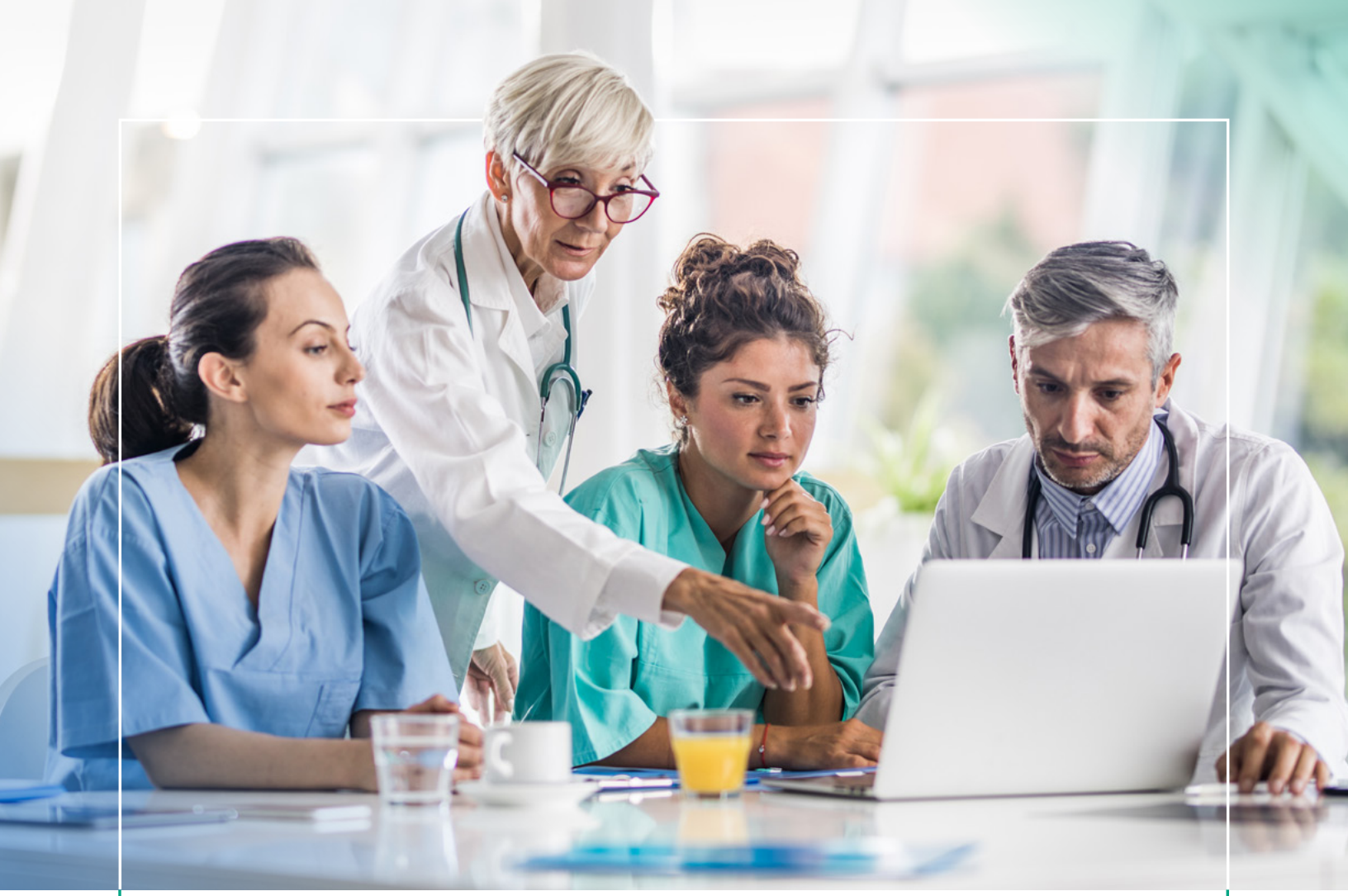

YOUR GUIDE TO PROGRAMS AND REWARDS

Quality Care Quarterly

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Inside this Issue

A Clinical Focus

Exploring the Impact of COVID-19 on Physical and Mental Health

It's no secret that people are feeling disconnected and exhausted when it comes to their work, health and safety. COVID-19 has added a tremendous amount of stress to everyone's lives and put a lot of distance – emotional and physical – between us.

