Humana quality measure guide

Your guide to HEDIS, HOS, CAHPS and Patient Safety measures for the Medicare Star Rating Program

Humana.

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Purpose and summary

The Centers for Medicare & Medicaid Services (CMS) created the Star Rating Program to assess the quality of care for Medicare enrollees electing Medicare Advantage (MA) coverage from health plans versus Original Medicare. The program is aligned with CMS' quality strategy goals to optimize health outcomes, improve patients' experience and access to care and maximize efficiency and cost savings.

This guide outlines the Star quality and performance measures that CMS, the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA®) use to evaluate the care and services provided to your MA patients. Humana strives to support you in providing quality services and improving the health outcomes of your Humana-covered patients.

The information offered in this guide is from the current Healthcare Effectiveness Data and Information Set (HEDIS®) Volume 2 Technical Specifications for Health Plans and its most current corresponding Value Set Directory, as well as the current CMS Medicare Part C & D Star Ratings Technical Notes available at www.cms. gov. This information is not meant to preclude clinical judgment. Treatment decisions should always be based on the clinical judgment of the physician or other healthcare provider at the time of care.

For each measure, we've provided:
• Measure name and abbreviation
• Weight assigned by CMS that is used when calculating summary or overall Star Ratings
• Definition of the measure, its eligible population and expected quality activity and/or outcome

• Best practices for addressing the measure with patients
• Applicable exclusions that will remove a patient from the eligible population for a measure
• Quality result percentage ranges (i.e., cut points) used to determine each of the measure's rating year Star level
• For HEDIS measures: the service(s) needed and coding guidance to ensure measure compliance
• For Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures: applicable question(s) from the respective survey administered to Medicare Advantage-covered patients
• For Patient Safety measures: the prescription drug activity needed for compliance

You also will find information for display measures within this guide. These measures are not currently part of the Star Rating Program, but in some cases they may be recent Star measures that underwent substantive changes and have been temporarily moved to display. These are often new measures being performance-tested before they are designated as a Star measure. They could also be former Star measures that may be retired in the future.

The information in this guide is subject to change based on CMS regulatory guidance and technical specification changes from NCQA and/or PQA. Measure details can change annually (e.g., service needed for compliance, applicable codes). The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.

Letter to providers

Dear valued Humana provider,

Thank you for your ongoing commitment to delivering high-quality, compassionate care to Humana-covered patients. We are honored to partner with you in the Star Rating Program, which continues to be a cornerstone of Humana's goal to advance health outcomes and improve patient experiences.

This guide is designed to support care teams in navigating the Star Rating Program, with the primary objective of improving patient outcomes and satisfaction. Our focus remains on ensuring that patients receive the right care at the right time, emphasizing preventive services, effective management of chronic conditions and ensuring smooth coordination of care throughout every stage of the care journey.

Included in this guide are updated details on Star measures, including HEDIS, HOS, CAHPS and Patient Safety, as defined by the CMS. You will find measure specifications, evidence-based best practices and coding guidelines. We also highlight the latest Humana resources to help your practice share pertinent data and access actionable reporting to drive quality improvement.

In addition to this guide, we provide the following resources:
- Your dedicated Humana representative is available to collaborate with your team and provide tools to identify patients eligible for Star and other quality measures.
- You can reach out to us with Star-specific questions at AskStars@humana.com.
- You can subscribe to our newsletter and stay in the know with the latest Star news, resources and administrative information at Huma.na/HPNStars.

Again, we are so appreciative of the high-quality care you provide and thank you for partnering in this program. Together, we are advancing health outcomes and shaping a healthier future for the communities we serve.

Sincerely,

Ryan Heyborne, M.D., MBA, FACEP, CPC
National Medical Director, Stars and Risk Adjustment

Keywords to understand this guide

Bonus year (BY)
Bonus year is the year in which CMS pays bonuses for currently enrolled members based on the prior calendar year's rating.

CAHPS
Consumer Assessment of Healthcare Providers and Systems (conducted on behalf of CMS) is a survey that assesses consumers' experiences with the quality of healthcare and plan services, and is focused on MA and prescription drug plans.

CMS
Centers for Medicare & Medicaid Services

Cut points/thresholds
Thresholds are percentage ranges, also referred to as cut points, used to determine the Star level of a measure based on its pass rate.

Exclusions
Exclusions are the CMS-determined criteria that exempt a Medicare Advantage member or an event from being included when determining the pass rate of a measure.

HEDIS
Healthcare Effectiveness Data Information Set is a registered trademark of the National Committee for Quality Assurance (NCQA).

HOS
Health Outcomes Survey is an annually reported outcome survey conducted on behalf of CMS.

IRE
Independent Review Entity, currently Maximus

Measure year (MY)
The period of time when patients are receiving their screenings, filling prescriptions and responding to surveys; information regarding this activity is exchanged with CMS or the IRE.

NCQA
National Committee for Quality Assurance

Patient Safety
This operational category assesses quality and performance of drug plan services; the PQA oversees the Patient Safety category.

PQA
Pharmacy Quality Alliance

Weights
The values assigned to measure types to indicate their impact on the overall or summary Star Rating of a plan.

How to use this guide

This guide is not meant to be read cover to cover. Sections have been broken out and linked throughout so users can easily jump to the section or page needed.

Buttons redirect to Coding and Threshold pages. Those pages also can return users to the original measure page.

Some pages will include links to additional relevant materials.

The Home icon on every page will return the user to the contents page.

Pages with this box will redirect to more information on supplemental data.

Supplemental data

The intent of supplemental data is to provide additional clinical information that may not be captured in claims data, making it instrumental in improving patient outcomes and helping to provide a more holistic view of a patient's care needs. The data is a supplement to claims and encounters that assists in calculating HEDIS measure compliance for Humana members.

