CarePlus HEALTH PLANS

# Star Rating quality measures tool (MY26)

## Healthcare Effectiveness Data and Information Set (HEDIS®)

**Breast Cancer Screening (BCS-E) Ages 52–74 | Weight 1**
Women who had a mammogram to screen for breast cancer (including digital breast tomosynthesis) performed on or between Oct. 1 two years prior to the measurement year and Dec. 31 of the measurement year (27-month period).

**Documentation tips and best practices:**
- Request past medical records for new patients, including mammogram history.
- Include key tests and exams in the patient record.
- Document mammogram (at minimum month and year) of the most recent and mastectomy status date of service (minimum year performed) in the medical record.
- Magnetic resonance imaging (MRI), ultrasounds or biopsies do not count toward this measure.

**Colorectal Cancer Screening (COL-E) Ages 45–75 | Weight 1**
Patients who had appropriate screening for colorectal cancer that encompasses the measurement year.
- Fecal occult blood test (FOBT), guaiac FOBT or immunochemical FOBT (FIT) is compliant for the year it is performed.
- Stool DNA (sDNA) with FIT test is compliant for the year it is performed and two years after.
- Flexible sigmoidoscopy or computed tomography (CT) colonography is compliant for the year it is performed and four years after.
- Colonoscopy is compliant for the year it is performed and nine years after.

**Documentation tips and best practices:**
- Medical record documentation must include the date the test was performed and the result.
- Prepare referral for colonoscopy while patients are in the office and hand it to them.
- Use standing orders and distribute FOBT or FIT kits to patients who need colorectal cancer screening.
- FOBT test in office or via digital rectal examination does not meet criteria.

**Care for Older Adults – Functional Status Assessment (COA–FSA)**
**Ages 66 and older | Weight 1**
Patients who had at least one completed functional status assessment in the current measurement year.

**Documentation tips and best practices:**
- Notation that activities of daily living (ADL) and instrumental activities of daily living (IADL) were assessed.
- FSA can be addressed via all telehealth methods.

**COA – Medication Review (COA–MDR) Ages 66 and older | Weight 1**
Patients who had at least one medication review conducted in the measurement year with a medication list present in the patient's medical record with a dated notation.

**Documentation tips and best practices:**
- Medication Review measure requires the medications list to be documented in the chart with the review.
- Patient does not need to be present during the medication review.
- If patient is not taking any medicine, create a dated notation in the medical record.

**Eye Exam for Patients With Diabetes (EED) Ages 18–75 | Weight 1**
Patients with diabetes (type 1 or type 2) who had either of the following:
- A retinal or dilated eye exam in the measurement year.
- A negative eye exam for retinopathy in the year prior to the measurement year.

**Documentation tips and best practices:**
- Consider using mobile eye exam units, such as fundus photography, which captures an image of the retina with a camera.

**Glycemic Status Assessment for Patients With Diabetes (GSD)**
**Ages 18–75 | Weight 3**
Patients with type 1 or type 2 diabetes who meet either of the following criteria during the measurement year or the year prior to the measurement year.
- Two diagnoses of diabetes on different dates of service.
- Pharmacy data showing one dispensed insulin or hypoglycemic/antihyperglycemic and at least one diagnosis of diabetes.

**Documentation tips and best practices:**
- Document the date the test was performed in the measurement year and the A1c level.
- Order labs prior to patient appointments.
- When point-of-care HbA1c tests are completed in office, bill for service with results.
- If result is greater than 9%, order and document follow-up HbA1c testing.

**Kidney Health Evaluation for Patients With Diabetes (KED)**
**Ages 18–85 | Weight 1**
Patients with diabetes (type 1 or type 2) who either had two diagnoses of diabetes on different dates of service or pharmacy data showing one dispensed insulin or hypoglycemic/antihyperglycemic and at least one diagnosis of diabetes. Patients must have at least one uACR identified by either of the following:
- The blood test must be an eGFR.
- A urine albumin-creatinine ratio lab test.
- Both a quantitative urine albumin test and a urine creatinine test with service dates four or fewer days apart.

