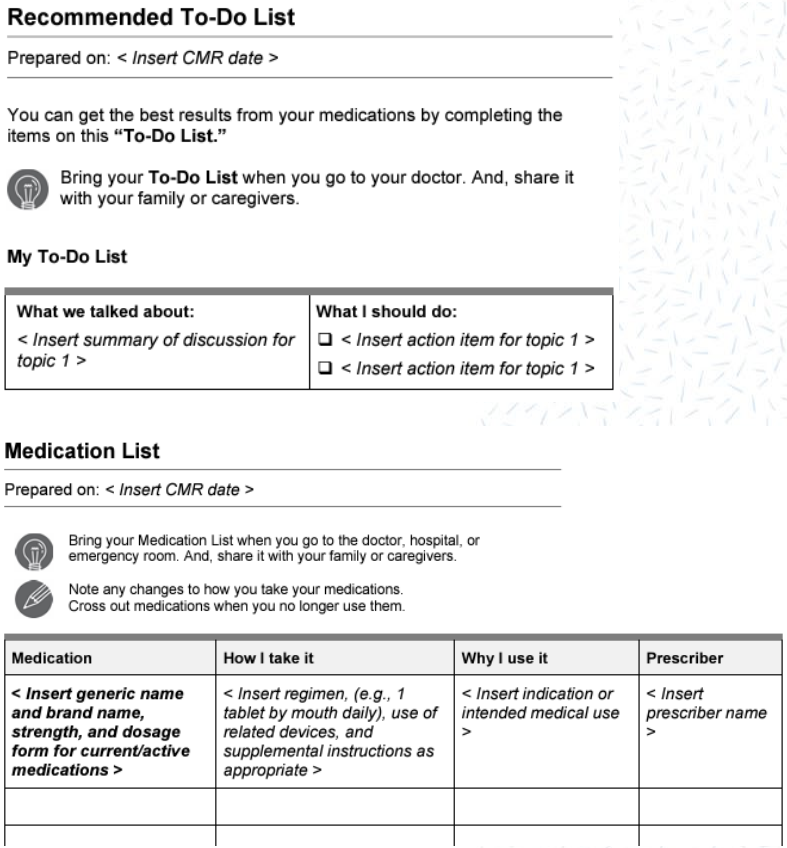
Whole person care discussing more than just medications:

- Comprehensive medication review one-on-one with patient
- Relevant pharmacy quality measures
- HEDIS measure gaps
- Chronic condition concerns with referrals to Care Management teams – Case Management or Disease Management
- Cost saving and coverage concerns

Patient provided with summary letter including what was discussed, an action plan and up to date medication list.

## What can providers expect?

May receive intervention recommendations from pharmacist (faxed to provider clinic)



**Recommended To-Do List**

Prepared on: < *Insert CMR date* >

You can get the best results from your medications by completing the items on this **"To-Do List."**

Bring your **To-Do List** when you go to your doctor. And, share it with your family or caregivers.

**My To-Do List**

| What we talked about: | What I should do: |
|---|---|
| < *Insert summary of discussion for topic 1* > | ❑ < *Insert action item for topic 1* ><br>❑ < *Insert action item for topic 1* > |

**Medication List**

Prepared on: < *Insert CMR date* >

Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.

Note any changes to how you take your medications. Cross out medications when you no longer use them.

| Medication | How I take it | Why I use it | Prescriber |
|---|---|---|---|
| ***< Insert generic name and brand name, strength, and dosage form for current/active medications >*** | < *Insert regimen, (e.g., 1 tablet by mouth daily), use of related devices, and supplemental instructions as appropriate* > | < *Insert indication or intended medical use* > | < *Insert prescriber name* > |
| | | | |
| | | | |

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# Patient Experience: Stars Measures

BlueCross BlueShield Kansas

# Stars 101

## HEDIS

**What is HEDIS:**
Standardized performance measures developed by NCQA to evaluate the quality of care, service and outcomes provided by MA Plans.

**# of measures: 9**

**Weight within the program: 24%**

**Measures:**
- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling Blood Pressure
- Follow Up Multiple Chronic Conditions
- Glycemic Status Diabetes
- Kidney Health Evaluation
- Statin Therapy Patients with Cardiovascular Disease
- Transitions of Care
- Plan All Cause Readmission

## CAHPS

**What is CAHPS:**
Annual survey capturing patient and member experience with both provider and health care plan, fielded March through May each year.