Data accuracy and transparency
- Supplemental data provides the ability to send a broader set of codes and clinical content with additional context and detail, eliminating the possibility of omission in auditing and future specification changes impacting compliance.
- Collected HEDIS data verified by certified auditors is sent to accrediting entities, such as NCQA, CMS and state-based health organizations, to help improve the standard of care for clinical performance. For more information, please visit www.ncqa.org/hedis/data-submission.

Recognizing that claims can be imperfect, supplemental data can be used to complement claims and account for non-payable services such as:
- Corrections to previously submitted coding
- Compliance activities occurring prior to the current measurement period
- Multiple member engagements required for outcome measures
- Information regarding other provider's care or prior plan activities

Star score impact
Star scores are enhanced by the addition of any missing or relevant data through supplemental data. In MY24, 42% of Humana's overall Star measure compliance was attributed to supplemental data.

Once established, a data feed automates the regular collection and submission of HEDIS measure data with up to 15 measures in scope.

Gap closure methods to remember

1 **Claims and encounters**
Always the most effective method of gap closure. Accurate and comprehensive coding is critical. This method will not capture information that occurred prior to Humana membership.

2 **Standard supplemental**
Can be used when coding is not complete or available. Once properly implemented, this method doesn't require auditing. It can be used to capture data prior to Humana membership.

3 **Non-standard supplemental**
Used to collect missing data not received via other structured methods. While easy for providers to extract, this method requires a manual data entry that must be audited. It can be used to capture data prior to Humana membership.

Measure	BCS-E	COL-E	KED	GSD	CBP	EED	OMW	TRC–MRP	TRC–NIA	TRC–PED	TRC–RDI	FMC	COA–MDR	COA–FSA
Claim/encounter	X	X	X	X	X	X	X	X		X		X	X	X
Compass EAF/MRU	X	X	X	X	X	X	X	X		X		X	X	X
Availity CQV	X	X	X	X	X	X	X						X	X
Medical record submission	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EAF form	X	X	X	X	X	X	X	X		X		X	X	X

Tools you can use

There are several ways to share clinical data with Humana based on a provider's workflow, capacity and member panel. The following are the most common ways to submit supplemental data. Reach out to your Humana representative to learn more.

Population Insights Compass
Humana's Population Insights Compass is a population health management platform used to share pertinent and timely data with providers, fostering collaboration between payers, providers and patients to improve health and cost outcomes. Based on the type of care opportunity presented, supplemental data can be submitted through Humana's portal via the Quality/Stars Measure Detail report. This data is processed and reviewed, and a status indicator is shared on whether the care opportunity was closed based on the records submitted.
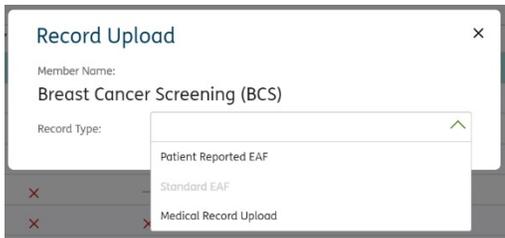
Icon	Description
+	Indicates the measure is available for attestation
⬆	Indicates documentation has been submitted for the displayed measure
🕐	Indicates documentation is pending validation
✔	Indicates documentation was validated and the measure is now compliant
✖	Indicates documentation did not meet the requirements and the measure remains noncompliant
—	Indicates the displayed measure is not eligible for attestation

For more information on how to use the Electronic Attestation Form (EAF) and medical record upload:
• Population Insights Compass
• Medical Record Upload Checklist

Availity
Availity® is a multi-payer digital application that is used to view and respond to health plan requests for clinical data on patients. Within the provider portal called Availity Essentials™, all providers and their clinical teams can access critical patient data in the Clinical Quality Validation (CQV), Risk Condition Validation (RCV) and Primary Care Provider Notification (PCPN) tools at no cost. These tools assist in the sharing of care opportunities and service or condition documentation. Nonstandard supplemental data, in the form of an attestation, and medical records are both submitted through Availity and are processed by Humana in order to close open care opportunities and validate risk conditions. For more information about Availity, go to Availity Essentials.

Submitting records manually
Although Humana has several platforms and tools to leverage for supplemental data, Humana does accept other types of submissions, including:
• Fax and physical mail
• Electronic upload via Humana's secure provider upload portal

Learn more about these methods here.

> ### What is an EAF?
> The Electronic Attestation Form is a listing of patients with open HEDIS measure opportunities. Physicians or physician office staff may complete the form with clinical service details from the patient record and return it to Humana to document completed HEDIS measure requirements. Learn more about timeline documentation here.

Social risk factors (SRF)

CMS has indicated that the Health Equity Index (HEI), which was to be renamed Equitable Health Outcomes for All (EHO4All), is discontinued for MY2026. It will be replaced by the CMS Stars Reward Factor. However, the CMS changes do not change the value in understanding patient social risk factors (SRF) or having more comprehensive strategies to help these individuals overcome barriers of receiving care. Humana will continue to include indicators of SRF in reporting.

CMS defines SRF as "factors related to health outcomes that are evident before care is provided, are not consequences of the quality of care, and are not easily modified by healthcare providers."[1,2]
• Dual-eligible for Medicaid and Medicare (full or partial)
• Disabled
• Low Income Subsidy (LIS)

Humana provides resources that can support the care of and conversations with SRF patients.
• There are many standardized, validated health-related social needs (HRSN) screening tools available, such as the Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool, built by CMS. Some electronic health records (EHR) have enhancements that integrate the HRSN screening tool as an assessment.
• HEDIS Social Needs Screening and Intervention flyer.
• The Humana Community Navigator allows providers to connect to utility services, food resources, housing support, transportation programs and more.
• For 211 helpline for community information and referrals, dial 211 or visit www.211.org.

1. Social Risk Factors: Definitions and Data, Accounting for Social Risk Factors in Medicare Payment, the National Academies Press, https://nap.nationalacademies.org/read/23635/chapter/4
2. https://www.aspe.hhs.gov/sites/default/files/migrated_legacy_files/171041/ASPESESRTCfull.pdf

Telehealth guidance

Now more than ever, telehealth options make it possible for patients, provider offices and health plans to remain committed to quality healthcare. The increased role of telehealth means there is a need for more guidance in measure reporting. Telehealth services include:
• Synchronous: real-time audio/video
• Audio-only: telephone visits
• Asynchronous: e-visits, virtual check-ins
Note: All require proper documentation and Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System codes per NCQA specs.

