The Medicare Advantage HEDIS and Star Measures Review

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Educational Webinar Series

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Meet our speakers

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Objectives

- Brief Introduction to CMS's Part C & D Star Rating program
- Gain a foundational understanding of Medicare Advantage HEDIS and Part D Star measures
- Discover effective strategies for enhancing documentation to boost gap closure
- Learn practical tips and tricks for optimizing your approach, workflows, and overall strategies
- Explore valuable resources to support your quality improvement initiatives

Disclosure/Disclaimer

- The content contained in this presentation is for informational or educational purposes only, and doesn't substitute or replace medical advice, consultations, diagnosis, or treatments by healthcare professionals.
- The measure discussion today will be guided by the latest NCQA HEDIS specifications and CMS Star Measures guidance. ***Quality Measures in Medicare Advantage payer/provider contracts may vary from HEDIS and CMS Star specifications.***
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What is Medicare Part C & D Star Ratings?

- Centers for Medicare & Medicaid Services (CMS)
- Medicare Advantage (MA) (Part C), Part D (PDP), and Part C&D (MAPD) Plans
    - Private insurance companies
- Provides comparative information on plan quality and performance to Medicare beneficiaries
- Ratings released in October
- Posted on the CMS Website and Medicare.gov
- Health plans are rated on a scale of 1 to 5 stars

Numeric	Graphic	Description
5	★★★★★	Excellent
4	★★★★	Above Average
3	★★★	Average
2	★★	Below Average
1	★	Poor

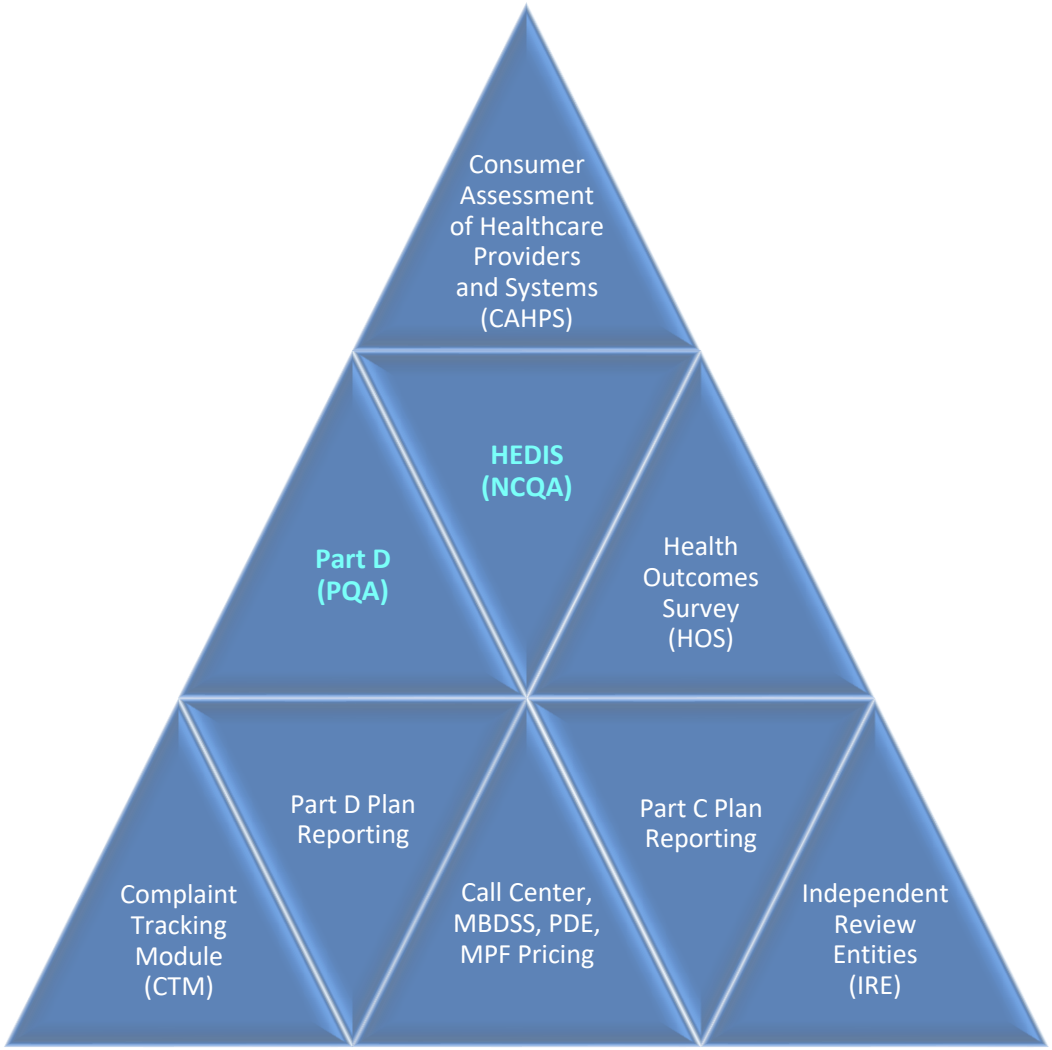
What makes up Star Ratings?

2026 Star Ratings - 45 Measures

- 33 Part C
- 12 Part D
- Measure weights 1-5
- Display measure weight - 0

Today we will cover:

- Healthcare Effectiveness Data and Information Set (HEDIS) Measures – National Committee for Quality Assurance (NCQA)
- Part D Statin Use in Persons with Diabetes Measure and Medication Adherence Measures – Pharmacy Quality Alliance (PQA)



Measure Data Sources

2026 Star Ratings – Part C Measures

Table 1. 2026 Star Ratings Part C Measures and Measure Weights

Measure Name	Weighting Category	Part C Summary and MA-PD Overall Weight
Breast Cancer Screening	Process Measure	1
Colorectal Cancer Screening	Process Measure	1
Annual Flu Vaccine	Process Measure	1
Improving or Maintaining Physical Health	Outcome Measure	1*
Improving or Maintaining Mental Health	Outcome Measure	1*
Monitoring Physical Activity	Process Measure	1
Special Needs Plan (SNP) Care Management	Process Measure	1
Care for Older Adults – Medication Review	Process Measure	1
Care for Older Adults – Pain Assessment	Process Measure	1
Osteoporosis Management in Women who had a Fracture	Process Measure	1
Diabetes Care – Eye Exam	Process Measure	1
Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
Kidney Health Evaluation for Patients with Diabetes	Process Measure	1
Controlling Blood Pressure	Intermediate Outcome Measure	3
Reducing the Risk of Falling	Process Measure	1
Improving Bladder Control	Process Measure	1
Medication Reconciliation Post-Discharge	Process Measure	1

https://www.cms.gov/files/document/2026-star-ratings-measures.pdf

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2026 Star Ratings – Part C Measures

Table 1. 2026 Star Ratings Part C Measures and Measure Weights

Measure Name	Weighting Category	Part C Summary and MA-PD Overall Weight
Plan All-Cause Readmissions	Outcome Measure	3
Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
Transitions of Care	Process Measure	1
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
Getting Needed Care	Patients' Experience and Complaints Measure	2
Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2
Customer Service	Patients' Experience and Complaints Measure	2
Rating of Health Care Quality	Patients' Experience and Complaints Measure	2
Rating of Health Plan	Patients' Experience and Complaints Measure	2
Care Coordination	Patients' Experience and Complaints Measure	2
Complaints about the Health Plan	Patients' Experience and Complaints Measure	2
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
Health Plan Quality Improvement	Improvement Measure	5
Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2
Reviewing Appeals Decisions	Measures Capturing Access	2
Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2

*Measure has a weight of 1 for the 2026 Star Ratings because it is considered a new measure.

https://www.cms.gov/files/document/2026-star-ratings-measures.pdf

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2026 Star Ratings – Part D Measures