When people started working from home, there was an automatic disconnect from coworkers. On top of that, there was added worry about contracting the virus, providing an educational environment for children, and being separated from family and friends. Fluctuating expectations and actual experiences with COVID-19 also continue to influence our emotions.

Recognizing the Signs of Stress

As we near the two-year mark of the beginning of the COVID-19 pandemic and approach another potentially disrupted holiday season, it's important to prioritize mental well-being. Make sure you're paying attention to the signs of stress — both in your own life and in your patients.

Most of the time, stress develops gradually. Look for:

- Fatigue and exhaustion
- A lack of motivation
- Symptoms of depression
- Perceptions of rejection or judgement
- A sense of falling short or failing to meet high standards
- A feeling that nothing you do makes a difference
- Using more tobacco products or drinking more alcohol

Those who are experiencing stress may also feel lethargic. This happens when the stress of an activity causes burnout.

COVID-19's Impact on Overall Health

The lifestyle changes associated with COVID-19 aren't the only potential stressors the illness poses to emotional and physical health. Contracting COVID-19 also impacts a person's overall well-being.

For most people, mild or moderate COVID-19 symptoms last about two weeks[1], but some develop ongoing health problems. Known as post-COVID conditions, these health problems may last for four or more weeks. According to the Centers for Disease Control and Prevention, the most common lasting symptoms are fatigue, shortness of breath, cough, and joint and chest pain[2]. Mental health problems can also arise from grief and loss, unresolved pain or fatigue, or post-traumatic stress disorder after treatment in the intensive care unit.

Dealing with COVID-19 Stressors

Some of the ways we can all work to manage stress include[3]:

- Eating healthy foods
- Exercising
- Focusing on physical health by:
  - Maintaining a healthy weight
  - Managing chronic conditions, like diabetes and high blood pressure
  - Quitting smoking
- Setting aside time for enjoyable activities, like reading, watching a favorite television show, or safely spending time with family and friends
- Unplugging and taking a break from reading, watching or listening to news stories, especially about the pandemic

When discussing stress and COVID-19 with your patients, consider reminding them about the most effective way to avoid short- and long-term symptoms of COVID-19: vaccination, appropriate social distancing, and masking. Additionally, talk with them about the importance of preventive care, including wellness exams and health screenings, and let them know if they are past due for needed services.

Finally, don't forget to take time for yourself. Health care workers are especially vulnerable to being overwhelmed by fear of contracting COVID-19 and treating patients. Suspicions of health care professionals' motives and treatment are compounding factors. Share your feelings with co-workers, family or friends, and seek out support groups if needed.

Deborah Gatlin, M.D.

Behavioral Health
Medical Director

BlueCare Tennessee

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[1] **hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/covid-long-haulers-long-term-effects-of-covid19**

[2] **cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Flong-term-effects.html**

[3] **cdc.gov/violenceprevention/about/copingwith-stresstips.html**

A Person-Centered Approach to Care and Leadership

How The Jackson Clinic Is Prioritizing Emotional Well-Being During the Pandemic

The team at The Jackson Clinic in Jackson, Tenn., recognizes the challenges that patients and staff members have faced due to the COVID-19 emergency.

By screening patients for social isolation and providing space for staff members to share and reconnect, the clinic has put special focus on caring for mind and body.

Identifying and Addressing Patient Isolation

The Jackson Clinic participates in the Health Starts pilot program, which is designed to identify non-clinical risk factors like social isolation, employment, and access to food and housing that may impact overall well-being. The team has found that social isolation is a recurring factor for many patients experiencing anxiety or depression.