General guidance
• Telehealth encounters can satisfy or discuss measures only if measure logic explicitly allows.
• Documentation must include:
   o Date and result of screening/test
   o Diagnosis codes for exclusions
   o Provider credentials where required
• **Patient-reported data is accepted for some measures** (e.g., blood pressure readings, A1c results) if documented in the patient's medical record.

Measure exclusions via telehealth
In addition to measures that can be completed via telehealth, it should be noted that some exclusions can be reported with telehealth, including:
• Advanced illness and frailty
• Hospice and palliative care
• End-stage renal disease (ESRD), pregnancy and certain cancers
Note: Must include valid diagnosis and encounter codes.

Star measures

Measure	Notes/requirements
Breast Cancer Screening (BCS-E)	Patient-reported screening allowed with documentation of last mammogram date.
Care for Older Adults (COA)	Telehealth encounters count for the required components (Medication Review, Functional Status Assessment) if performed by a qualified provider and documented.
Colorectal Cancer Screening (COL-E)	Patient-reported screening allowed.
Controlling High Blood Pressure (CBP)	Blood pressure readings can be captured during telehealth or self-reported if taken with a digital device. The hypertension diagnosis and/or the blood pressure reading can take place during a telehealth visit. Only one of the two eligible visits can be telehealth.
Eye Exam for Patients With Diabetes (EED)	Must be performed by eye care professional or AI reading center. Results are not required but a documented negative result will remove the patient from the denominator in the following year.
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	The provider must conduct the telehealth visit within the specified time frame. Patient-reported visits are not sufficient for this measure.
Glycemic Status Assessment for Patients With Diabetes (GSD)	Glucose readings can be captured during telehealth or self-reported if taken with a digital device.

Thresholds and cut points

What are thresholds and cut points?
CMS defines cut points, also known as thresholds, as measurement ranges that determine Star Ratings. Thresholds are established to determine performance based on the percentage of compliant patients to achieve a certain Star level. Thresholds are established by CMS for each year and are updated to reflect significant changes in industry performance and distribution of scores.

Star Rating Program evolution
Recent changes to the Star Rating Program, which is designed to promote continuous quality improvement, have made it harder for plans to achieve 4- and 5-star ratings. As outliers are removed, the thresholds are higher as seen over the last few years of program results.[1] Our goal is to provide the highest level of care and service to the MA members enrolled in Humana plans.

Humana strives to support a different kind of healthcare for Medicare members by setting new and higher targets for performance improvement that bridge the gap between the last CMS published thresholds and current performance requirements. Humana incorporates historical CMS Star data, internal performance data and industry data into our analytics to project future thresholds for the measures within the Star Rating Program. Additional analysis identifies the provider thresholds required to compliment Humana's improvement initiatives and meet overall performance objectives.

How are thresholds calculated?
Each measure has its own specific thresholds based on compliance rates and informed by CMS requirements. The Humana MY26 thresholds will be the basis for provider performance and incentives in 2026. These thresholds will be utilized in our reporting and will be available in Compass with MY26 Star reporting. The Patient Experience (PE) thresholds represented are created by Humana, driven by Humana's PE survey.
- Humana's PE survey is influenced by CAHPS and HOS.
- The survey questions focus on a different level of experience than CAHPS and HOS and are specific to individual visits rather than specific time frames of care.

More detail around Star-level thresholds is available here.

How are thresholds shown in reporting you receive from Humana?
Similar to the Star Rating Program cycle, thresholds become available on an annual basis and are integrated into Humana's reporting as they become available. It is important to note that in addition to MY there is also mention of BY, which refers to the health plan payment year rather than the provider payment year in the event of an incentive program. Based on the time of year, Humana reporting will show MY performance data and finalized thresholds.

There are two key milestones for data updates:
1. **April:** MY data flips from the previous year to the current year. The current MY that has been added will not have a threshold available because the newest BY threshold will not be available until October. Only the prior BY threshold can be viewed and may assist in directional planning and performance assessment.
2. **October:** CMS releases Star Rating results prior to the Annual Election Period (AEP), however, the thresholds will not be used in Humana's provider performance evalation. Humana's prior released thresholds will remain relevant Star reporting.

1. Centers for Medicare & Medicaid Services. (Oct. 10, 2024). 2025 Medicare Advantage and Part D Star Ratings. CMS Newsroom Fact Sheet. Retrieved from www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings

Annual Wellness Visit

Annual Wellness Visits are more than a yearly check-in—they're a key driver toward better quality outcomes and a stronger patient experience. While Annual Wellness Visits do not directly satisfy Star Ratings measures, they play a vital role in influencing outcomes. Internal studies have shown that patient measure compliance is highest among patients who have had an Annual Wellness Visit or Annual Preventive Physical Exam. It takes 10 or more office visits with a PCP to achieve similar measure compliance as one Annual Preventive Physical Exam.

Benefits of Annual Wellness Visits

Completing an Annual Wellness Visit allows providers to identify care opportunities for their patients, improving the patient experience and provider-patient relationship. Providers can appropriately refer and assist in scheduling additional appointments to address patient needs, whether those are related to condition management, preventive screenings, risk assessments, medication adherence, immunizations or monitoring physical health.

Impact on patient experience

The Annual Wellness Visit serves as a chance to build trust and improve how patients feel about their care. Here's why it matters:

Creates a personalized care plan

Patients appreciate when their care feels tailored to their needs, helping them feel supported and understood.

Strengthens communication and engagement

A dedicated visit focused on prevention gives providers time to listen, answer questions and set goals. This interaction can significantly improve how patients rate provider communication and their overall experience.