**Documentation tips and best practices:**
- Coordinate diabetic care as needed with specialists such as endocrinologists, nephrologists, cardiologists and ophthalmologists.

**Controlling High Blood Pressure (CBP) Ages 18–85 | Weight 3**
Patients with a diagnosis of hypertension (HTN) whose blood pressure (BP) was adequately controlled < 140/90 during the measurement year become eligible for this measure once they have had two outpatient visits—both with a diagnosis of hypertension.

**Documentation tips and best practices:**
- Both systolic and diastolic must be controlled, retake BP if elevated.
- If multiple BP measurements occur on the same date, use the lowest systolic and lowest diastolic BP reading.
- BP must be the latest reading and must occur after the second diagnosis of HTN.
- Do not round BP values up—record exact values.

**Osteoporosis Management in Women Who Had a Fracture (OMW)**
**Ages 67–85 | Weight 1**
Female patients who suffered a fracture and who had either a bone mineral density (BMD) test or prescription to treat or prevent osteoporosis in six months after the fracture.

**Documentation tips and best practices:**
- Dispense medication to treat or prevent osteoporosis within 90 days or through mail-order prescription.
- Schedule and complete a BMD test within 180 days for patients with recent fractures.
- Fractures of face, skull, fingers or toes are excluded.

**Statin Therapy for Patients with Cardiovascular Disease (SPC–E)**
**Ages 21–75 | Weight Display**
Patients who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high- or moderate-intensity statin medication during the measurement year.

**Documentation tips and best practices:**
- Encourage patient adherence with 90- to 100-day supply for long-term medications.
- Encourage use of mail-order and generic medications.

**Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) Ages 18 and older | Weight 1**
Patients with multiple high-risk chronic conditions who visit an emergency department (ED). The high-risk chronic conditions in scope include chronic respiratory conditions (chronic obstructive pulmonary disease, asthma and emphysema), Alzheimer's disease and related disorders, stroke and transient ischemic attack, chronic kidney disease, depression, heart failure, acute myocardial infarction and atrial fibrillation.

**Documentation tips and best practices:**
- FMC is an event-based measure. For each ED visit, there will be a care opportunity that needs to be addressed by a clinician.
- Implement processes with hospitals to facilitate sharing of discharge information.
- Work with hospitals to obtain access to electronic health records.
- Obtain census information from EDs/facilities whenever possible. Allow scheduling flexibility to accommodate a follow-up visit within seven days of the ED visit.

**Plan All-Cause Readmissions (PCR) Ages 18 and older | Weight 3**
Patients who have had an acute inpatient or observation stay and experience unplanned readmission to a hospital within 30 days, either for the same condition or for a different reason.

**Documentation tips and best practices:**
- Be aware of the daily discharge census.
- When possible, manage scheduling capacity to ensure discharged patients can be seen within seven days.
- Conduct a medication reconciliation during first post-discharge visit with the patient.
- Promote health plan services (e.g., transition of care, care coordination, home health, etc.).
- Connect patients to community resources and/or health plan care management services to help remove barriers to care and/or access to resources.

**Transitions of Care (TRC)**
**Ages 18 and older | Weight 1 (with four component measures)**
TRC measures evaluate patient engagement provided within 30 days after an acute or nonacute discharge on or between Jan. 1 and Dec. 1 of the measurement year. The measure is an average of four nonweighted components: Medication Reconciliation Post-Discharge (MRP), Notification of Inpatient Admission (NIA), Patient Engagement after Inpatient Discharge (PED) and Receipt of Discharge Information (RDI). Any documentation that does not include a time frame or date stamp does not meet criteria.

**Documentation tips and best practices:**
- MRP – Documentation of medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the day the patient is discharged from the hospital for 30 days after discharge (31 total days).
- NIA – Documentation of receipt of notification of inpatient admission on the day of admission or the two following days.
- PED – Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- RDI – Documentation of receipt of notification of inpatient discharge on the day of discharge or the two following days.