Patients who report mental health issues or who are experiencing loneliness or social isolation are referred to the clinic's behavioral health department for a more in-depth psychosocial assessment. Depending on the results, patients may then work with the department's team of providers and social workers to find solutions and discuss coping mechanisms.

Emphasizing Connectedness and Emotional Support

Setting aside time for employees to connect and give voice to their feelings has been a key part of The Jackson Clinic's strategy for navigating the pandemic.

"The nature of the situation, with turnover, burnout, compassion fatigue and the job market such that they are, kept bringing us back to leadership in the clinic," said Sarah Johnson, MHA/INF, R.N., Director of Population Health and Value-Based Contracting at The Jackson Clinic. "I've said over and over that the person who has the most ability to impact someone's job and work environment is their direct supervisor. We really wanted to reach the people managing staff in the hopes they're able to invest in and encourage those staff members."

To help connect leaders across the organization, The Jackson Clinic began hosting a series of monthly outreach sessions. At the first meeting, the Chief Medical Officer, Chief Executive Officer and President addressed the group and provided words of encouragement. Then, time was set aside for an open discussion that gave team members time to acknowledge how hard the past year has been and voice any fatigue or frustration.

"We've never had a cross-departmental meeting this big before," Johnson said. "We expected to hear a lot of fatigue, but what came out of the meeting was really exciting and overwhelmingly positive. People were taking the time to acknowledge how hard their peers worked and how proud they are of each other."

The first meeting took place during a time when COVID-19 cases were decreasing in the area, but the decrease didn't last. When the next meeting occurred a month later, cases were spiking across the region.

"During that second meeting, we had a psychologist come in," Johnson said. "She talked about compassion fatigue and self-assessment, as well as coping mechanisms, goals, and supportive avenues that are available to employees."

Each session has also featured a clinic physician, who is invited to speak about a topic that they're passionate about. The topic can be something that applies to their work or their personal lives.

"It's been fun to see our physicians not just as doctors, but as people," Johnson said. "One thing the pandemic has done is caused people to work more and communicate less. Our whole goal is to support and connect with each other."

Promoting Preventive Care

Like many providers, The Jackson Clinic saw a decline in preventive care appointments during 2020. Some of the biggest decreases the team noted were in the number of patients getting routine breast cancer screening and diabetes care.

To help encourage people to receive care and make sure they feel safe coming to the office, the team issued a mask mandate that's still in effect and has encouraged vaccination among staff members and providers. The clinic also offers different avenues for patients to receive care, including drive-through flu vaccine clinics and telehealth appointments.

"We offer telehealth for every type of appointment, including well visits," said Sarah Johnson, MHA/INF, R.N., Director of Population Health and Value-Based Contracting at The Jackson Clinic. "If tests are needed – for example, if the provider orders a chest X-ray or labs – patients can come into the office just for that service after speaking with their provider through telehealth."

Additionally, The Jackson Clinic started using a new platform that lets people check in for visits remotely. Two days before the visit, patients complete an electronic check-in process. Then, they get a text message to respond to when they arrive at the office. Staff receives an alert that the patient is there, and the patient can wait in their car until a room is ready, bypassing the waiting room entirely. The new process is optional but has been well-received. A large majority of the 8,000-9,000 patients seen at the clinic each week choose to wait in their cars, according to Johnson.

"We've tried to follow the Centers for Disease Control and Prevention (CDC) guidelines so that people feel good about the environment they're in," Johnson said. "We've also tried to continue doing a good job of discussing the importance of screening. The big things we saw, like decreases in mammogram and diabetes compliance, are improving. We've been happy to see that."

"The thing that I've been most passionate about as we come through and reflect on the past 18-24 months is that you have to see every patient, employee, etc. as a person and continue to have compassion for them. When you get tired or frustrated, that's when you have to tell yourself, 'It's not about me; it's about the patient.' I've found that if you do that, you're much more likely to be fulfilled in the care you're providing."

Sarah Johnson, MHA/INF, R.N.