**# of measures: 9**

**Weight within the program: 23%**

**Measures:**
- Annual Flu Vaccine
- Care Coordination
- Customer Service
- Getting Appts and Care Quickly
- Getting Needed Care
- Getting Needed Rx
- Rating of Drug Plan
- Rating of Health Care Quality
- Rating of Health Plan

## Pharmacy

**What is Pharmacy:**
Measures that focus on member experience, drug safety and heavy focus on medication adherence for chronic conditions like diabetes, hypertension and high cholesterol.

**# of measures: 6**

**Weight within the program: 16%**

**Measures:**
- Concurrent Use of Opioids/Benzos
- Med Adherence Cholesterol
- Med Adherence Diabetes Meds
- Medication Adherence Hypertension
- Poly RX Multi Anticholinergics
- Statin Use with Diabetes

## HOS

**What is HOS:**
Annual survey capturing patient/member reported outcomes. It is related to patient-provider relationships and asks questions related to physical and mental health, incontinence, physical activity and fall risk and prevention.

**# of measures: 5**

**Weight within the program: 7%**

**Measures:**
- Improving/Maintaining Mental Health
- Improving/Maintaining Physical Health
- Improving Bladder Control
- Monitoring Physical Activity
- Reducing the Risk of Falls

## Operations

**What is Operations:**
Measurement of health plan administrative, logistical and service oriented performance measures to determine the efficiency and quality of the behind-the-scenes functions.

**# of measures: 7**

**Weight within the program: 16%**

**Measures:**
- Call Center FL/TTY Part C
- Call Center FL/TTY Part D
- Complaints about the Health Plan
- Members Choosing to Leave
- MPF Price Accuracy
- Plan Makes Timely Decisions
- Plan Decisions Appeals

# What is CAHPS?

## Consumer Assessment of Health Care Providers and Systems (CAHPS)

- CAHPS is an annual survey that asks patients to evaluate their experience with health care. The survey is governed by Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA).
- The survey is given annually between Feb. and June. It can be completed via mail, phone or online.
- Results are calculated and released between July and Oct.

# Why is CAHPS Important?

Positive health outcomes

Better business outcomes

Patient experience & awareness

# CAHPS Survey Topics and Tips

# Overall Rating of Health Care Quality

Where zero is the worst heath care possible and 10 is the best health care possible, what number would you use to rate all of your health care in the last 6 months?

## Tips for Success:

- Survey your patients. Ask how you can improve their health care experience.
- Create a patient council for regular feedback.
- Remember that every patient contact has an impact on that patient's perception.

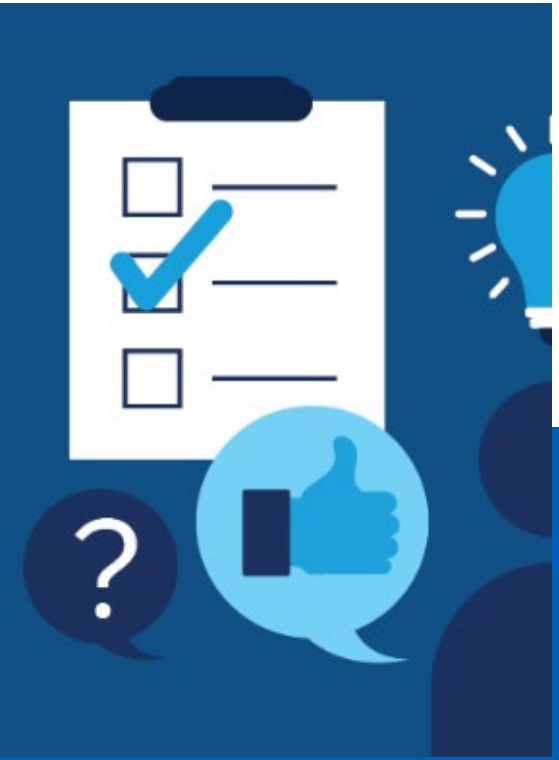
# Getting Appointments and Care Quickly

- When you needed care right away, how often did you get care as soon as you needed it?
- How often did you get an appointment for routine care as soon as you needed it?

## Tips For Success:

- Clearly communicate the reason for delays. Patients are more tolerant if they know the reason for the delay.
- Implement advanced access scheduling, offer telehealth and schedule routine visits and follow-ups in advance.