Promotes confidence and peace of mind

By reviewing medications, future screenings and lifestyle recommendations, patients leave with a clear roadmap for their health—reducing uncertainty and increasing satisfaction.

Supports whole-person care

Addressing physical, mental and functional health during Annual Wellness Visits demonstrates a commitment to the patient's overall well-being, which can resonate strongly in patient surveys.

For additional topics in the "Making It Easier for Physicians and Other Healthcare Providers" series, please visit: **Humana.com/MakingItEasier**

Health Risk Assessment (HRA)

What are HRAs and why are they important?

The Health Risk Assessment (HRA) is a questionnaire that collects information about the medical history and lifestyle of patients on Special Needs Plans (SNP). It is designed to evaluate health risks and quality of life, allowing health plans and providers to better customize care. Benefits of completing an HRA include:

- **Informed decision-making:** Creating a clearer picture of overall health empowers patients to make lifestyle changes with the support of their provider(s) and health plan.[1]
- **Early detection**: Identifying potential health issues before they become serious allows for early intervention.
- **Maximizing benefits**: Ensuring patients are using plan benefits and programs at no extra cost improves engagement and health outcomes.
- **Personalized care**: Connecting SNP patients to Humana care management clinicians for curated assistance can lead to 12% higher HEDIS scores and increases patients satisfaction with their healthcare experience.[2]

What are SNPs?

A SNP is a type of MA plan for patients with chronic or disabling conditions, which provide additional support in the form of programs and benefits such as transportation. There are three types of SNPs: Chronic Condition SNP (C-SNP), Dual Eligible SNP (D-SNP) and Institutional SNP (I-SNP). Learn more about the plans from our Special Needs Plan Overview.

These plans were created to focus on the needs of some of your most vulnerable patients. Providers can help ensure critical care needs are met and their patients receive appropriate care coordination from their health plan by assisting patients in completing HRAs online or via phone.

Humana supports the annual completion of HRAs for SNP members through:
- Telephonic outreach
- In-person or digital point of sale coordination by sales agents prior to a member's plan going into effect
- Direct to member mailed marketing efforts
- Digital online survey via humana.com/survey
- Home health visit integration

SNPs have similar quality improvement requirements as other MA plans, and those requirements are tailored to the specific needs of the patients they serve. Health plans are held accountable for several Star measures and performance metrics regarding this population.

Measure/metric	Definition
Care for Older Adults – Functional Status Assessment (COA–FSA)	Completion of an HRA, including the assessment of activities of daily living, can satisfy this measure.
Care for Older Adults – Medication Review (COA–MDR)	HRAs do not include a medication review, however it is important that providers help facilitate a risk assessment and medication review to fully evaluate the needs of a patient.
Special Needs Plan (SNP) Care Management	Completion of an annual comprehensive HRA ensures Humana's care management team has the information needed to help address a patient's health needs and risks and partner with providers to improve health outcomes.

1. https://www.wellsource.com/health-risk-assessments
2. https://provider.humana.com/patient-care/health-programs/chronic-care-programs

Rewards from Go365

The chart below outlines activities your patients may get rewarded for when they participate in Go365.* Encourage patients to sign in to Go365.com to view the activities and reward values that align with their insurance plan.

Medicare Advantage, D-SNP and Group Medicare patients

Preventive activities

Eligible screenings may include:

- Annual Wellness Visit
- Mammogram
- Colonoscopy (45+)
- Diabetic screenings
  - Kidney urine test
  - Kidney blood test
  - Eye exam
  - Hemoglobin HbA1c test

Fitness activities

Eligible activities include completing a workout tracked via SilverSneakers®, fitness device, online or paper-based tracker (minimum 5,000 steps per day).

Other physical activities may include golfing, cycling, swimming, Zumba, yoga, strength training, etc.

Educational activities

Attend a health education or art class, participate in an athletic event, go to a social club or attend a religious gathering.

Go365 members can redeem their rewards for gift cards to help support daily living needs.

These gift cards cannot be used to purchase prescription drugs or medical services covered by Medicare, Medicaid or other federal healthcare programs; alcohol; tobacco; e-cigarettes; or firearms. These cards must not be converted to cash.

Download the Diabetic screenings flyer.

*Eligibility for some activities is based on clinical triggers. Activity and reward values vary by plan.

What is the Star Rating Program?

The Star Rating Program was created by the Centers for Medicare & Medicaid Services (CMS) to raise the quality of care for MA enrollees and to reduce federal healthcare expenditures. The program holds health plans accountable for the care provided to MA members by physicians, hospitals and other healthcare providers.

Stronger relationships are created among plan administrators, physicians and patients.

Provider benefits
- Improved communications with patients and health plans
- Stronger support for managing chronic conditions
- Greater focus on preventive medicine and early disease detection
- Increased patient safety awareness
- Opportunities to improve patient outcomes
- Additional compensation for value-based relationships that meet Star performance goals

Patient benefits
- Improved relations with physicians
- Greater care coordination
- Greater health plan focus on access to care
- Increased levels of customer service
- Greater focus on preventive services for early detection and healthcare that matches individual needs
- Improved health and lower costs

Humana's goal
Support providers by identifying care opportunities that will improve the health outcomes and care experience of patients.

Provider-facing Humana consultants
- Reporting on health status of eligible patients
- Assistance with claims and error correction

Resources for CMS requirements
- Training
- Quality Measure Guide
- Flyers

Patient outreach to improve engagement and health outcomes
- Telephone campaigns
- Postcards
- Surveys

Assistance with electronic data collection
- Electronic health record (EHR) or electronic medical record (EMR)
- Electronic Attestation Form (EAF)
- Stars Quality Report (SQR)

How is success measured?

Humana
Evaluates member care and awards incentives to providers annually

CMS
Awards plan administrator scores annually based upon a four-year cycle

Documented patient care by the provider influences these categories.