DIRECTOR OF POPULATION HEALTH AND VALUE-BASED CONTRACTING AT THE JACKSON CLINIC

A Clinical Focus

Flu Vaccines are More Important Than Ever

This year, in light of COVID-19, it's more important than ever to educate your patients about the importance of the flu vaccine. According to the **National Committee for Quality Assurance (NCQA)**, the flu vaccine can reduce flu-related hospitalizations by 71%.

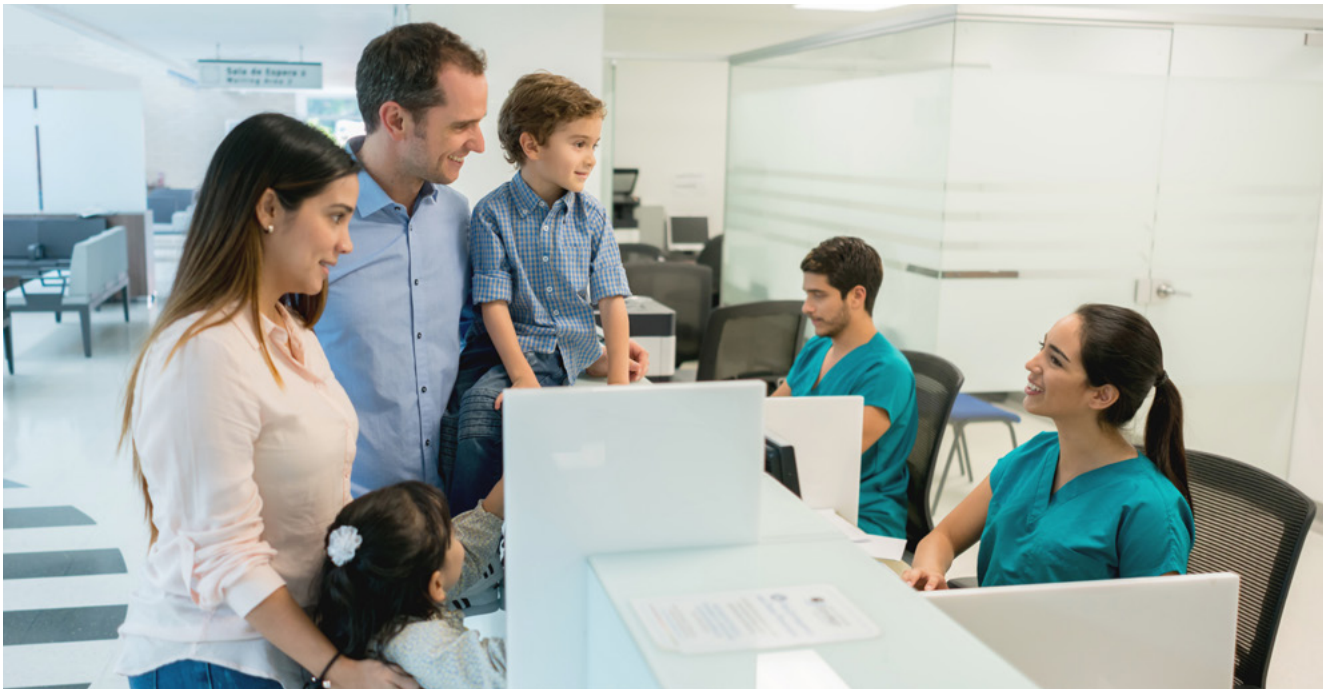
Even if your patients missed the optimal vaccination window this fall, it's still important for them to consider receiving the vaccine. Consider offering these reminders to prepare your team – and your patients if appropriate.

- Talk with your patients about the heightened importance of getting the flu vaccine and staying healthy during cold and flu season.
- The US Centers for Disease Control and Prevention recommends everyone six months of age and older consider the annual flu vaccination.
- Discuss whether getting the flu vaccine while also getting a COVID-19 initial series vaccine or CDC-recommended COVID-19 vaccine booster is appropriate.
- Patients in the third trimester of pregnancy can receive the flu vaccine to help protect their infants during the first months of life.