# Care Coordination



## Survey Questions:

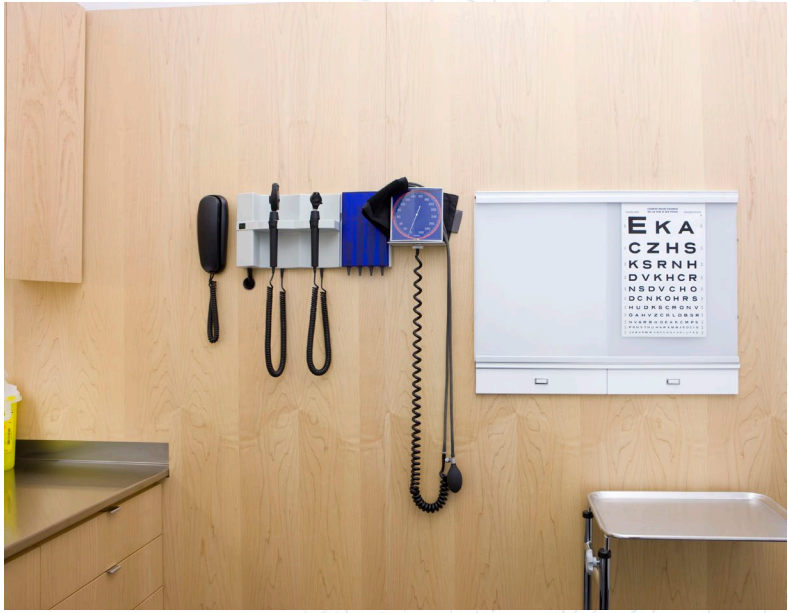
- Whether the doctor had medical records and other information about the patient's case.
- Whether there was follow-up with the patient's test results and how quickly the patient got the test results.
- Whether the doctor spoke with the patient about prescription medications.
- Whether the patient received help managing care.

## Tips for Success:

- Evaluate current process for retrieving medical records from specialists or outside facilities to further streamline the process.
- Review current process for providing results to patients including verification of contact information.
- Provide resources (or resource guide) for patients identified as needing further assistance managing care

# Getting Needed Care

- How often did you get an appointment to see a specialist as soon as you needed?
- How often was it easy to get the care, tests or treatment you needed?




## Tips for Success:

- Provide clear communication to patients and set realistic expectations.
- Provide clear communication as to why certain tests or treatments are being ordered

# What is HOS?

## Health Outcome Survey

- HOS is a health plan member survey by CMS that gathers health status data specifically.
- Members are given a baseline survey between late July and Nov. and then asked to complete a follow-up survey 2 years later, between late July and Nov.
- Baseline results are calculated and released in May of the year following the baseline survey, while results for the follow-up survey are provided during the summer of the following year.

# Why is HOS Important?

Support quality improvement activities

Improve the overall health of the patient population

Patient experience & awareness

# HOS Topics and Tips for Success

# Improving/Maintaining Physical Health

## Survey Questions:

- In general, would you say your health is: Excellent, Very Good, Good, Fair or Poor?
- Is your health limiting activities you do in a typical day?
- During the past 4 weeks, have you had any problems with your work or other regular daily activities as a result of your physical health?

## Tips for Success:

- Re-evaluate or develop a plan with your patients to take steps to improve physical health.
- Utilize your annual wellness visits/annual physicals or comprehensive visits to kick-start conversation with patients.
- Develop a plan for the steps to take when you ask patients if they have pain and how is it affecting their ability to complete daily activities. Ask how you as a provider can support them.

# Monitoring Physical Activity

## Survey Questions: In the past 12 months, did…

- You talk with a doctor or other health care provider about your level of exercise or physical activity?
- A doctor or health care provider advise you to start, increase or maintain your level of exercise or physical activity?

## Tips for Success:

- Utilize your annual wellness visits/annual physicals or comprehensive visits to kick-start conversation with patients.
- Show interest in ensuring your patients remain active.
- Develop a plan with your patient to take steps, start or increase physical activity.
- Evaluate resources to provide to members – especially those with limited mobility – safe and effective exercises.

# Reducing the Fall Risk

## Survey Questions: In the past 12 months…

- Did you talk to with your doctor or health care provider about falling or problems with balance or walking?
- Did you fall in the past 12 months?
- Has your doctor or health care provider done anything to help you prevent falls or treat problems with balance or walking?