Table 2. 2026 Star Ratings Part D Measures and Measure Weights

Measure Name	Weighting Category	Part D Summary and MA-PD Overall Weight
Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2
Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
Drug Plan Quality Improvement	Improvement Measure	5
Rating of Drug Plan	Patients' Experience and Complaints Measure	2
Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2
MPF Price Accuracy	Process Measure	1
Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3
Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3
Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3
MTM Program Completion Rate for CMR	Process Measure	1
Statin Use in Persons with Diabetes (SUPD)	Process Measure	1

https://www.cms.gov/files/document/2026-star-ratings-measures.pdf

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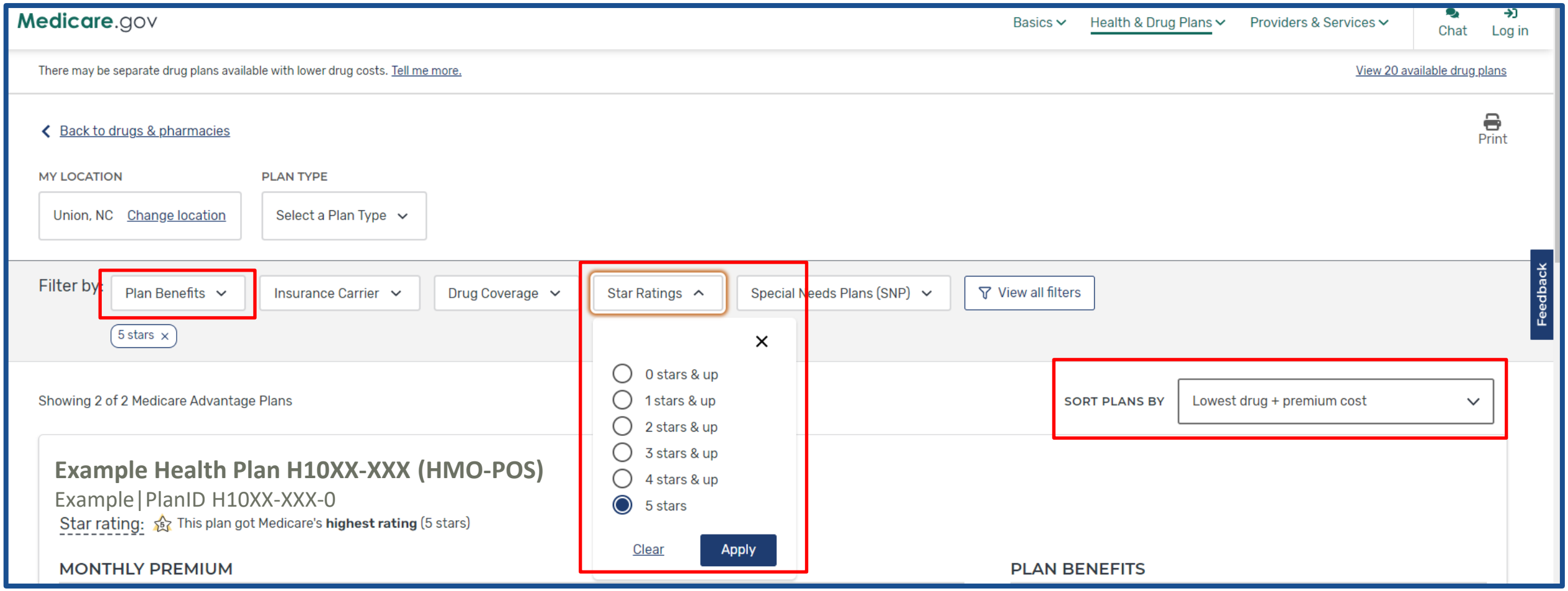
Why are star ratings important to patients?



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Why are star ratings important to providers?

MA Health Plan
4 Star

XYZ Provider Group
3 Star

Dr. Sneezy
3 Star

Dr. Grumpy
3 Star

ABC Provider Group
5 Star

Dr. Happy
5 Star

Dr. Friendly
5 Star

Medicare Advantage

Payer/Provider

Contract

★★★★★

Potential Incentive
Or
Shared Savings Payments

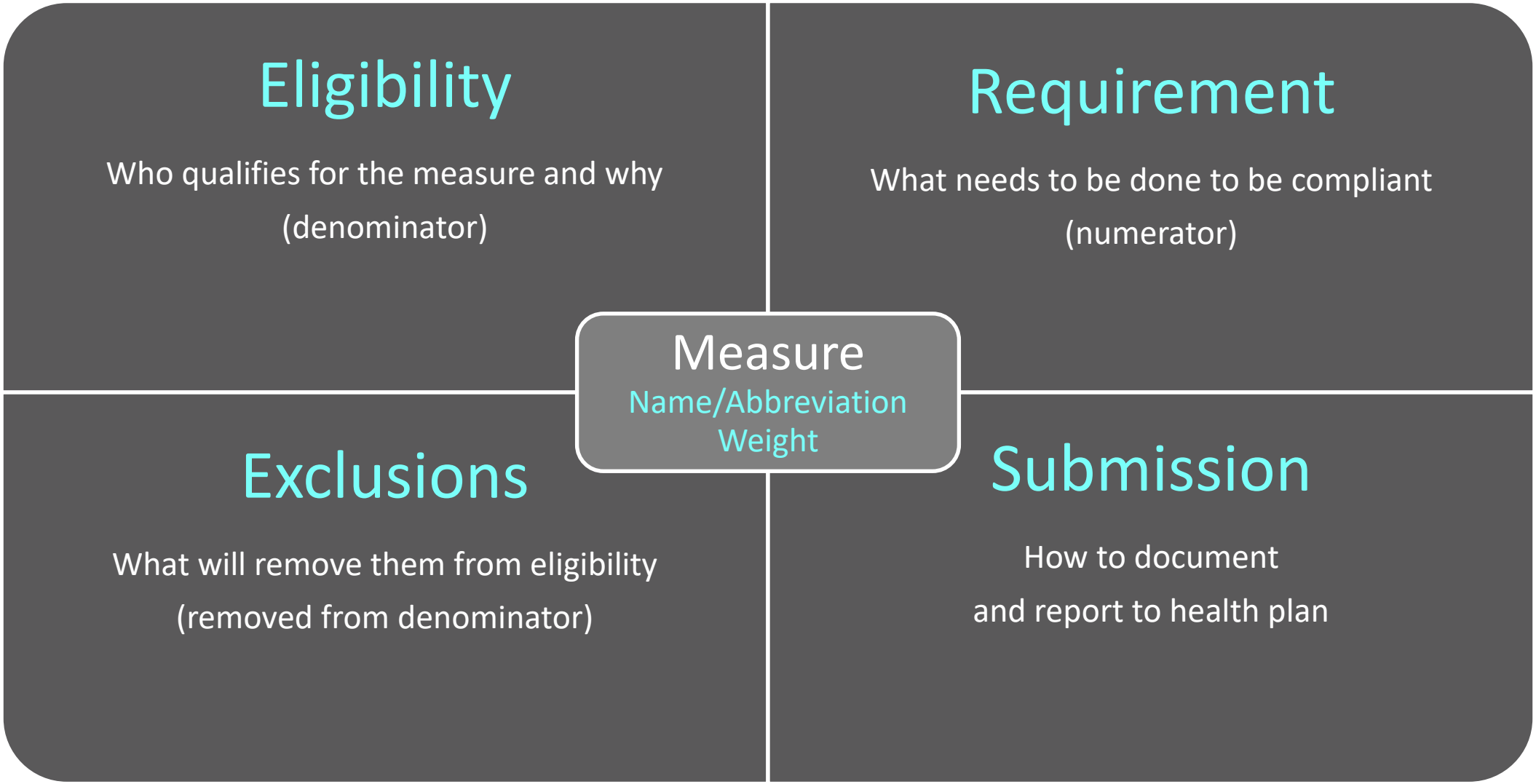
Why are star ratings important to health plans?

- Medicare consumer decisions
- Quality Bonus Payment
- Rebate Percentage
- Special Enrollment Period
- Contract Termination – Low Performance

Important Terms

- **Measurement Year (MY) –** the calendar year when services are provided.
- **Patient Reported –** data or feedback provided directly by patients about their own health care and documented in their record.
- **Supplemental Data –** additional information used to complement the primary data which could include patient reported outcomes, survey data, clinical data, EHR data, or provider reported data not captured through standard billing codes.
- **CPTII –** codes used for data collection and reporting purposes.
- **Thresholds** - usually set as a percentage of numerator/denominator, that define the minimum or maximum values that must be achieved to reach the desired performance (star level).