According to the **CDC**, patients who are 65 years and older are at higher risk of serious complications and hospitalization from the flu. Other high-risk patient groups include pregnant people, young children, people with disabilities and those with chronic conditions such as asthma, heart disease and stroke, HIV/AIDS, cancer and chronic kidney disease.

Resources

- **National Committee for Quality Assurance (NCQA)**
- **Live Attenuated Influenza Vaccine (LAIV4)**
- **CDC**



Keeping Up With All the Care Your Patients Receive

Primary care providers, behavioral health practitioners and other clinicians all strive to take good care of their patients and understand their situations. But in today's very mobile society, it can be difficult to keep up with all the care and treatments your patients are getting from other providers. That's why care coordination is so important.

Care coordination is the deliberate organization of patient care activities between two health care providers. This close communication during the coordination of care helps ensure each member of the medical team has access to essential information, and that patients have clear instructions on self care.

During the COVID-19 health emergency, there are additional situations to be aware of:

- Patients may experience additional stressors and engage with a behavioral health provider for the first time. It's important to make sure these patients give permission for care coordination.
- More patients are being seen through telehealth, so it's important to plan ahead for any complications in the care coordination process.

Be sure to ask patients about care they receive from other providers and alert them when you get health care information from your colleagues. It's a great way to get started and let patients know their health team is working together to provide the best possible care.

Transition of Care Measure

New for 2022

The Centers for Medicare and Medicaid Services (CMS) will retire the stand-alone Medication Reconciliation Post-Discharge (MRP) measure at the end of the year, and replace it with Transitions of Care (TRC) for 2022. The single-weighted TRC measure incorporates MRP with three additional components.

The new TRC measure assesses the percentage of discharges (acute and/or non-acute) for members, 18 years and older, who had each of the four reported components between Jan. 1 and Dec. 1 of the measurement year. The four components are:

- Notification of inpatient admission
- Receipt of discharge information
- Patient engagement after inpatient discharge
- Medication reconciliation post-discharge

Members may be in the measure more than once if there are multiple discharges during the measurement year. For each discharge, the criteria for each of the four components must be met to make the TRC measure compliant. Members who receive hospice care anytime during the measurement year are excluded from this measure.

Information on appropriate medical record documentation and administrative codes will be included in your 2022 Medicare Advantage Quality Program Information Guide and in a TRC booklet available on our MA Quality Initiatives page on **provider.bcbst.com**.

Help Ensure Your Diabetic Patients Get Needed Care

November was National Diabetes Month and the holidays are arriving quickly. Now's the time to make sure your diabetic patients have met all recommended national quality of care guidelines for the calendar year.

Collaboration between primary care providers and specialists managing a patient's care can help identify and close gaps in care.

National recommendations for diabetic patients include:

- A documented blood pressure controlled and verified by a reading of 139/89 or less.
- An HbA1c that's controlled and verified by a documented reading of 7.9% or less.
- A yearly eye exam specifically for diabetic retinopathy that's read by an ophthalmologist or optometrist.
- A yearly kidney screening that includes both an Estimated Glomerular Filtration Rate (eGFR) **AND** a Urine Albumin-to-Creatinine Ration (uACR). The uACR should be both a quantitative urine albumin test and a urine creatinine test with service dates four or less days apart.
- All adult patients with diabetes should be given a statin medication (unless there are significant contraindications or complications).