For more details on these measures, please review the **CarePlus quality measure guide**.

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# Health Outcomes Survey (HOS)

**Improving Bladder Control (IBC) Ages 65 and older | Weight 1**
Percentage of surveyed patients who reported having any urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a provider.

**Questions to ask:**
- In the past six months, how much of a problem, if any, is bladder control for you?
- Does urine leakage interfere with your daily activity or with your sleep?

**Documentation tips and best practices:**
- Discuss bladder control issues and symptoms during annual visits.
- Determine if exercise or other treatment, such as medications or surgery, may help.

**Monitoring Physical Activity in Older Adults (MPA)**
**Ages 65 and older | Weight 1**
Percentage of patients surveyed who have had a visit to the doctor in the past 12 months and who received advice to start, increase or maintain their level of exercise or physical activity.

**Questions to ask:**
- What do you do to keep physically active?
- How many days a week are you physically active?

**Documentation tips and best practices:**
- Explain to patients that an exercise regimen could increase quality of life and longevity.
- Include recommended activity with frequency and duration in patient after-visit summary.

**Reducing the Risk of Falling (ROF) Ages 65 and older | Weight 1**
Percentage of surveyed patients who have had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.

**Questions to ask:**
- Have you fallen, had balance trouble or had trouble walking in the past 12 months?
- Do you use a cane or walker (or other), and, if so, how comfortable are you using it?

**Documentation tips and best practices:**
- Take advantage of the Centers for Disease Control and Prevention's (CDC) Stopping Elderly Accidents, Deaths & Injuries (STEADI) online training and materials.
- Talk with your patients about the factors that can lead to a higher risk of falls.

**Improving or Maintaining Physical Health (IMPH)**
**Ages 65 and older | Weight 3**
Percentage of surveyed patients whose physical health status was the same or better than expected after two years.

**Questions to ask:**
- Have you had any issues staying physically active?
- Do you have questions about the exercises we've recommended?

**Documentation tips and best practices:**
- Assess the overall physical health of your patients annually.
- Determine an exercise or physical therapy program that is appropriate for patients' needs and abilities.

**Improving or Maintaining Mental Health (IMMH)**
**Ages 65 and older | Weight 1**
Percentage of surveyed patients whose mental health status was the same or better than expected after two years.

**Questions to ask:**
- Do you feel like you've been doing OK managing your stress?
- Have you been experiencing extra anxiety recently?

**Documentation tips and best practices:**
- Provide questionnaires that ask patients questions about their mental health.
- Provide written materials regarding mental well-being and identify local resources that can assist patients.

# Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

**Annual Flu Vaccine (FLU) Ages 18 and older | Weight 1**
Percentage of surveyed patients who report receiving an influenza vaccination between July of the prior year and the date on which they are responding to the Medicare CAHPS survey (March–June each year).

**Documentation tips and best practices:**
- Recommend patients get the flu shot during their regularly scheduled appointment during flu season.
- Ensure practice staff is aware of community resources for flu vaccines.

**Care Coordination (CC) Ages 18 and older | Weight 2**
Assesses how well patient care is coordinated, including whether doctors had the records and information they needed about patients' care and how quickly patients got their test results.

**Question to ask:**
- Did your physician/staff provider follow up on your tests promptly?

**Documentation tips and best practices:**
- Document in medical records services rendered with date of service and results.
- Schedule specialist follow-ups on behalf of your patients before they leave your office.
- Ask patients to follow up within one month of specialist visits to discuss their results.
- Provide a medication action plan and/or personal medication list to educate and help patients organize medication-related information.

**Getting Appointments and Care Quickly (GACQ)**
**Ages 18 and older | Weight 2**
Assesses how quickly the patients were able to get appointments and care.

**Question to ask:**
- Have you experienced any difficulty scheduling your appointments with our office?

**Documentation tips and best practices:**
- Schedule patients' follow-up visits before they leave the current appointment.
- Try to take patients back to the exam room within 15 minutes of their scheduled appointment time even if they aren't seeing the physician right away.
- If possible, avoid overscheduling patients to prevent appointments from backing up.