Category	MY26
CAHPS: Consumer Assessment of Healthcare Providers and Systems	23%
HOS: Health Outcomes Survey	12%
HEDIS: Healthcare Effectiveness Data and Information Set	25%
Patient Safety	8%
IRE: Independent Review Entity	5%
CMS: Centers for Medicare & Medicaid Services	14%
Improvement	13%

Plan administrators' scores impact all categories
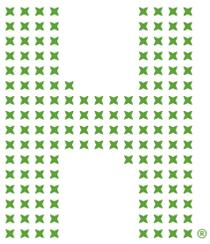
Healthcare Effectiveness Data and Information Set (HEDIS)

Developed by the NCQA, HEDIS is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans the specific areas in which a stronger focus could lead to improvements in patient health. HEDIS reporting is required by NCQA for compliance and accreditation. HEDIS measures are created for all types of health plans—commercial, Medicaid and Medicare. Listed here are those chosen by CMS to include in the Medicare Star Rating Program as they align with their domains of care for Medicare beneficiaries. The HEDIS measures are targeted specifically to patient activities that will lead to improvements in patient health.

Changes to HEDIS measures

Statin Therapy for Patients With Cardiovascular Disease (SPC)
- Moves from 1x measure to a display measure

HEDIS (measured January–December)	ABBR	Weight
Preventive screening		
Breast Cancer Screening	BCS-E	1x
Colorectal Cancer Screening	COL-E	1x
Osteoporosis Management In Women Who Had a Fracture	OMW	1x
Care for Older Adults*		
COA – Functional Status Assessment	COA–FSA	1x
COA – Medication Review	COA–MDR	1x
Condition management		
Cardio		
Controlling High Blood Pressure	CBP	3x
Statin Therapy for Patients With Cardiovascular Disease	SPC	Display
Diabetes		
Eye Exam for Patients With Diabetes	EED	1x
Glycemic Status Assessment for Patients With Diabetes	GSD	3x
Kidney Health Evaluation for Patients With Diabetes	KED	1x
Care Coordination		
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions	FMC	1x
Plan All-Cause Readmissions	PCR	3x
Transitions of Care	TRC	1x
Notification of Inpatient Admission	TRC–NIA	**
Receipt of Discharge Information	TRC–RDI	**
Patient Engagement After Inpatient Discharge	TRC–PED	**
Medication Reconciliation Post-Discharge	TRC–MRP	**

Follow this icon in future pages to review measure thresholds.

Follow this icon in future pages to review measure coding.

 * Measures apply only to SNPs.
** The TRC score is achieved by averaging four components.

Humana

Preventive screenings

Breast Cancer Screening (BCS-E)

Breast Cancer Screening (BCS-E) MY26 | Weight = 1

Measurement period
Oct. 1, 2024–Dec. 31, 2026

Eligible population
Women ages 52*–74 during the measurement period, including those recommended for routine breast cancer screening with any of the following criteria:
- Administrative gender of female at any time in the patient's history
- Sex assigned at birth of female at any time in the patient's history
- Sex parameter for clinical use of female during the measurement period

Service required
Mammogram(s) performed on or between Oct. 1 two years prior to the measurement period and Dec. 31 of the measurement period (27-month period)

Mammogram or mastectomy status must be documented in the medical record:
- Results are not required
- Documentation in the medical record must include:
  o Type and date of most recent mammogram with as much specificity as possible (minimum of month and year) or mastectomy status and date of procedure (minimum is year performed)

The following types and methods of mammograms can be used to satisfy this measure: all types of mammograms including screening, diagnostic, film, digital, digital breast tomosynthesis.

Note: Biopsies, breast ultrasounds and MRIs are not compliant.

Exclusions
At any time during the patient's history:
- Patients who had a bilateral mastectomy (double mastectomy) at the same time or two unilateral mastectomies removing both breasts at different times
- Patients who had gender-affirming chest surgery

During the measurement period:
- Patients in hospice, using hospice services or receiving palliative care
- Patients who died
- Patients 66 years of age and older living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older with frailty and advanced illness

Measure best practices
- Obtain and review past medical records for new patients, including mammogram history.
- Ensure office processes include key tests and exams into the patient record, and confirm the look-back period is two years.
- When referring/ordering mammograms, ensure office practices have a process for appropriate follow-up and documentation of test. Document date of service (at minimum month and year) of the most recent mammogram in the medical record.
- Document mastectomy status and date of service (minimum year performed) in the medical record. Supplemental data can be used to communicate historical evidence of testing and mastectomies completed.
- Ask specifically about mammogram history.
- Schedule a mammogram prior to the Annual Wellness Visit.

* Women must be 52 years of age in the measurement period. However, since the measure has a "look-back" period of two years, the patient may have been 50 years of age at the time of the screening.

Preventive screenings

Colorectal Cancer Screening (COL-E)

Colorectal Cancer Screening (COL-E) MY26 | Weight = 1

Measurement period
Jan. 1–Dec. 31

Eligible population
45–75 years of age during the measurement period

Service required
All eligible patients must have an appropriate colorectal cancer screening that encompasses the measurement period and is documented in the medical record.
- Type and date of screening must be reported in the medical record.
- Submitted records must include most recent colorectal screening with date of service (minimum of month and year) or colorectal cancer and/or colectomy status date of procedure (minimum is year performed).
- Records must be reported via Electronic Clinical Data Systems (ECDS), which is a method of reporting clinical data electronically.
- Providers do not need to change their documentation or claim/encounter processes.

Appropriate screenings include:
- Fecal occult blood test (FOBT)
- Guaiac FOBT or immunochemical FOBT (FIT)
- Stool DNA (sDNA) with FIT test (two years before the measurement period and during the measurement period)
- Flexible sigmoidoscopy or computed tomography (CT) colonography (four years before the measurement period and during the measurement period)
- Colonoscopy (nine years before the measurement period and during the measurement period)

Note: The FOBT and FOBT FIT are not compliant for a calendar year but only for the year in which they are performed. Example: FOBT performed on Dec. 15, 2026, is only compliant until Dec. 31, 2026.