When caring for your diabetic patients, keep these additional tips for closing HEDIS®* gaps in care top of mind:

- The gaps for A1c and blood pressure (B/P) can reopen during the year based on results. The **last result documented will be the representative level for the year for that patient.**
- Patients can now self-report B/P levels during telehealth or telephone visits if the level was taken on a digital device. Document the date of the B/P level and the fact that it was taken using a patient-reported digital device in the chart.
- Providers who are performing in-office retinal imaging and sending results to eye care professionals to review and interpret can use CPT® II codes, such as 2022F, 2024F, 2026F.
- CPT® II code 3051F represents an HbA1c level greater than or equal to 7.0% and less than 8.0%.
- CPT® II code 3044F represents an HbA1c level less than 7.0%.
- A visit to a nephrologist alone doesn't close the gap in care for diabetic kidney monitoring. Patients must have the testing done as listed above.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Some sample codes for the Kidney Health Evaluation for Patients with Diabetes include:

Value Set Name	Code	Code System
Estimated Glomerular Filtration Rate Lab Test	80047	CPT®
Estimated Glomerular Filtration Rate Lab Test	80048	CPT®
Estimated Glomerular Filtration Rate Lab Test	80050	CPT®
Estimated Glomerular Filtration Rate Lab Test	80053	CPT®
Estimated Glomerular Filtration Rate Lab Test	80069	CPT®
Estimated Glomerular Filtration Rate Lab Test	82565	CPT®
Quantitative Urine Albumin Lab Test	82043	CPT®
Urine Creatinine Lab Test	82570	CPT®

For more information about the Comprehensive Diabetes Care quality measure, view our Quality Care Measures guides. You can find guides for each line of business online here: **provider.bcbst.com/working-with-us/quality-initiatives/**.

Behavioral Health Assessments: An Important Part of Well-Child Care

Developmental and behavioral health screenings are key components of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well-child exams. Children and adolescents with BlueCare Tennessee coverage are eligible for preventive care at the same intervals recommended by the **Bright Futures/ American Academy of Pediatrics Periodicity Schedule**.

The Periodicity Schedule recommends psychological/behavioral assessments for children and teens of all ages. Older children and teens also need depression, alcohol, tobacco and drug use screenings. Consider setting aside time during each well-visit to speak privately with adolescents about mental health concerns and substance use and answer any questions they may have.

Connecting Your Patients to Help

If you have a pediatric or adolescent patient who needs behavioral health support, we're here to help. For cases requiring immediate attention, please call the Behavioral Health Crisis Line at (423) 535-2737. To request case management, call 1-888-416-3025 and state that you need a Behavioral Health Case Manager.

Care for Older Adults (COA) and Pain Assessments

Care for Older Adults (COA) is a measure included in the 2021 Provider+ Partnerships Program. Reported by Special Needs Plans (SNP) and Medicare-Medicaid Plans (MMP) only, the intent of the COA measure is to ensure that older adults enrolled in these plans receive appropriate screenings and services. Providers should ensure that the pain component of the COA measure is completed each year for patients enrolled in an SNP.

COA Pain Assessment Component

- For SNP members age 66 years and older
- At least one **pain assessment** annually
- Documentation in the medical record must include evidence of a pain assessment and the date it was performed.

Criteria for a pain assessment includes:

- Documentation in the medical record that the patient was **assessed for pain** (could be positive or negative findings)

OR

Results of a Standardized Pain Assessment Tool not limited to:

- Numeric rating scales (verbal or written)
- Face, Legs, Activity, Cry, Consolability (FLACC) Scale
- Verbal descriptor scales (5 to 7-word scales, present pain inventory)
- Pain thermometer
- Pictorial pain scales (Faces Pain Scale, Wong-Baker Pain Scale)
- Visual analogue scale
- Brief pain inventory
- Chronic pain grade
- Patient Reported Outcomes Measurement Information System (PROMIS) Pain Intensity Scale
- Pain Assessment in Advanced Dementia (PAIN AD) Scale

These items don't meet the criteria for a pain assessment:

- Notation of a pain management plan alone
- Notation of pain treatment alone
- Notation of screening for chest pain alone
- Services provided in an acute inpatient setting

Sample Codes

- **CPT®:** 1125F, 1126F

Exclusions

- Members in Hospice

Best Practices and Tips to Help Close This Care Opportunity

Assess your patient's pain at every visit using either a standard pain assessment tool or documenting a positive or negative finding of pain. When documenting positive findings of pain, please provide a detailed assessment including the patient's pain location, intensity and severity.