Understanding the Components



HEDIS Summary Report

Total Eligible	Total Passed	Pass %	HEDIS Star Level	Patient Safety Star Level	Overall Star Level
2,522	1,837	72.84%	2.00	4.00	2.65

Measure	Category	Wgt	Elig	Pass	Gap	Pass %	Star Lvl	Gap Star 2	Gap Star 3	Gap Star 4	Gap Star 5
Breast Cancer Screening	HEDIS	1	119	93	26	78.1%	4	0	0	0	6
Care for Older Adults - Functional Status	HEDIS	0	68	47	21	69.1%	N/A	0	0	0	0
Care for Older Adults - Medication Review	HEDIS	1	68	42	26	61.7%	1	9	17	23	26
Care for Older Adults - Pain Assessment	HEDIS	1	68	39	29	57.3%	1	14	20	25	28
Colorectal Cancer Screening	HEDIS	1	273	196	77	71.7%	3	0	0	4	28
Controlling High Blood Pressure	HEDIS	3	295	180	115	61.0%	1	3	33	51	74
Diabetes Care - Blood Sugar Controlled	HEDIS	3	113	71	42	62.8%	2	0	14	23	31
Eye Exam for Patients With Diabetes	HEDIS	1	113	79	34	69.9%	3	0	0	6	15
Follow-up after ED Visit (FMC)	HEDIS	1	43	24	19	55.8%	2	0	1	4	8
Kidney Health Evaluation for Patients With Diabetes	HEDIS	1	149	59	90	39.5%	3	0	0	15	31
Medication Adherence for Cholesterol (Statins)	Rx Safety	3	366	339	27	92.6%	5	0	0	0	0
Medication Adherence for Diabetes Medications	Rx Safety	3	134	119	15	88.8%	3	0	0	2	5
Medication Adherence for Hypertension (RAS antagonists)	Rx Safety	3	286	272	14	95.1%	5	0	0	0	0
Plan All-Cause Readmissions	HEDIS	3	22	20	2	11.7%	1	0	0	0	0
Statin Therapy for Patients with Cardiovascular Disease	HEDIS	1	34	26	8	76.4%	1	2	4	5	6
Statin Use in Persons with Diabetes (SUPD)	Rx Safety	1	119	97	22	81.5%	1	2	8	11	15
Transitions of Care - Medication Reconciliation Post-Discharge	HEDIS	1	63	54	9	85.7%	5	0	0	0	0
Transitions of Care - Notification of Inpatient Admission	HEDIS	1	63	27	36	42.8%	3	0	0	13	24
Transitions of Care - Patient Engagement After Inpatient Discharge	HEDIS	1	63	53	10	84.1%	3	0	0	2	5
Transitions of Care - Receipt of Discharge Information	HEDIS	1	63	0	63	0.0%	1	11	20	35	45

Example: BCS

93 Numerator

119 Denominator

93 ÷ 119 = .78

78% = 4 Stars

Exclusions

For All Measures

- Patients who **died** during the measurement year
- Patients in **hospice**, using hospice services
- Receiving **palliative care** at any time during the measurement year (claims or supplemental data- no lab claims)

Applies to: BCS, COL, CBP, GSD, EED, KED, OMW, SPC

Medicare patients ages 66 and older enrolled in an **Institutional Special Needs Plan** (I-SNP) or **living long term in an institution** any time during the measurement year

Applies to: BCS, COL, CBP, GSD, EED, KED, OMW, SPC

- Patients ages **66** and older with **advanced illness and frailty**. Advanced illness code during current or prior year. Frailty exclusion requires two different dates of service during the measurement year.
- One dispensed dementia medication

Applies to: CBP, KED, OMW

- Patients ages **81** and older with **Frailty Only**. Frailty exclusion requires two different dates of service during the measurement year.

(via claims only – no lab claims)

Poll Question

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Detailed Measure Review

Care of Older Adults (COA) – Medication Review

Description of measure: The percentage of patients who are ages 66 years and older, and who are enrolled in a Special Needs Plan (SNP) who had at least one medication review conducted by a prescribing practitioner or clinical pharmacist during measurement year and the presence of a medication list in the medical record.

Exclusions

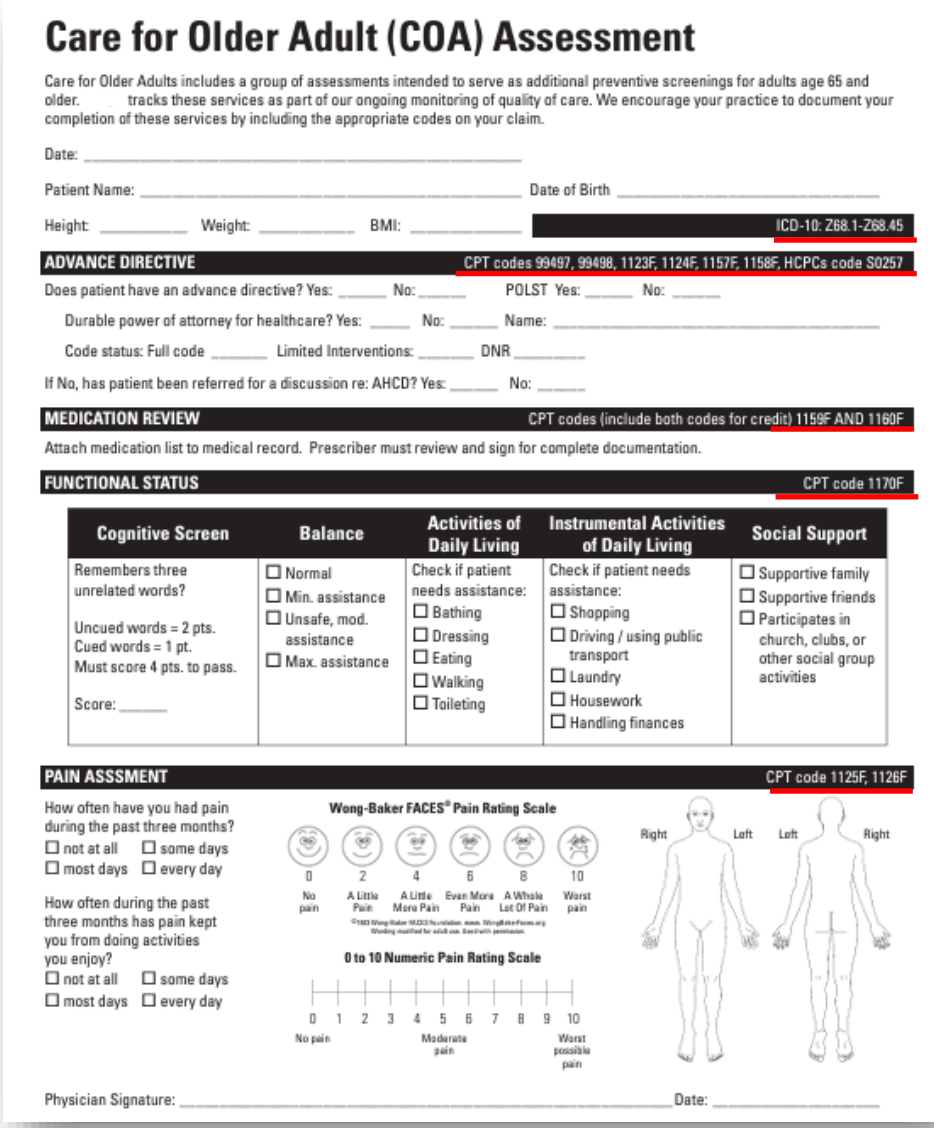
- Patients who receive hospice services any time during the measurement year.
- Patients who died during the measurement year.

Supplemental documentation examples

- Documentation must come from the same medical record, and it must include one of the following:
  - At least one medication review conducted by a prescribing practitioner or clinical pharmacist during measurement year, the presence of a medication list in the medical record, and the date when it was performed
    OR
  - Notation that the member isn't taking any medication and the date when it was noted
- Document must contain date of service, patient's name, date of birth, and provider's name and credentials.

- CPTII codes submitted on a claim.