Exclusions
At any time during the patient's history:
- Patients with a history of colorectal cancer and/or total colectomy

During the measurement period:
- Patients in hospice, using hospice services or receiving palliative care
- Patients who died
- Patients 66 years of age and older living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older with frailty and advanced illness
- Patients who were dispensed dementia medications

Measure best practices
- Obtain and review new patients' past 10 years of medical records to determine any colon cancer screenings they may have had in that time period.
- Have a process for appropriate follow-up and documentation of a test when ordering/referring patients for colon cancer screenings.
- Document date of service (at minimum month and year) of the most recent colon cancer screening in the medical record.
- Ask specific questions about colon cancer screening history.
- Schedule a colorectal cancer screening or order at-home test kit. Doing so at the beginning of the year, in conjunction with an Annual Wellness Visit will address the opportunity early and allow conversation regarding results.

Preventive screenings

Osteoporosis Management In Women Who Had a Fracture (OMW)

Osteoporosis Management In Women Who Had a Fracture (OMW) MY26 | Weight = 1

Measurement period
July 1, 2025–June 30, 2026

Eligible population
Women 67–85 years of age during the measurement period who suffered a fracture

Service required
Within 180 days (six months) of either the fracture date (or of the discharge date if hospitalized for fracture), all eligible women must have either:
- A bone mineral density (BMD) test in any setting **or**
- Osteoporosis medication or osteoporosis therapy

Exclusions
Patients are removed from eligibility with evidence of the following:
- Fractures to the face, skull, fingers or toes
- BMD test within 24 months prior to the fracture
- Dispensed or active prescription to treat or prevent osteoporosis within the 12 months prior to the fracture
- Osteoporosis therapy within 12 months prior to the fracture

During the measurement period:
- Patients in hospice, using hospice services or receiving palliative care
- Patients who died
- Patients 67 years of age and older living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 67–80 years of age with both frailty and advanced illness
- Patients 81 years of age with frailty
- Patients who were dispensed dementia medications

Note: Supplemental data is appropriate for evidence of compliance. However, it cannot be submitted to support an exclusion. It cannot be used to report a completed BMD test prior to the fracture date. Only claims can be accepted in this case.

Measure best practices
- When reviewing daily EHR reports, take note of women who may have been to the ED or admitted to the hospital for a fracture.
- Ask patients to call their primary care physician if they've sustained a fracture.
- Discuss with the patient the option to prescribe FDA-approved medications and discuss lifestyle changes to treat or prevent osteoporosis (such as exercise, vitamins, mineral supplements) or for them to complete a BMD test.
- For new patients, obtain medical records and look for evidence of a BMD test 24 months prior to the fracture or evidence of conditions that would exclude a patient from the measure.
- When documenting medication or a test, ensure proper documentation of the specifics in the medical record (test date and finding, medication name, dispense date, dosage/strength and administration route) and submit as a claim or supplemental data.

Condition management – cardio

Controlling High Blood Pressure (CBP)

Controlling High Blood Pressure (CBP) MY26 | Weight = 3

Measurement period
Jan. 1–Dec. 31

Eligible population
18–85 years of age who have been diagnosed with hypertension twice. Eligibility for this measure depends upon a diagnosis of hypertension following two outpatient visits—both with a diagnosis of hypertension. There must be two different dates of service.

Service required
The final reported blood pressure reading of the measurement period must be documented and must be less than 140/90 and recorded in the medical record.

Note: If there are multiple BPs on the same date of service, use the lowest systolic and diastolic BP on that date as the representative BP.

Patient-reported blood pressure readings are accepted.

Exclusions
During the measurement period:
- Patients with a diagnosis of end-stage renal disease (ESRD)
- Patients with a diagnosis of pregnancy
- Patients in hospice, using hospice services or receiving palliative care
- Patients who died
- Patients 66 years of age and older living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66–80 years of age and older with both frailty and advanced illness
- Patients 81 years of age with frailty
- Patients who were dispensed dementia medications

Measure best practices
- In-office measurement: Ensure accurate measurement by implementing and maintaining office practices such as:
  o Providing at least five minutes of quiet rest prior to reading
  o Using correct cuff size
  o Retaking in same visit if systolic BP >=140 mm Hg and/or diastolic BP >= 90 mm Hg
- Virtual measurement: Coach the patient on best practices, such as sitting up straight with feet on floor; not taking reading over clothing; and avoiding smoking and caffeine prior to the reading
- Follow-up: For patients out-of-range (140/90 or greater):
  o Assess for adherence barriers; consider simplified medication options, such as 90/100 day fills, mail order and combination pills
- Review and discuss medication options: Clinical guidelines generally recommend medication adjustments including increasing dosages and/or adding medications.
  o Recommend at-home monitoring of blood pressure and provide supporting materials
  o Consider follow-up in approximately a month; offer virtual options where appropriate/convenient

Condition management – cardio

Statin Therapy for Patients With Cardiovascular Disease (SPC-E)

Statin Therapy for Patients With Cardiovascular Disease (SPC) MY26 | Weight = Display

Measurement period
Jan. 1–Dec. 31

Eligible population
21–75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD). Patients will be part of the numerator by event or diagnosis.

Event (during prior year):
- Inpatient discharges with a myocardial infarction (MI)
- Visits in any setting for coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI) or any other revascularization procedure

Diagnosis:
- Claims submitted during the current and prior measurement period:
  - o Only outpatient visits can include telehealth
  - o With a diagnosis of ischemic vascular disease (IVD)
  - o In an inpatient or outpatient setting
  - o At least one acute inpatient discharge

Service required
Must be prescribed one fill of high- or moderate-intensity statin medication during the measurement period.
- There are no exclusions based upon intolerance or allergies.
- Document in medical record the statin name, date it was dispensed, dosage/strength and administration route when given to the patient in a clinical setting.
- This documentation can then be submitted as supplemental data.