**Getting Needed Care (GNC) Ages 18 and older | Weight 2**
Assesses how easy it was for patients to get needed care and see specialists.

**Question to ask:**
- Do you have any questions from your recent specialist visit?

**Documentation tips and best practices:**
- Schedule specialist follow-up visits on behalf of patients before they leave.
- If your office is unable to schedule specialist appointment for patient, give them the names and phone numbers to call specialists.
- Use specialist appointment reminder cards so patients remember that your office assisted in scheduling the follow-up appointment.
- If a service requires preauthorization, obtain approval in a timely manner.

**Getting Needed Prescription Drugs (GNRx)**
**Ages 18 and older | Weight 2**
Assesses how easy it is for patients to get the medicines prescribed by their doctor.

**Question to ask:**
- Are you obtaining all the medications ordered by your physicians?

**Documentation tips and best practices:**
- Check if a medication requires preauthorization before it can be dispensed or administered.
- Offer 90- to 100-day fills for prescriptions.
- Utilize health plan pharmacy resources.

**Rating of Healthcare Quality (RHCQ) Ages 18 and older | Weight 2**
Assesses patients' view of the quality of the healthcare they received.

**Question to ask:**
- How do you feel about managing your health condition? Do you have what you need?

**Documentation tips and best practices:**
- Ask questions to understand the patient's current experience and perception of the care they are receiving from your practice, specialists and other healthcare providers.
- Provide insights on patients' perception of the healthcare they are receiving.
- Make efforts to confirm patients understand their care plan, services performed or ordered, how to manage their chronic conditions, and when and how to best take their medication.

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# Patient Safety

**Medication Adherence – Diabetes Medications (MAD)**
**Ages 18 and older | Weight 3***
Patients with a prescription for diabetes medication with at least two diabetes medication prescription fills on unique dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

**Medication Adherence – Cholesterol (statins) (MAC)**
**Ages 18 and older | Weight 3***
Patients with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

**Medication Adherence – Hypertension (ACE/ARB) (MAH)**
**Ages 18 and older | Weight 3***
Patients with a prescription for a blood pressure medication with at least two diabetes medication prescription fills on unique dates fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

**Documentation tips and best practices:**
- Recommend patients switch to 90- to 100-day supplies from their community pharmacy or via a mail-order pharmacy.
- Encourage discussions with patients to identify and resolve medication adherence barriers.
- Update prescription dosage rather than encourage patient to split medications.
- Utilize health plan pharmacy resources.

**Statin Use in Persons with Diabetes (SUPD) Ages 40–75 | Weight 1**
Patients who received at least two diabetic medication fills during the measurement year and were dispensed a statin medication fill during the measurement year.

**Documentation tips and best practices:**
- Recommend patients switch to 90- to 100-day supplies from their community pharmacy or via a mail-order pharmacy.
- Encourage discussions with patients to identify and resolve medication adherence barriers, including common side effects.

**Concurrent Use of Opioids and Benzodiazepines (COB) Ages 18 and older | Weight 1**
Patients having had two or more fills for opioids on different dates of service (claims can be for same or different opioids).

**Documentation tips and best practices:**
- Review patient medications regularly, especially for those who utilize specialists and receive care through other facilities such as hospitals and urgent care clinics.
- Monitor the use of high-risk medications in patients and work with them to discontinue any that are inappropriate or should not be taken with other prescribed medications.

**Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH) Ages 65 and older | Weight 1**
Patients who have had two or more fills of same ACH medication on different dates of service, with no more than one gap in enrollment of up to 31 days during the measurement year.

**Documentation tips and best practices:**
- Before prescribing a new medication, check to see if it's on the POLY–ACH measure drug list and review all patient-reported medications and what is notated in the patient charts.

* Changes for this measure in 2026 include the measure being moved to a 1x weight by CMS but will stay at 3x weight for CarePlus. CMS calculations will be risk adjusted, but CarePlus' provider reporting/incentives will not include any risk adjustment methodologies.