Note: *A review of side effects for a single medication at the time of prescription alone isn't sufficient.*



Care for Older Adult (COA) Assessment

Care for Older Adults includes a group of assessments intended to serve as additional preventive screenings for adults age 65 and older. tracks these services as part of our ongoing monitoring of quality of care. We encourage your practice to document your completion of these services by including the appropriate codes on your claim.

Date: _____

Patient Name: _____ Date of Birth _____

Height: _____ Weight: _____ BMI: _____ ICD-10: Z68.1-Z68.45

ADVANCE DIRECTIVE CPT codes 99497, 99498, 1123F, 1124F, 1157F, 1158F, HCPCs code S0257

Does patient have an advance directive? Yes: _____ No: _____ POLST Yes: _____ No: _____

Durable power of attorney for healthcare? Yes: _____ No: _____ Name: _____

Code status: Full code _____ Limited Interventions: _____ DNR _____

If No, has patient been referred for a discussion re: AHCD? Yes: _____ No: _____

MEDICATION REVIEW CPT codes (include both codes for credit) 1159F AND 1160F

Attach medication list to medical record. Prescriber must review and sign for complete documentation.

FUNCTIONAL STATUS CPT code 1170F

Cognitive Screen	Balance	Activities of Daily Living	Instrumental Activities of Daily Living	Social Support
Remembers three unrelated words? Uncued words = 2 pts. Cued words = 1 pt. Must score 4 pts. to pass. Score: _____	☐ Normal ☐ Min. assistance ☐ Unsafe, mod. assistance ☐ Max. assistance	Check if patient needs assistance: ☐ Bathing ☐ Dressing ☐ Eating ☐ Walking ☐ Toileting	Check if patient needs assistance: ☐ Shopping ☐ Driving / using public transport ☐ Laundry ☐ Housework ☐ Handling finances	☐ Supportive family ☐ Supportive friends ☐ Participates in church, clubs, or other social group activities

PAIN ASSSMENT CPT code 1125F, 1126F

How often have you had pain during the past three months?
☐ not at all ☐ some days
☐ most days ☐ every day

How often during the past three months has pain kept you from doing activities you enjoy?
☐ not at all ☐ some days
☐ most days ☐ every day

Wong-Baker FACES® Pain Rating Scale

0 No pain · 2 A Little Pain · 4 A Little More Pain · 6 Even More Pain · 8 A Whole Lot Of Pain · 10 Worst pain

0 to 10 Numeric Pain Rating Scale

0 1 2 3 4 5 6 7 8 9 10
No pain · Moderate pain · Worst possible pain

Right Left Left Right

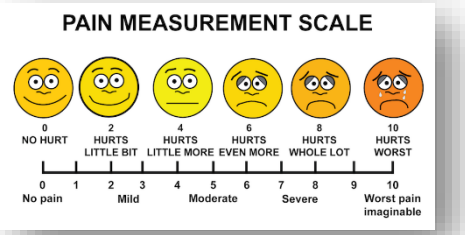
Physician Signature: _____ Date: _____

Care of Older Adults (COA) – Pain Screening

Description of measure: The percentage of patients who are ages 66 years and older and who are enrolled in a Special Needs Plan (SNP) who had documentation in the medical record of evidence of at least one pain assessment during the measurement year and the date it was performed.

Exclusions

- Patients who receive hospice services at any time during the measurement year.
- Patients who died during the measurement year.



Supplemental documentation examples

- Documentation for pain assessment must include one of the following:
  - Documentation that the patient was assessed for pain (which may include positive or negative findings for pain)

  OR
  - Result of assessment using a standardized pain assessment tool

- CPTII codes submitted on a claim.

Note: A pain assessment performed in an acute inpatient setting isn't acceptable. Documentation of a pain management plan or a pain treatment plan alone doesn't meet the criteria. Documentation of screening for chest pain or documentation of chest pain alone doesn't meet the criteria.

Note: *Documentation in the History of Present Illness (because it states what's going on presently) and Review of Systems (should be looked over during one of the member's visits every year) both meet the criteria to close a pain assessment gap if they don't assess chest pain alone. Acceptable: Review of Systems - Abdomen is non-tender and/or no arthralgias. A pain scale is the easiest way to meet pain assessment criteria. Ask the member on a scale of 0-10 what their pain level is and document it in the medical record (e.g., vitals or in the exam part of the visit).*

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Breast Cancer Screening (BCS-E)

Description of measure: The percentage of women 50 to 74 years of age who had at least one (1) mammogram every two (2) years (from October 1, two years prior to measurement year and December 31 of the measurement year – 27 months total). (Ex. MY2024 - Oct 1, 2022 to Dec 31, 2024)

All types and methods of mammograms: screening, diagnostic, film, digital, or digital breast tomosynthesis meet compliance. MRIs, ultrasounds, or biopsies **don't count** toward this measure.

Exclusions

- Medicare patients ages 66 and older enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in an institution at any time during the measurement year.
- Patients ages 66 and older with frailty and advanced illness. Frailty exclusion requires two different dates of service during the measurement year.
- One dispensed dementia medication
- Patients in hospice, using hospice services, or receiving palliative care at any time during the measurement year.
- Patients who died during the measurement year.
- Documentation in the medical record of bilateral mastectomy or two unilateral mastectomies at any time during the member's history (the year the mastectomy was done must be documented). A single unilateral mastectomy doesn't count as a full exclusion.
- Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria at any time during the member's history through the end of the measurement period.

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Breast Cancer Screening (BCS-E)

Supplemental documentation examples

- Radiology report of a mammogram.
- Progress note indicating date mammogram was completed (**month and year** must be documented if report isn't available). Results aren't required on progress notes but are recommended. Ex. Bilateral mammogram done Nov 2022.
- Progress note with documentation of bilateral mastectomy or two unilateral mastectomies (**year done** must be documented). (e.g., Right unilateral mastectomy 1977, left unilateral mastectomy 1985, or bilateral mastectomy done 1987)
- Documents must contain the patient's name, date of birth, date, type of exam, and provider's name and credentials.
- Reporting CPTII codes will NOT close the gap for this measure.

Note: Member must be enrolled with a medical benefit throughout the participation period. No more than one gap in enrollment of up to 45 days for each full calendar year of the participation period. No gaps in enrollment are allowed from October 1 two years prior to the measurement period through December 31 two years prior to the measurement period.

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Colorectal Cancer Screening (COL-E)

Description of measure: The percentage of members 50 to 75 years of age who had appropriate screening for colorectal cancer. (Age range has been extended to 45 to 75 for NCQA, not yet adopted for Medicare STARS Measure)

- Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) during the measurement year (digital rectal exams (DRE) or FOBT test performed in the office setting **won't** meet compliance). (MY2024 - 2024 only)
- Stool-DNA (sDNA) - (Cologuard®) test during the measurement year or two prior years. (MY2024 - 2022 through 2024)
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. (MY2024 - 2020 through 2024)
- Computerized tomography (CT) colonography during the measurement year or four prior years. (MY2024 – 2020 through 2024)
- Colonoscopy during the measurement year or nine prior years. (MY2024 - 2015 through 2024)

Exclusions

- Medicare patients ages 66 and older enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in an institution any time during the measurement year.
- Patients ages 66 and older with frailty and advanced illness. Frailty exclusion requires two different dates of service during the measurement year.
- Patients in hospice, using hospice services, or receiving palliative care any time during the measurement year.
- Patients who died during the measurement year.
- Documentation in the medical record of colorectal cancer any time in a member's history through December 31 of the measurement year (cancer of the small intestine doesn't count).
- Total colectomy (partial colectomy doesn't count).

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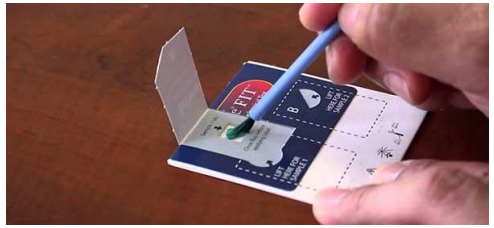
Colorectal Cancer Screening (COL-E)



Fecal Occult Blood Test (FOBT)

- ✓ Detects hemolyzed blood within a stool sample by a chemical reaction.
- ✓ Red meats and certain vegetables can cause a false positive result.
- ✓ Uses three consecutively passed stools from different days.