Exclusions
Some SPC exclusions will consider event/diagnosis from the measurement period. During the measurement period or prior year:
- Pregnancy or in vitro fertilization (IVF)
- Dispensed clomiphene medication\end-stage renal disease (ESRD)
- Cirrhosis
- Myalgia, myositis, myopathy or rhabdomyolysis

During the measurement period:
- Patients in hospice, using hospice services or receiving palliative care
- Patients who died
- Patients with myalgia or rhabdomyolysis caused by a statin anytime during the patient's history (reaction does not have to occur in the current year but must be documented yearly)

Measure best practices
- Ensure a comprehensive review of new to practice/new to Medicare patients who have been diagnosed with atherosclerotic cardiovascular disease to evaluate their current statin therapy.
- Ensure the practice has a process to conduct reviews of patients' records when diagnosed with atherosclerotic cardiovascular disease, especially those who are also receiving care from specialists.
- Ensure there is a process for evaluating current statin therapy and ensuring the patient is on a high- to moderate-dose therapy.
- As patients are beginning statin therapy, discuss common side effects and ask them to connect with the healthcare provider before discontinuing.

Condition management – diabetes

Eye Exam for Patients With Diabetes (EED)

Eye Exam for Patients With Diabetes (EED) MY26 | Weight = 1

Measurement period
Jan. 1–Dec. 31

Eligible population
18–75 years of age with type 1 or type 2 diabetes

Service required
- Dilated/retinal eye exam performed by an eye care professional (optometrist or ophthalmologist) during the current measurement period and noted in the patient's record.
- Document the date of most recent diabetic eye exam with results and name the eye care provider in the patient's medical record. If possible, retain the most recent eye exam record in the patient's medical record.
- If the patient was appropriately tested in the year prior to the measurement year and the result was negative for diabetic retinopathy, the patient should not be in the denominator for the current year. If they are, submit coding and exam records.

Exclusions
During the measurement period or the year prior:
- Did not have a diagnosis of diabetes, in any setting and did have a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting

Anytime in patient's history, including measurement period:
- Bilateral eye enucleation
- Two unilateral eye enucleations 14 days apart or a left and right unilateral eye enucleation on the same or different dates of service

During the measurement period:
- Patients in hospice, using hospice services or receiving palliative care
- Patients who died
- Patients 66 years of age and older living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older with frailty and advanced illness.
- Patients who were dispensed dementia medication

Note: Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and do not require an exam.

Measure best practices
- Ask specifically about retinal eye exam history.
- Schedule an appropriate eye exam prior to Annual Wellness Visit.
- Ensure the practice has a process to conduct reviews of patients' records when diagnosed with diabetes and those who are new to the practice or Medicare, especially those who are also receiving care from specialists, and submit records that document evidence of completed tests in the measurement period through supplemental data.
- Ensure processes exist when referring patients to eye specialists to follow up with specialists or patients to obtain records and result of the exam.
- Submit claims with appropriate CPT Category II codes to indicate the result of the exam when performing the exam in the office (via fundus photography) with results interpreted by an appropriate eye care professional, at a reading center with a retinal specialist serving as medical director, or a system with artificial intelligence.
- Submit supplemental data when a claim is not submitted that includes the record and result of the exam including place of service, provider and result. (Patients whose exams have negative results showing no evidence of retinopathy will be compliant with this measure for the year in which the screening occurred and the following measurement period.)

Condition management – diabetes

Glycemic Status Assessment for Patients With Diabetes (GSD)

Glycemic Status Assessment for Patients With Diabetes (GSD) MY26 | Weight = 3

Measurement period
Jan. 1–Dec. 31

Eligible population
18–75 years of age who have been diagnosed (twice) with type 1 or 2 diabetes

Service required
Glycemic status assessment must be taken in the measurement period. The last recorded reading of the measurement period is the reading of record for compliance. Compliance is achieved when the glucose is 9% or less.

Glycemic status assessment can be either:
• Hemoglobin A1c (HbA1c)
• Glucose management indicator (GMI). For GMI, a date range is required.

HbA1c testing is still required for diagnosed diabetics who do not use a continuous glucose monitoring device.
• If multiple glycemic status assessments (HbA1c or GMI review) are recorded for a single date, use the lowest result.

Exclusions
During the measurement period:
• Patients who did not have a diagnosis of diabetes, in any setting, during the measurement period or the year prior to the measurement period and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting
• Patients in hospice, using hospice services or receiving palliative care
• Patients who died
• Patients 66 years of age and older living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
• Patients 66 years of age and older with frailty and advanced illness

Measure best practices
• Ensure processes exist to regularly test HbA1c at patient visits during the year.
• Ensure the practice has a process to conduct reviews of patients' records when diagnosed with diabetes and those who are new to the practice or Medicare, especially those who are also receiving care from specialists, and submit records that document evidence of completed tests in the measurement period through supplemental data.
• Verify that provider documentation and coding practices include submitting the appropriate CPT Category II codes or Logical Observation Identifier Names and Codes (LOINC) codes with claims and encounters. Without these codes, the gap will not be closed.
• Have processes to monitor diabetic patients who are not getting in for regular exams and have them get in-office or in-lab tests completed.
• For patients who are not able/willing to go to an office or lab, verify they have received a test kit from Humana and encourage completion of that test kit.
• Execute processes to monitor patients with greater than 9% HbA1c levels and encourage the appropriate follow-ups and retesting.
• When documenting in a medical record, include the date the HbA1c or GMI test was performed and the results of the test. The medical record must include the date range used to derive the values, and the finding must be in the format of a value (e.g., 7%). Missing values or results recorded in a format other than the above example will not be compliant.

Condition management – diabetes

Kidney Health Evaluation for Patients With Diabetes (KED)

Kidney Health Evaluation for Patients With Diabetes (KED) MY26 | Weight = 1

Measurement period
Jan. 1–Dec. 31

Eligible population
18–85 years of age with type 1 or 2 diabetes

Service required
Diabetic patients must have an annual kidney health evaluation to assess kidney function. The evaluation is a kidney health evaluation that must include both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) within the measurement period.
- Two urine tests may replace a ratio test:
  - o One must contain a quantitative urine albumin test
  - o One must contain a urine creatinine test
  - o The two urine tests must be performed within four days of one another.