## Tips for Success:

- Review medications and provide education on those that increase fall risk.
- Discuss home and public safety tips, such as removing tripping hazards, using handrails where available or installing in home, and using nightlights.
- Promote exercise.
- Develop resources or quick tips to provide.

# Improving or Maintaining Mental Health

## Survey Questions: In the past four weeks…

- Have you had any problems with your work or daily activities as a result of any emotional problems, such as being depressed
  or anxious?
- How much time has your emotional problems interfered with your social activities, like visiting with friends, relatives, etc.?

## Tips for Success:

- Utilize your annual wellness visits/annual physicals or comprehensive visits to kick-start conversation with patients.
- Re-evaluate or develop a plan with your patients to take steps to address and improve mental health.
- Evaluate resources to provide to members.

# Improving Bladder Control

## Survey Questions: In the past six months…

- In the past six months, have patients experienced leaking urine, also called urinary incontinence?
- During the past six months, how much did leaking urine make you change your daily activities or interfere with your sleep?
- Have you talked with a doctor about any approaches to control or manage leaking urine?

## Tips for Success:

- Utilize your annual wellness visits/annual physicals or comprehensive visits to kick-start conversation with patients.
- Ask the hard question while showing support.
- Develop a plan with your patients to help support and improve their bladder control.
- Develop and utilize informational materials for this sensitive topic.
- Evaluate resources to provide to patients, including treatment options

# Risk Adjustment

BlueCross BlueShield Kansas

# Risk Adjustment: What is it? Why is it Important?

## Predicting Health Care Costs

Risk adjustment is a **payment model** used by the Centers for Medicare and Medicaid Services (CMS) to do the following:

- Predict health care expenditures of individuals based on diagnoses and demographics.
- Predict health care costs based on actuarial risk of enrollees – chronic conditions, age, race, socioeconomic status and gender.

**Risk adjustment goals:**

- Ensure patients with varying degrees of health conditions have access to affordable health care
- Provide providers with improved understanding of patient health and potential conditions
- Mitigate impact of higher-risk populations

# What goes into a Risk Adjustment program?

# Prospective Risk Adjustment 101

## Supports proactive, in-year risk capture

Captures member health conditions in the current year.

## Identifies suspected and undocumented chronic conditions

Uses claims, historical diagnoses, utilization patterns and analytics to flag conditions that are likely present but not yet captured in the current year.

## Enables providers. Manages member outreach

Directs clinical reviews via Patient Assessment Forms delivered to providers and provides educational materials. Performs outreach to higher risk members via In Home Assessment.

## Risk adjustment analytics and performance

Analyzes risk adjustment and condition trends over time, provider's performance vs peers and the overall financial impact of the program.

# Prospective Risk Adjustment 101

### Purpose of Retrospective Risk Adjustment
Reviews historical claims and medical records to validate diagnosis codes for risk adjustment accuracy and compliance.

### Scope and Activities
Includes validating HCC diagnoses, ensuring documentation compliance and removing unsupported diagnoses to reduce audit risk.

### Compliance and Expertise
Requires knowledge of ICD-10-CM coding, HCC logic and CMS guidelines to maintain data accuracy and minimize compliance risk.

### Impact and Usage
Supports audit readiness, informs leadership decisions, financial projections and strengthens data integrity for risk adjustment.

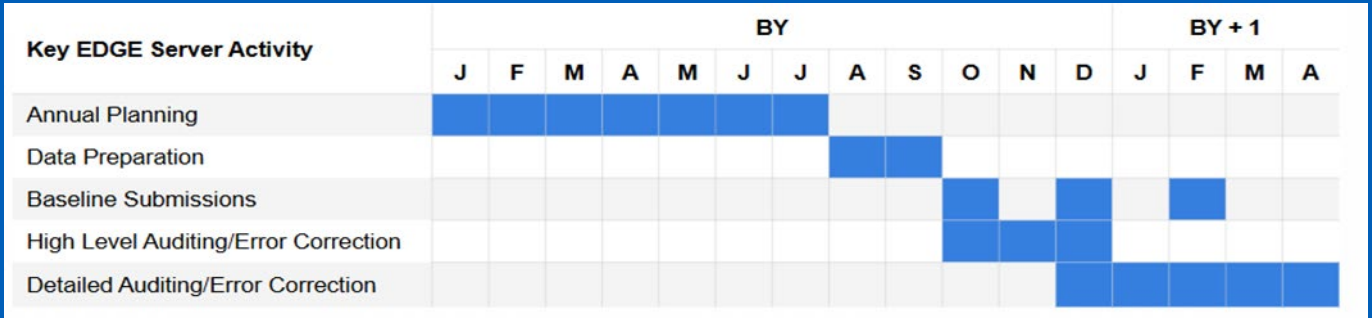
**Retrospective Teams**
Supports audit readiness, informs leadership decisions, financial projections and strengthens data integrity for risk adjustment.