(Measurement Year Only)

Fecal Immunochemical Test (FIT)

- ✓ Uses an antibody specific to human globin to directly detect hemolyzed blood, eliminating the need to modify diet or medications.
- ✓ Only one stool specimen is needed.

(Measurement Year Only)

Stool-DNA (Cologuard®)

- ✓ Uses advanced stool DNA technology to detect DNA and blood cells released from altered cells and can detect both precancer and cancer, if present.
- ✓ Full stool sample is mailed to Exact Science Laboratories.

(MY and 2 years prior)

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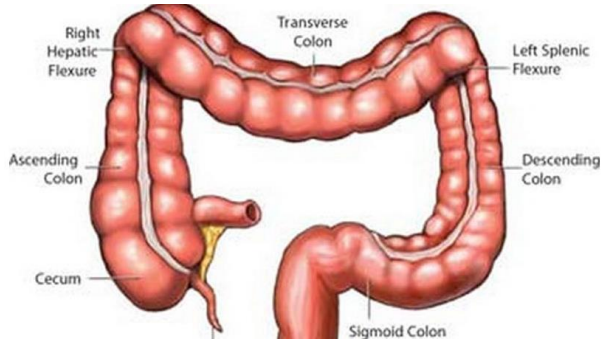
Colorectal Cancer Screening (COL-E)

Supplemental documentation examples

- Procedure report - Document must indicate the date and type of colorectal cancer screening done.
  - A full colonoscopy is one that evaluates the entire colon. That is, the colonoscope is advanced past the splenic flexure all the way to the cecum.
  - For a flexible sigmoidoscopy, must indicate the type of screening or that the scope advanced to the sigmoid colon.
- Procedure report isn't required but suggested, documentation can be patient reported if the type of test and year are documented on the progress note (Acceptable: Colonoscopy done in 2015). Abbreviations are not allowed (Unacceptable: *Colon 2018* or Colon Cancer Screening 2015)
- *Pathology* or *lab report* with an indication of the type of screening (e.g., colonoscopy, flexible sigmoidoscopy, FIT, Cologuard) and the date the screening was done.
- Documents must contain the patient's name, date of birth, type of exam done with the year the exam was done, and provider's name and credentials.
- Reporting CPTII codes will **not** close the gap for this measure.

Note: In October 2020 CMS announced that for Medicare members, evidence is sufficient to cover a blood-based biomarker test as an appropriate colorectal cancer screening test once every three years, or at the interval designated in the Food and Drug Administration (FDA) label if the FDA indicates a specific test interval. However, these tests haven't yet been approved by NCQA to close HEDIS® gaps.



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Controlling High Blood Pressure (CBP)

Description of measure: The percentage of members 18 to 85 years of age who had a diagnosis of hypertension (HTN) (I10 Essential (primary) hypertension) and whose most recent blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. Blood pressure readings must occur on or after the second diagnosis of hypertension.

Exclusions

- Pregnancy
- Patients ages 66 and older living long-term in an institution or enrolled in an Institutional Special Needs Plan (I-SNP).
- Patients 66 to 80 years of age with frailty and advanced illness. Patients 81 years old with frailty only. Frailty exclusion requires two different dates of service during the measurement year.
- Patients in hospice, using hospice services, or receiving palliative care at any time during the measurement year.
- Dementia medications
- Non-acute inpatient admission during the measurement year.
- Patients who died during the measurement year.
- Evidence of end-stage renal disease (ESRD), dialysis, nephrectomy (removal of a kidney), or kidney transplant on or before December 31 of the measurement year.

Note: Hypertension diagnosis reported with I11 – Hypertensive heart disease, I12 hypertensive CKD, I13 Hypertensive heart and CKD, or I15 Secondary hypertension doesn't qualify for the measure.

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Controlling High Blood Pressure (CBP)

Supplemental documentation examples

- Blood pressure readings can be collected via outpatient and telehealth visits including real-time, interactive audio/video visits, audio-only, and online assessments as well as remote monitoring devices that transmit results to the office.
- Blood pressures reported by the patient are accepted if they're being taken by a digital device and recorded in the member's chart. If the type of device isn't documented, it's understood that the device is digital. Self-reported blood pressures taken with a manual cuff and stethoscope **aren't** acceptable.

- CPTII codes submitted on a claim.

Note: Don't include blood pressure readings that are: (1) taken during an acute inpatient stay or ED visit, or (2) taken on the same day as a diagnostic test or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, except for fasting blood tests.

Note: If there are multiple blood pressures on the same date of service, then report the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure (e.g., If 150/87 and 135/92, then report 135/87).

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Glycemic Status Assessment for Patients with Diabetes (GSD)

Description of Measure: The percentage of members 18–75 years of age with diabetes (types 1 or 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was 9 or below.

Patients are identified based on any of the following activity during the current OR prior measurement year:

- Claim(s) submitted with a diagnosis of diabetes (Type 1 or Type 2) for: one acute inpatient stay or two outpatient visits: observation, office visit, telehealth, emergency department, non-acute inpatient visits, or online assessments (can be any combination of visit types that occurred on different dates of service).

OR

- An insulin, hypoglycemic, or antihyperglycemic medication dispensed on an ambulatory basis during the measurement year or the year prior **AND** have at least one diagnosis of diabetes during the measurement year or the year prior. (Glucophage, or metformin, as a solo agent, isn't included because it's used to treat conditions other than diabetes)

Note: For those who wear a continuous glucose monitoring system (CGM), the glucose management indicator (GMI) essentially estimates A1C.

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Glycemic Status Assessment for Patients with Diabetes (GSD)

Exclusions

- Patients ages 66 and older living long-term in an institution or enrolled in an Institutional Special Needs Plan (I-SNP).
- Patients ages 66 and older with frailty AND advanced illness. Frailty exclusion requires two different dates of service during the measurement year.
- Patients in hospice, using hospice services, or receiving palliative care at any time during the measurement year.
- Dementia medications
- Patients who died during the measurement year.

Supplemental documentation examples

- All documentation must contain the patient's name, date of birth, the **date the test was done** (date of progress note does not count), and **type of test** done, the **results**, and the provider's name and credentials. (Result and date of service must be on the same document).
- Lab reports, progress notes, or consultation reports
- Diabetes flow sheets or vital sheets with A1c documentation.
- Continuous glucose monitoring data
- Lab report isn't required but recommended. Patient-reported results can be used if the documentation is made on the progress note.
- Member-reported GMI results can be documented in the medical record and do not need to be collected by a PCP or specialist.
- CPTII codes submitted on a claim

Eye Exam for Patients with Diabetes (EED)

Description of measure: The percentage of members 18 to 75 years of age with diabetes (Type 1 or Type 2) who had a retinal eye exam performed during the measurement year or a **negative** dilated or retinal eye exam during the **previous** measurement year.

Patients are identified based on any of the following activity during the current or prior measurement year:

- Claim(s) submitted with a diagnosis of diabetes (Type 1 or Type 2) for: one acute inpatient stay or two outpatient visits: observation, office visit, telehealth, emergency department, non-acute inpatient visits, or online assessments (can be any combination of visit types that occurred on different dates of service).

OR

- An insulin, hypoglycemic, or antihyperglycemic medication dispensed on an ambulatory basis during the measurement year or the year prior **AND** have at least one diagnosis of diabetes during the measurement year or the year prior. (Glucophage, or metformin, as a solo agent, isn't included because it's used to treat conditions other than diabetes)

Exclusions

- Patients ages 66 and older living long-term in an institution or enrolled in an Institutional Special Needs Plan (I-SNP).
- Patients ages 66 and older with frailty and advanced illness. Frailty exclusion requires two different dates of service during the measurement year.
- Patients in hospice, using hospice services, or receiving palliative care at any time during the measurement year.
- Dementia medications
- Patients who died during the measurement year.
- Bilateral eye enucleation any time during the patient's history or the current measurement year.