When completing a pain assessment, remember PQRST:

- **P**rovocation - What caused it? What were you doing? What makes it better/worse? Triggers? What relieves/aggravates it?
- **Q**uality/Quantity – What does it feel like? Ex: sharp, dull, stabbing, shooting, etc
- **R**egion/Radiation – Where is pain located? Does it radiate?
- **S**everity – Pain scale, interfere w/activities? How long does it last?
- **T**iming – When did it start? How long did it last? How often does it occur? Other signs/symptoms?

If you have any questions, contact your Quality Incentive Consultant. The best quality outcomes require all of us working together.

TennCare Makes 90-Day Prescription Fills a Permanent Pharmacy Benefit

Effective Sept. 1, 2021, the 90-day supply benefit for select prescriptions became permanent for BlueCare Tennessee members. The TennCare Pharmacy Program established this as a temporary benefit in April 2020 in response to the COVID-19 emergency.

What Medications Does the 90-day Supply Benefit Include?

The 90-day supply benefit includes maintenance medications on the **TennCare 90-Day Supply List**. Therapeutic classes of maintenance medications include, but aren't limited to:

- **Cardiovascular disease agents:** Angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers, beta blockers, calcium channel blockers, etc.
- **Central nervous system agents:** Anticonvulsants, antidepressants, antipsychotics, etc.
- **Diabetes agents:** Insulin and oral hypoglycemics
- **Diabetic supplies**
- **Lipotropics (statins)**

The benefit excludes opioids and other controlled substances.

How Does This Benefit Impact Providers?

The 90-day supply benefit helps increase member access to select maintenance medications. Enhanced access to medications may positively affect member health, leading to improved performance on these medication-related HEDIS quality measures:

- Adherence to Antipsychotic Medications in Individuals with Schizophrenia (SAA)
- Antidepressant Medication Management (AMM)
- Comprehensive Diabetes Care (CDC)
- Controlling High Blood Pressure (CBP)
- Persistence of Beta Blocker Treatment After a Heart Attack (PBH)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)

Tips and Best Practices for Maximizing This Benefit

- **Consider writing a prescription for a 90-day supply,** based on clinical appropriateness, when treating chronic conditions.
- **Encourage your patients to ask their pharmacist to dispense a 90-day supply.**
  - Pharmacists can dispense a 90-day supply if the amount doesn't exceed the total quantity authorized or remaining on the prescription.
- **Bookmark the link to the TennCare pharmacy benefit manager (PBM) website** for easy access to the 90-Day Supply List: **optumrx.com/oe_tenncare/prescriber**.
  - Go to **Program Information**, under the **Prescriber** tab. Then, click on the arrow next to **90-Day Supply List** to download.

- **Please note:** The new 90-Day Supply List is independent of the Auto-Exempt and Attestation Lists, so there may be drugs on the list that are still subject to script limits. This may not occur frequently, but it's possible, so please check the Auto-Exempt and Attestation Lists to confirm.

› **Check the PBM site regularly.** Medication lists are subject to change without notice.

- Under the **Prescriber** tab of the PBM site, **review the Prescriber Communications section** to stay up to date about Pharmacy Program changes.

› If you don't want your patient to receive a 90-day supply, **please include a note on the prescription** to only dispense the specified amount.

For more information about the 90-day supply benefit or if you have questions, please contact the TennCare PBM Pharmacy Support Center at 1-866-424-5520 or email PBM Provider Liaisons at **tnrxeducation@optum.com**.

Statin-Associated Muscle Symptoms (SAMs) and the Nocebo Effect

According to the Centers for Disease Control and Prevention (CDC), more than 25% of U.S. adults over 40 years of age take a statin medication. That's more than 25 million adults. The benefits of statins, including reducing the risk of heart attacks and strokes caused by blood clots, are well known and documented. The most effective statins can reduce a patient's low-density lipoprotein (LDL) cholesterol level by 55-65% at the maximum dosage. Also, 86% of statins on the market are available in the generic form. Despite the known cardiovascular benefits and increased affordability, an estimated 10% of patients in the U.S. discontinue statins because they experience symptoms that they assume are statin related.