**Chart Retrieval Teams**
Responsible for obtaining complete medical records from providers, managing complex EMR systems and workflows.

**Coding Teams**
Review records to validate diagnoses, apply ICD-10-CM guidelines and ensure HCC mapping accuracy.

# External Data Gathering Environment (EDGE)

- Established by Centers for Medicare & Medicaid Services (CMS) to receive, store and analyze enrollment and claims data.
- Data is used to calculate risk adjustment payments and monitor program compliance.
- CMS publishes annual EDGE server business rules to ensure the data submitted by is accurate, complete and consistent.
- The server applies a risk adjustment model that considers demographic information and diagnostic codes from claims to estimate the expected health care costs for each member.
- CMS uses Risk Adjustment Data Validation (RADV) audits to confirm the diagnosis and claims information submitted.



# What Can Providers do to Help?

## Coding

- Code all diagnosis codes on every claim, every year
- Submit all ICD-10 codes to reduce medical record retrieval

## Medical Records

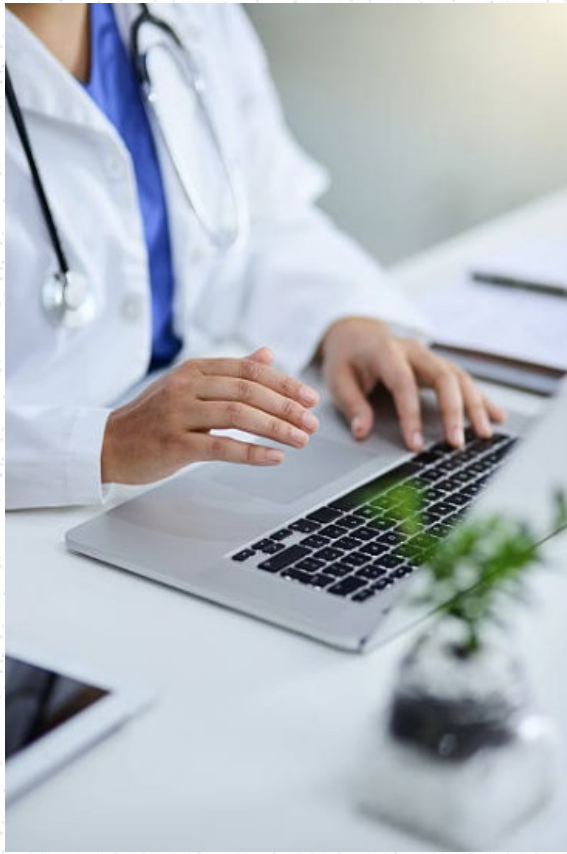
- Ensure records are accurate, complete and up to date (clinical notes + test results)
- Document all chronic, acute and status conditions at each encounter
- All entries must include proper dates and valid signatures per CMS guidelines

## Patient Assessment

- Use annual wellness visit to review and document all active conditions (ACA & MA members)
- Use patient assessment forms to identify and code suspected conditions
- Diagnoses must be submitted on valid claims to be captured

## Diagnosis Codes

- Use accurate ICD-10 codes reflecting current conditions at highest specificity
- Code all encounters using MEAT (monitored, evaluated, assessed/addressed and treated) guidelines and submit to the health plan



# Coding

BlueCross BlueShield Kansas

# Coding CPT II Codes

# 2026 CPT II Code Sets

## Prenatal and Postpartum Care (PPC)

| CPT II Code | Description |
|---|---|
| 0500F | Initial prenatal care visit. Report at first prenatal encounter with the health care professional providing obstetrical care; include visit date and last menstrual period [LMP] |
| 0501F | Prenatal flow sheet documented by first prenatal visit (includes BP, weight, urine protein, uterine size, fetal heart tones, estimated delivery date; if reported -- 0500F is not required) |
| 0502F | Subsequent prenatal care visit. Excludes visits for conditions unrelated to pregnancy or consultation-only visits. |
| 0503F | Postpartum care visit |