Eye Exam for Patients with Diabetes (EED)

Supplemental documentation examples

- Document must contain patient's name, date of birth, date of exam, type of exam done (dilated), and provider's name and credentials.
- A note or letter prepared by an ophthalmologist, optometrist, patient-reported documentation by PCP, or other healthcare professional indicating an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed, and the results.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present. (Acceptable: Last dilated diabetic eye exam with John Smith, OD, done June 2023 negative for retinopathy).
- If documentation of a diabetic eye exam by an optometrist or ophthalmologist isn't specific enough to meet the criteria, the medical record must indicate that a dilated or retinal exam was performed. If the words "dilated" or "retinal" are missing, a notation of "dilated drops used" and findings for macula and vessels will meet the criteria for a dilated exam.
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who's a retinal specialist.
- Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.
- Documentation doesn't have to state specifically “no diabetic retinopathy” to be considered negative for retinopathy, however, it must be clear that the patient had a dilated or retinal exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates “diabetes without complications” doesn't meet the criteria.
- CPTII codes submitted on a claim.

Note: A slit-lamp examination won't meet criteria to close the measure. There must be additional documentation of dilation or evidence of retina examined for a slit lamp to be considered compliant. Blindness isn't an exclusion. Hypertensive retinopathy is handled the same way as diabetic retinopathy.

Kidney Health Evaluation for Patients with Diabetes (KED)

Description of measure: The percentage of members 18 to 85 years of age with diabetes (Type 1 or Type 2) who had an estimated glomerular filtration rage (eGFR) **and** a urine albumin-creatine ratio (uACR).

Patients are identified based on any of the following activities during the current OR prior measurement year:

- Claim(s) submitted with a diagnosis of diabetes (Type 1 or Type 2) for: one acute inpatient stay or two outpatient visits: observation, office visit, telehealth, emergency department, non-acute inpatient visits, or online assessments (can be any combination of visit types that occurred on different dates of service).

OR

- An insulin, hypoglycemic, or antihyperglycemic medication dispensed on an ambulatory basis during the measurement year or the year prior **AND** have at least one diagnosis of diabetes during the measurement year or the year prior. (Glucophage, or metformin, as a solo agent, isn't included because it's used to treat conditions other than diabetes)

(Diabetes Care – Nephropathy Monitoring (also known as CDC–Neph) was retired as of MY2022)

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Kidney Health Evaluation for Patients with Diabetes (KED)

Exclusions

- Members who use hospice services or elect to use a hospice benefit or receive palliative care regardless of when the services began during the measurement year.
- Members ages 66 and older as of December 31 of the measurement year who had a diagnosis of frailty and advanced illnesses. Frailty exclusion requires two different dates of service during the measurement year.
- Members 81 years of age or older in the measurement year with a frailty diagnosis during the measurement year.
- One dispensed dementia medication (Donepezil, Donepezil-memantine, galantamine, rivastigmine, or memantine)
- Medicare members ages 66 and older as of December 31 of the measurement year who are either enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in an institution.
- Members who died during the measurement year.
- Evidence of ESRD or dialysis treatment at any time in the member's history through the end of the measurement year.

Supplemental documentation:

- Lab reports patient's name, date of birth, date test was done, and type of test done

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Osteoporosis Management in Women Who Had a Fracture (OMW)

Description of measure: The percentage of women 67 to 85 years of age who suffered a fracture (July 1 to June 30) and had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis (pharmacy claims) in the six months after the fracture (180 days).

Exclusions

- Medicare patients ages 66 and older enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in an institution any time during the measurement year.
- Patients ages 66 and older with frailty and advanced illness. Patients 81 years old with frailty only. Frailty exclusion requires two different dates of service during the measurement year.
- Patients in hospice, using hospice services, or receiving palliative care any time during the measurement year.
- Dispensed dementia medications.
- Patients who died during the measurement year
- BMD 24 months (730 days) prior to episode date.
- Osteoporosis therapy or dispensed prescription to treat Osteoporosis 12 months (365 days) prior to episode date.

Note: *This measure varies in that it has a different intake period of a 12-month (one-year) window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year (not January 1 to December 31 of the measurement year window).*

Patients with fractures only to finger, toe, face, and skull are not included in this measure.

Osteoporosis Management in Women Who Had a Fracture (OMW)

Supplemental documentation examples

- Document must contain patient's name, date of birth, type of exam, date it was done, and provider's name and credentials.
- Evidence of a BMD test 24 months (730 days) prior to the IESD (Index Episode Start Date) or six months (180 days) after the IESD.
- Osteoporosis therapy or dispensed prescription medication within 12 months prior to IESD or six months (180 days) prior to IESD. Treatment for osteoporosis to include the following: generic or brand name, strength/dose, route, and date when medication was dispensed to the member (other dates - start date, prescribed dates, etc. **don't** meet criteria).
- Reporting CPTII codes won't close the gap for this measure.

Approved Osteoporosis Medications	
Description	Prescription
Bisphosphonates	Alendronate Alendronate-cholecalciferol Ibandronate Risedronate Zoledronic acid
Other agents	Abaloparatide Denosumab Raloxifene Romosozumab Teriparatide

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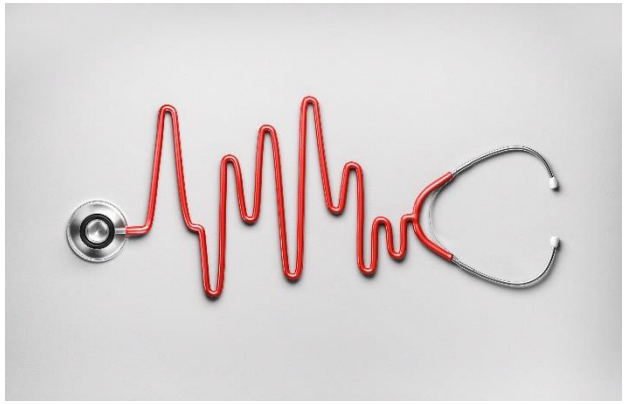
Follow-up After ED Visit (FMC)

Description of measure: The percentage of emergency department (ED) visits for members 18 years of age and older with multiple high-risk chronic conditions who had a follow-up service within seven days (total of eight days) of ED visit from January 1 to December 24 of the measurement year. Each condition is diagnosed on **two different** qualifying events in the current or prior measurement year.



Qualifying chronic conditions (Each bullet is considered a chronic condition)

- COPD and asthma
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Depression
- Heart failure
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

Qualifying events

Two or more outpatient visits with an eligible chronic condition during the measurement year or the year prior to the measurement year.

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Follow-up After ED Visit (FMC)

Exclusions

- Patients using hospice care during the measurement year.
- Patients who died during the measurement year.
- Exclude ED visits followed by admission to an acute or non-acute inpatient care setting on the date of the ED visit or within seven days after the ED visit, regardless of the principal diagnosis for admission.
- An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from the measure because admission to an acute or nonacute setting may prevent an outpatient follow-up visit from taking place.

Any of these types of visits will qualify for gap closure

- Outpatient or telephone visit (with or without telehealth modifier)
- Behavioral health visit (phone or face-to-face)
- Transitional care management service
- Case management visits or complex care management
- Telehealth visit
- E-visit or virtual check-in (virtual check-in visits CPT codes G2010 and G2012)
- Observation visit
- Substance use disorder service
- Domiciliary or rest home visit

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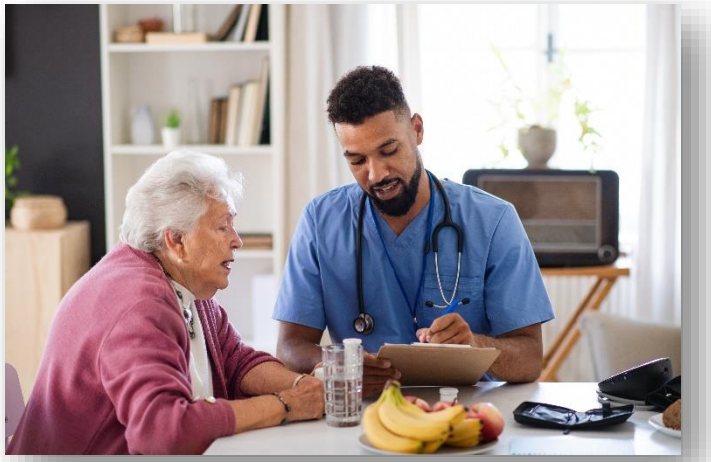
Follow-up After ED Visit (FMC)

Supporting documentation:

- Notation in the chart must be dated within 7 days of the ED Visit or on the ED discharge date and include the name and credentials of the person completing the follow up and notation of the clinical decision-making orders, verbal assessment of a condition, changes in treatment, counseling, new orders, and/or patient education.
- A telephone visit containing the above required elements with the patient's guardian or spouse could be used.