The most common side effects reported are muscle aches and pains. Muscle symptoms are commonly called statin-associated muscle symptoms (SAMs), a term that doesn't indicate or imply a causal relationship between the statin and the symptoms. Analyses of multiple double-blind randomized controlled studies of all currently available statins, up to maximum recommended doses, have shown that **no more than 1%** of patients develop muscle symptoms that are likely **caused by statin drugs**. However, most providers still receive patient reports of muscle aches and pains observationally.

The Nocebo Effect

A plausible explanation for the different results from observational reports and blinded randomized trials is the nocebo effect. The nocebo effect, opposite of the placebo effect, results when a patient is conditioned to expect a negative response or anticipate negative effects. This can cause adverse events, usually subjective. Still, the symptoms are real and can be severe for some patients even though the vast majority may not be due to a drug-related cause.

When a patient reports muscle pain, the possibility of an adverse statin drug interaction should be considered and addressed if necessary. If there's uncertainty, providers can consider measuring a creatinine kinase (CK) level (a marker in the blood that could indicate muscle damage). If the CK level is normal, the patient can be reassured that muscle damage hasn't occurred and a statin rechallenge may be acceptable.

Rechallenging a Statin

Most patients **can tolerate a statin rechallenge** with an alternative statin or alternative regimen, such as a reduced dose. Resuming and maintaining treatment with a statin (when myopathy has been excluded) reduces the risk of atherosclerotic vascular events. Health care providers should anticipate concern and hesitancy from patients when starting a statin medication.

In return, providers should welcome questions and be prepared to discuss risks and benefits of statins. It's not unusual for a patient to try two or more statins and/or regimens before finding the treatment that works best for them. Open communication and provider-patient collaboration is vital in ensuring patients maintain adherence.

Following Up Makes a Difference

Following up with your patients helps improve their experience and your success. Many providers are seeing a rise in patients who need more care coordination, like appointment scheduling, discharge medications, transportation or even reminders of upcoming appointments.

Follow-up care is always recommended after hospitalization (FUH), ER visits for mental illness (FUM), ER visits for alcohol and other drug abuse (FUA), and high-intensity care for substance use disorder (FUI).

Follow-Up Measure Descriptions

FUH Measure Description

- This measure assesses the percentage of discharges for members six years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.
- Rates are reported for the percentage of discharges for which the member received follow-up care within both 7 and 30 days of discharge.

FUM Measure Description

- This measure examines the percentage of ER visits for members six years and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.

Rates are reported for the percentage of ER visits where the member received follow up within both 7 and 30 days of the ER visit.

FUA Measure Description

- This measure shows the percentage of ER visits for members 13 years and older, with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had follow-up for AOD.
- Rates are reported for the percentage of ER visits where the member received follow up within both 7 and 30 days of the ER visit.

FUI Measure Description

- This measure looks at the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years and older that result in a follow-up visit or service for substance use disorder.
- Rates are reported for the percentage of visits or discharges where the member received follow up for substance use disorder within both 7 and 30 days after the visit or discharge.

Tips and Best Practices for FUH, FUM, FUA and FUI

- Schedule follow up with the appropriate practitioner within seven days.
- Explain the importance of follow-up visits to your patients.
- Contact patients who miss their initial follow-up appointment and reschedule the visit as soon as possible.
- Share information about established patients with hospital or Crisis Stabilization Unit staff to make sure your patient's discharge needs are met.
- If you're contacted by another health care professional about patient follow up, try to accommodate visits within seven days.
- A telehealth visit with a principal mental health diagnosis of alcohol or other drug abuse or dependence will meet criteria for a follow-up visit.

To purchase copies of this publication, including the full measures and specifications, contact NCQA Customer Support at 888-275-7585 or visit **www.ncqa.org/publications**.

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