# 2026 CPT II Code Sets

## Eye Exam for Patients with Diabetes

| CPT II Code | Description |
|---|---|
| 2022F | Dilated retinal eye exam with interpretation; **with evidence** of retinopathy |
| 2023F | Dilated retinal eye exam with interpretation; **without evidence** of retinopathy |
| 2024F | 7-field stereoscopic retinal photos with interpretation; **with evidence** of retinopathy |
| 2025F | 7-field stereoscopic retinal photos with interpretation; **without evidence** of retinopathy |
| 2026F | Eye imaging validated to match 7-field retinal photos; **with evidence** of retinopathy |
| 2033F | Eye imaging validated to match 7-field retinal photos; **without evidence** of retinopathy |
| 3072F | **Low risk** for retinopathy. No evidence of retinopathy in the prior year. |

# 2026 CPT II Code Sets

## Glycemic Status Assessment for Patients with Diabetes

| CPT II Code | Description |
|---|---|
| 3044F | Most recent HbA1c level **< 7.0%** |
| 3051F | Most recent HbA1c level **≥ 7.0% and < 8.0%** |
| 3052F | Most recent HbA1c level **≥ 8.0% and ≤ 9.0%** |
| 3046F | Most recent HbA1c level **> 9.0%** |
| 3048F | Most recent LDL-C **< 100 mg/dL** |
| 3049F | Most recent LDL-C **100–129 mg/dL** |
| 3050F | Most recent LDL-C **≥ 130 mg/dL** |

# 2026 CPT II Code Sets

## Controlling High Blood Pressure

| CPT II Code | Description |
|---|---|
| 3074F | Most recent systolic blood pressure **< 130 mm Hg** |
| 3075F | Most recent systolic blood pressure **130–139 mm Hg** |
| 3077F | Most recent systolic blood pressure **≥ 140 mm Hg** |
| 3078F | Most recent diastolic blood pressure **< 80 mm Hg** |
| 3079F | Most recent diastolic blood pressure **80–89 mm Hg** |
| 3080F | Most recent diastolic blood pressure **≥ 90 mm Hg** |

# Coding ICD-10-CM Z-Codes for SDoH

# 2026 ICD-10-CM code sets for SDoH

## *Education & Employment*

### Problems Related to Education and Literacy (Z55)

| ICD-10-CM Code | Description |
|---|---|
| Z55.0 | Illiteracy and low-level literacy |
| Z55.1 | Schooling unavailable and unattainable |
| Z55.2 | Failed school examinations |
| Z55.3 | Underachievement in school |
| Z55.4 | Educational maladjustment and discord with teachers and classmates |
| Z55.8 | Other problems related to education and literacy |
| Z55.9 | Problems related to education and literacy, unspecified |

### Problems Related to Employment and Unemployment (Z56)

| ICD-10-CM Code | Description |
|---|---|
| Z56.0 | Unemployment, unspecified |
| Z56.1 | Change of job |
| Z56.2 | Threat of job loss |
| Z56.3 | Stressful work schedule |
| Z56.4 | Discord with boss and workmates |
| Z56.5 | Uncongenial work environment |
| Z56.6 | Other physical and mental strain related to work |
| Z56.81 | Sexual harassment on the job |
| Z56.82 | Military deployment status |
| Z56.89 | Other problems related to employment |
| Z56.9 | Problems related to employment, unspecified |

# 2026 ICD-10-CM code sets for SDoH

## *Occupational & Housing Concerns*

### Occupational Exposure to Risk Factors (Z57)

| ICD-10-CM Code | Description |
|---|---|
| Z57.0 | Noise |
| Z57.1 | Radiation |
| Z57.2 | Dust |
| Z57.31 | Environmental tobacco smoke |
| Z57.39 | Other air contaminants |
| Z57.4 | Toxic agents in agriculture |
| Z57.5 | Toxic agents in other industries |
| Z57.6 | Extreme temperature |
| Z57.7 | Vibration |
| Z57.8 | Other risk factors |
| Z57.9 | Unspecified risk factors |

### Problems Related to Housing and Economic Circumstances (Z59)

| ICD-10-CM Code | Description |
|---|---|
| Z59.0 | Homelessness |
| Z59.1 | Inadequate housing |
| Z59.2 | Discord with neighbors, lodgers and landlord |
| Z59.3 | Problems related to living in residential institution |
| Z59.4 | Lack of adequate food and safe drinking water |
| Z59.5 | Extreme poverty |
| Z59.6 | Low income |
| Z59.7 | Insufficient social insurance and welfare support |
| Z59.8 | Other problems related to housing and economic circumstances |
| Z59.9 | Problem related to housing and economic circumstances, unspecified |