Note: FMC is an event-based measure. For each ED visit, there's a care opportunity that needs to be addressed. Any claim that comes in with an appropriate clinical code would be considered toward the measure. There's not a provider type requirement defined in the FMC measure specifications. A telephone visit done by a Physician, PA, RN, LPN, MA or anyone the provider delegates this task to meets compliance.



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Plan All-Cause Readmissions (PCR)

Description of measure: The percentage of patients 18 years old and older, the number of acute inpatient and observation stays during the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 days, and the predicted probability of an acute readmission (includes observations stays to inpatient admissions). The denominator for this measure is based on discharges, not members.

Exclusions

- Planned admissions for chemotherapy, rehabilitation, transplant, etc., aren't included as readmissions. Rehabilitation exclusions are limited to fitting and adjustment of the prosthesis and other medical devices, such as infusion pumps, neuropacemakers, etc.
- Pregnancy
- Patients in hospice or using hospice services any time during the measurement year.
- Patients with four or more hospital stays (acute inpatient and observation) between January 1 and December 1 of the current measurement year (known as outliers).
- Stays with discharge dates from December 2 to December 31.
- For stays that included a direct transfer, exclude the original admission's discharge date. Only the last discharge should be considered.
- Members who died during the hospital stay.
- Hospital stays where the index admission date is the same as the index discharge date.

Note: *There's no particular service needed for compliance. The lower the number of patients that get readmitted during 30 days of discharge the better. Inpatient and observation stays where the discharge date from the first one and the admission date from the second one are two or more days apart must be considered distinct stays.*

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Transitions of Care (TRC)

Description of measure: Members ages 18 and older with a discharge from **January 1 to December 1** who had each of the following (four rates are reported):

1. **Notification of Inpatient Admission** – Documentation of notification received on the day of admission through two days after the admission (3 days total) (e.g., communication between inpatient provider and staff and the member's PCP or ongoing care provider)
2. **Receipt of Discharge Information** – Documentation of discharge information received on the day of discharge through two days after discharge (3 days total) (e.g., discharge Summary)
3. **Patient Engagement after Inpatient Discharge** – Documentation of patient engagement provided within 30 days after discharge. (e.g., outpatient visit (home or office), telephone visit, telehealth (audio and video), e-visit, or virtual check-in. Please note that patient engagement that occurs on the day of discharge **doesn't** meet compliance.
4. **Medication Reconciliation Post Discharge** – Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 days total). Review and documentation of discharge medications reconciled with the most recent medication list in the outpatient medical record can be done by the prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse. (e.g., note in EMR that refers to the admission and mentions that no medications were prescribed upon discharge.)

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Transitions of Care (TRC)

Exclusions

- Patients in hospice or using hospice services any time during the measurement year.
- Discharges after December 1st of measurement year.
- Members who died during the measurement year.

Note: *Qualifying event is based on discharges, not patients. If the patient had more than one discharge, then the patient will count once for each discharge during the time period. If the patient is readmitted or transferred to an inpatient skilled nursing facility or nursing facility on the date of discharge, or the 30 days following (31 days) reconciliation of medication is based upon the* ***last*** *discharge date.*

Submission

- Claims using CPT codes 99495 or 99496 – Transition of care will satisfy all four rates since the use of these codes requires that four rates are documented to bill them.
- Claims using other office visit CPT codes within 30 days of discharge will satisfy patient engagement **only**.
- If an office visit occurred within 30 days of discharge and medication reconciliation was done, the claim must include both the CPT code for the office visit and the CPTII code 1111F.
- Claims with CPTII code 1111F within 30 days of DC will account for medication reconciliation post-discharge rate **only**.

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Statin Therapy for Patients with Cardiovascular Disease (SPC)

Description of measure: The percentage of males 21 to 75 years of age and females 40 to 75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one moderate or high-intensity statin medication during the measurement year. Members are identified for the eligible population in two ways: by event or by diagnosis (e.g., MI, CABG, PCI, or IVD diagnosis).

Exclusions

- Patients in hospice, using hospice services or receiving palliative care any time during the measurement year.
- Medicare patients ages 66 and older enrolled in an Institutional Special Needs Plan (I-SNP) or living long term in an institution any time during the measurement year.
- Patients ages 66 and older with frailty and advanced illness. Frailty exclusion requires two different dates of service during the measurement year.
- Dispensed dementia medications.
- Patients who died during the measurement year.
- Pregnancy
- In-vitro fertilization in the measurement year or year prior.
- Dispensed at least one prescription for clomiphene during measurement year or prior year.
- ESRD or dialysis during measurement year or prior year.
- Cirrhosis during measurement year or prior year.
- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.

Moderate and High Intensity Statin Medications	
Moderate	High Intensity
Atorvastatin 10-20 mg	Atorvastatin 40-80 mg
Amlodipine-Atorvastatin 10-20 mg	Amlodipine-Atorvastatin 40-80 mg
Rosuvastatin 5-10 mg	Rosuvastatin 20-40 mg
Simvastatin 20-40 mg	Simvastatin 80 mg
Ezetimibe-simvastatin 20-40 mg	Ezetimibe-simvastatin 80 mg
Pravastatin 40-80 mg	
Lovastatin 40 mg	
Fluvastatin 40-80 mg	
Pitavastatin 1-4 mg	

Submission:

- Pharmacy Claims
- PN or Claims with ICD10 for Exclusions

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Statin Use in Persons with Diabetes (SUPD) (Part D)

Description of measure: The percentage of members 40 to 75 years of age during the measurement year with diabetes who **received at least two diabetic medication fills** during the measurement year and **do not have** clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed a statin medication fill during the measurement year.

Exclusions

- Patients in hospice, using hospice services, or receiving palliative care any time during the measurement year.
- Patients who died during the measurement year.
- Pregnancy, lactation, or undergoing fertility therapy during the measurement year.
- ESRD or dialysis during measurement year.
- Cirrhosis during measurement year.
- Myopathy, or rhabdomyolysis during the measurement year.
- Pre-diabetes during the measurement year.
- Polycystic ovarian syndrome during measurement year.
- Patients who had at least one of the following during the year prior to the measurement year: IVD, MI, CABG, PCI.

Submission:

- Pharmacy Claims
- PN or Claims with ICD10 for Exclusions

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Medication Adherence (Part D)

Description of measure: There are three measures embedded in medication adherence: diabetes, hypertension (renin angiotensin system antagonists), and cholesterol (statin) medications. The percentage of plan members with a prescription for diabetes, hypertension, or cholesterol medication who fill their prescription often enough to cover 80% or more of the time they're supposed to be taking the medication Proportion of Days Covered (PDC). Patients will be added to the denominator for this measure when a second fill of the medication has been picked up, but the PDC is based on the first fill date. The Pharmacy Quality Alliance (PQA) is the steward of these measures.

Exclusions

- Hypertension medications – Hospice, ESRD, and prescription filled for Entresto (Sacubitril/Valsartan)
- Cholesterol medications – Hospice and ESRD
- Diabetes medications – Hospice, ESRD, prescriptions filled for insulin

Note: Pharmacy claim submissions that show the patient has filled their prescription on time and has missed less than 20% of the days is the only way to prevent patients from showing up as gaps (fail). No supplemental data submission or CPTII coding is allowed.

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Poll Question

Questions?

[Visit us in the VBC Exhibit Hall]

VBCExhibitHall.com

Thank you for joining us

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Appendix

Care of Older Adults (COA) – Functional Status Assessment

Description of measure: The percentage of patients who are ages 66 years and older, and who are enrolled in a Special Needs Plan (SNP) who had a functional status assessment during the current measurement year.

Exclusions

- Patients who receive hospice services at any time during the measurement year.
- Patients who died during the measurement year.

Supplemental documentation examples

- Assessment of activities of daily living (ADL) = basic activities such as transferring, ambulating, bathing, etc. (5 components)

or

- Instrumental activities of daily living (IADL) = more complex requiring physical and mental functions such as using the phone, preparing meals, arranging transportation, and managing finances. (4 components)
- Results using a standardized functional assessment tool
- Document must contain the date of service, patient's name, date of birth, and provider's name and credentials.

- CPTII codes submitted on a claim.

Advanced Illness and Frailty Exclusion - Details

National Committee for Quality Assurance (NCQA) has recognized that there are certain preventive screenings and other treatments that become less important than coordinating care for conditions or frailties that impact function and overall quality of life in the face of declining health. So, the NCQA now includes an exclusion for advanced illness and frailty for several HEDIS measures.

Advanced illness exclusions are based on any of the following claim(s) with an advanced illness code **during the current or prior year** for:

- Two outpatient visits, ED visits, observation, or non-acute inpatient visits, telephone visits, e-visits, or virtual check-ins. Visit type doesn't need to be the same but must be on different dates of service.
- One acute inpatient stay.
- One dispensed dementia medication (Donepezil, Donepezil-memantine, Galantamine, Rivastigmine, or Memantine).

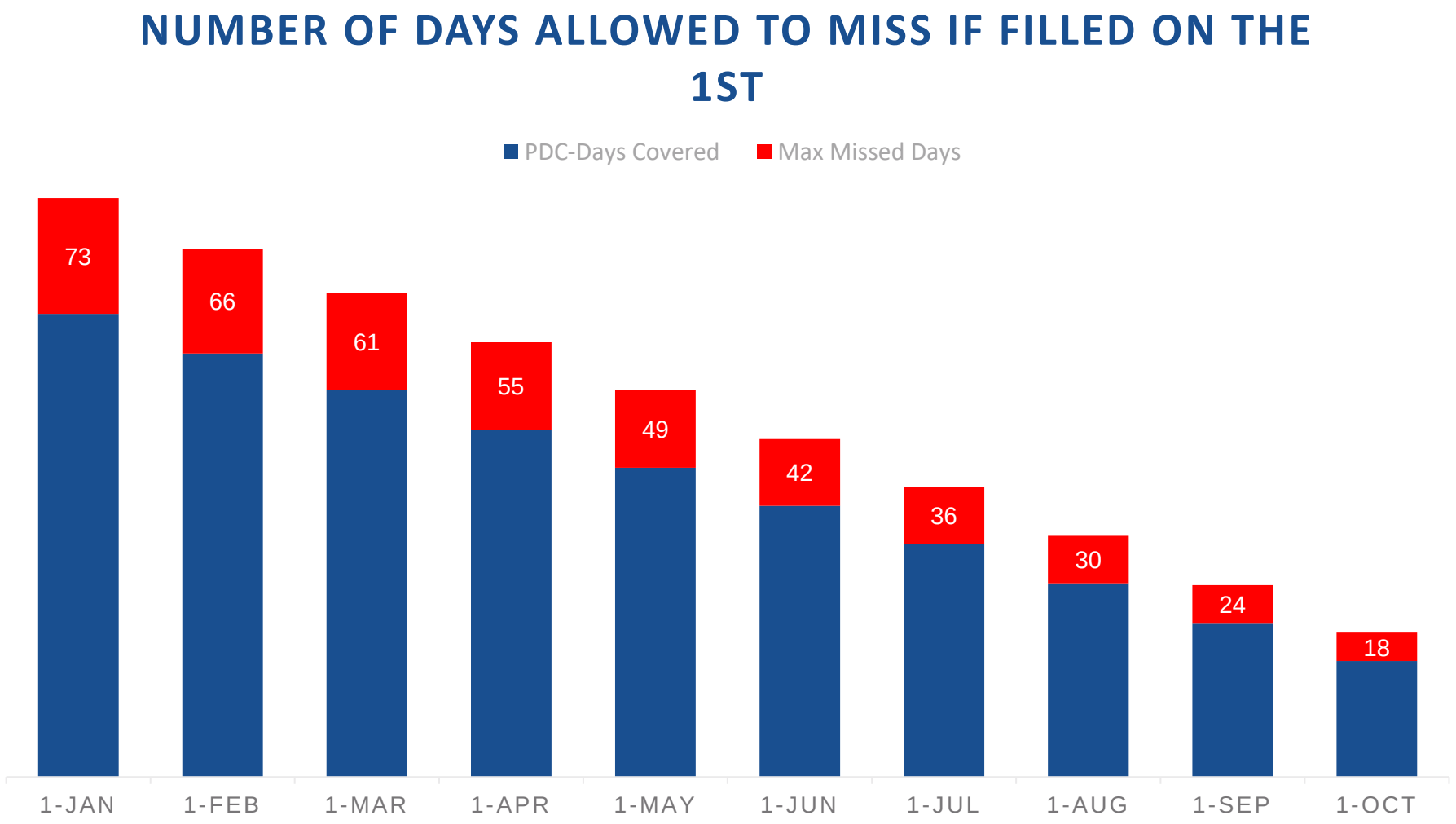
Frailty exclusions require claims for **two different** dates of service **during the measurement year**.

***Note**: Patients can only be excluded via appropriate and applicable coding on submitted claims. No supplemental data is allowed. Lab claims cannot be used for exclusions.*

Advanced illnesses are severe chronic conditions such as, but not limited to, Alzheimer's disease, dementia, heart failure, emphysema, and end-stage renal disease.

Frailties are durable medical equipment (DME) usage or services such as home health and skilled nursing, which are indicators of limited mobility or physical functionality (diagnoses). Examples of Frailties: durable medical equipment, such as a cane, walker, commode chair, hospital bed, or wheelchair. ICD-10 diagnosis for: weakness, age-related physical debility, other fatigue, history of falling, dependence on wheelchair, dependence on supplemental oxygen, other abnormalities of gait, etc.

Medication Adherence PDC Days



PDC = proportion of days covered: PDC is determined by dividing the days of medication coverage, which is determined based on the claims billed to the insurance plan, by the number of days in the period being measured. The specific number of days included in the measurement period, or calendar year, is determined based on the start date of the medication (first fill date).

If a patient PDC is greater than or equal to 80%, the patient is adherent (pass).

A rate lower than 80% is considered nonadherent (gap or fail).

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CPTII Codes Quick Guide

Controlling High Blood Pressure (CBP)	
SYST up to 129	3074F
SYST 130-139	3075F
SYST 140 or higher	3077F
AND	
DIAST up to 79	3078F
DIAST 80-89	3079F
DIAST 90 or higher	3080F

Glycemic Status Assessment for Patients with Diabetes (GSD)	
A1c up to 6.9	3044F
A1c 7.0 to 7.9	3051F
A1c 8.0 to 9.0	3052F
A1c > 9.0%	3046F

Eye Exam for Patients with Diabetes (EED)
No evidence of retinopathy in PRIOR year's dilated exam 3072F

Care of Older Adult (COA) Pain Screening	
Persistent Pain	1125F
Not Persistent	1126F

Care of Older Adult (COA) Med Review	
Meds Documented in chart	1159F
Medication Reviewed	1160F

Care of Older Adult (COA) Functional Status	
Persistent Pain	1170F

TRC- Medication Reconciliation (MRP)
(within 30 days of discharge)
1111F

Note: *Fonts in red identify values that are higher than required to close gap in care; therefore, reporting them won't close the gaps for those measures.*

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Resources

2024 Star Ratings Fact Sheet - https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-star-ratings

2024 Star Ratings Technical Notes - https://www.cms.gov/files/document/2024-star-ratings-technical-notes.pdf

2026 Star Rating Measures and Weights - https://www.cms.gov/files/document/2026-star-ratings-measures.pdf

Medicare Enrollment Dashboard - https://data.cms.gov/tools/medicare-enrollment-dashboard

CMS Measure Inventory Tool - https://cmit.cms.gov/cmit/#/MeasureInventory

PQA Measure Overview - https://www.pqaalliance.org/measures-overview#cob-add-info

NCQA HEDIS Information - https://www.ncqa.org/hedis/

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