# 2026 ICD-10-CM code sets for SDoH

## *Social & Upbringing Factors*

### Problems Related to Social Environment (Z60)

| ICD-10-CM Code | Description |
|---|---|
| Z60.0 | Problems of adjustment to life-cycle transitions |
| Z60.2 | Problems related to living alone |
| Z60.3 | Acculturation difficulty |
| Z60.4 | Social exclusion and rejection |
| Z60.5 | Target of perceived adverse discrimination and persecution |
| Z60.8 | Other problems related to social environment |
| Z60.9 | Problems related to social environment, unspecified |

### Problems Related to Upbringing (Z62)

| ICD-10-CM Code | Description |
|---|---|
| Z62.0 | Inadequate parental supervision and control |
| Z62.1 | Parental overprotection |
| Z62.21 | Child in welfare custody |
| Z62.22 | Institutional upbringing |
| Z62.29 | Other upbringing away from parents |
| Z62.3 | Hostility toward and scapegoating of child |
| Z62.6 | Inappropriate (excessive) parental pressure |
| Z62.810 | Personal history of physical abuse in childhood |
| Z62.811 | Personal history of psychological abuse in childhood |
| Z62.812 | Personal history of neglect in childhood |
| Z62.813 | Personal history of forced labor or sexual exploitation in childhood |
| Z62.819 | Personal history of unspecified abuse in childhood |
| Z62.820 | Parent-biological child conflict |
| Z62.821 | Parent-adopted child conflict |
| Z62.822 | Parent-foster child conflict |
| Z62.890 | Parent-child estrangement |
| Z62.891 | Sibling rivalry |
| Z62.898 | Other specified problems related to upbringing |

# 2026 ICD-10-CM code sets for SDoH

## *Family & Psychosocial Circumstances*

### Problems Related to Primary Support Group (Z63)

| ICD-10-CM Code | Description |
|---|---|
| Z63.0 | Problems in relationship with spouse or partner |
| Z63.1 | Problems in relationship with in-laws |
| Z63.31 | Absence of family person due to military deployment |
| Z63.32 | Other absence of family person |
| Z63.4 | Disappearance and death of family member |
| Z63.5 | Disruption of family by separation or divorce |
| Z63.6 | Dependent relative needing care at home |
| Z63.71 | Stress on family due to return from military deployment |
| Z63.72 | Alcoholism and drug addiction in family |
| Z63.79 | Other stressful life events affecting family and household |
| Z63.8 | Other specified problems related to primary support group |
| Z63.9 | Problem related to primary support group, unspecified |

### Problems Related to Certain Psychosocial Circumstances (Z64)

| ICD-10-CM Code | Description |
|---|---|
| Z64.0 | Problems related to unwanted pregnancy |
| Z64.1 | Problems related to multiparity |
| Z64.4 | Discord with counselor |

# 2026 ICD-10CM code sets for SDoH

## *Other Psychosocial Circumstances & Access to Care*

### Problems Related to Psychosocial Circumstances (Z65)

| ICD-10-CM Code | Description |
|---|---|
| Z65.0 | Conviction in civil and criminal proceedings without imprisonment |
| Z65.1 | Imprisonment and other incarceration |
| Z65.2 | Problems related to release from prison |
| Z65.3 | Problems related to other legal circumstances |
| Z65.4 | Victim of crime and terrorism |
| Z65.5 | Exposure to disaster, war, and other hostilities |
| Z65.8 | Other specified psychosocial circumstances |
| Z65.9 | Problem related to unspecified psychosocial circumstances |

### Problems Related to Medical Facilities and Health Care (Z75)

| ICD-10-CM Code | Description |
|---|---|
| Z75.0 | Medical services not available at home |
| Z75.1 | Person awaiting admission to adequate facility elsewhere |
| Z75.2 | Other waiting period for investigation and treatment |
| Z75.3 | Unavailability and inaccessibility of health care facilities |
| Z75.4 | Unavailability and inaccessibility of other helping agencies |
| Z75.5 | Holiday relief care |
| Z75.8 | Other problems related to medical facilities and health care |
| Z75.9 | Problem related to medical facilities and health care, unspecified |

# Q&A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## Thank you for attending!

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