Both eGFR and uACR results are needed for compliance. Both should be submitted within the measure year.

Supplemental data can be used to close a gap in the current year or to report a required exclusion (see exclusion list).

Exclusions

During the measurement period or the year prior:
- Patients who did not have a diagnosis of diabetes and did have a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes.

During the measurement period:
- Patients in hospice, using hospice services or receiving palliative care
- Patients who died
- Patients with ESRD or dialysis
- Patients 66 years of age and older living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66–80 years of age with both frailty and advanced illness
- Patients 81 years of age and older with frailty

Measure best practices
- Review diabetes services needed at each office visit.
- Refer patients for both an estimated eGFR and a urine albumin creatinine ratio (uACR) during the measurement year if not able to complete in office.
- Ensure the practice has a process to conduct reviews of patients' records when diagnosed with diabetes, and those who are new to the practice or Medicare, especially those who are also receiving care from specialists.
- Submit records that document evidence of completed tests in the measurement year through supplemental data.
- At least once a year, ensure both tests are conducted for this measure regardless of other semi-quantitative methods that might be used.
- Ensure claims and encounters are submitted timely and, if no claim is submitted, provide evidence and results of tests via supplemental data records. Ensure tests meet the appropriate time frame for measure compliance.

Care for Older Adults – Functional Status Assessment (COA–FSA)

Care for Older Adults – Functional Status Assessment (COA–FSA) MY26 | Weight = 1

Measurement period
Jan. 1–Dec. 31

Eligible population
66 years of age or older by end of the measurement period who had documentation in the medical record of at least one completed functional status assessment in the current measurement period. COA measures apply to Special Needs Plan (SNP) patients only.

Service required
At least one functional status assessment during the measurement period. Documentation in the medical record must include the following:
- Evidence of a complete functional status assessment and the date when it was performed
- Notations for a complete functional status assessment must include one of the following:
  - o Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using the toilet and walking
  - o Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications and handling finances
  - o Result of assessment using a standardized functional status assessment tool

Note: A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement period. Do not include comprehensive functional status assessments performed in an acute inpatient setting.

Exclusions
During the measurement period:
- Patients in hospice or using hospice services
- Patients who died

Measure best practices
- Perform a comprehensive functional status assessment with older patients as a part of the Annual Wellness Visit or physical exam. These can be conducted via all telehealth methods including audio-only telephone visit, e-visit and virtual check-in.
- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data.

Care for Older Adults – Medication Review (COA–MDR)

Care for Older Adults – Medication Review (COA–MDR) MY26 | Weight = 1

Measurement period
Jan. 1–Dec. 31

Eligible population
66 years of age or older by end of the measurement period. COA measures apply to Special Needs Plan (SNP) patients only.

Service required
• Clinician review and reconciliation of medications, including prescriptions, over the counter and herbal or supplemental therapies.
• Complete COA assessment form annually with eligible patients.

Both of these services must occur:
1. Documentation of a dated and signed medication review conducted by a healthcare provider with prescribing authority or a clinical pharmacist
2. A medication list present in the same medical record with a dated notation or transitional care management services

Notes:
• Do not include medication lists or medication reviews performed in an inpatient setting.
• If the patient is not taking medication, this must be notated in the patient medical record.
• There is no "result" that needs to be submitted, and a note in the medical record is sufficient.

Exclusions
During the measurement period:
• Patients in hospice or using hospice services
• Patients who died

Measure best practices
• Complete medication review annually.
• Ensure clinician review and reconciliation of medications. Documentation of the review must include the date of the review and medication list codes from the same date of service for compliance.
• Complete reviews by either in-person visit or via telehealth methods, including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals. Neither an outpatient visit nor patient presence are required.
• Complete the COA assessment form annually with eligible patients. The completed form can be submitted via supplemental data.
• Follow the necessary steps to close the gap for an initial qualifying event, even if there is a second qualifying event in the same measurement period.

Care coordination

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) MY26 | Weight = 1

Measurement period
Jan. 1–Dec. 24*

Applicable data collection method
Administrative only

Eligible population
18 years of age and older 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.

Service required
Patients must have a follow-up encounter or service within seven days after ED visit (eight days total including day of). Follow-up can take place in any of the following ways or facilities:
- An outpatient, telephone or telehealth visit, including those for behavioral health (BH) services in a clinic, at home or at a community mental health center
- An intensive outpatient encounter or partial hospitalization stay, including observation visits
- Transitional care management services
- A case management visit
- Complex care management services
- Monitored electroconvulsive therapy in an outpatient, ambulatory surgical, community mental health or partial hospitalization setting
- An e-visit or virtual check-in
- A substance use disorder service
- A domiciliary or rest home visit

Exclusions
During the measurement period:
- Patients in hospice, using hospice services or receiving palliative care
- Patients who died
- Any ED visit that results in an inpatient admission on the day of, or within seven days following, the ED visit
- ED visits occurring within the same eight-day period. In this situation, only the first visit is eligible.

Measure best practices
- Implement processes with hospitals to facilitate sharing of ED disposition information.
- Work with hospitals to obtain access to electronic health records.
- Obtain census information from EDs/facilities whenever possible.
- Educate and encourage patients to notify their primary care physician (PCP), following an ED visit for additional guidance.
- Allow scheduling flexibility to accommodate a follow-up visit within seven days of the ED visit, including telehealth visits.
- Ensure via claim or documentation in the patient record there was appropriate follow-up with the patient via in-office or telehealth appointment.

Note: FMC is an event-based measure. For each ED visit, there will be a care opportunity that needs to be addressed.

* Odd ending date to allow for seven-day follow-up period

Care coordination

Plan All-Cause Readmissions (PCR)

Plan All-Cause Readmissions (PCR) MY26 | Weight = 3

Measurement period
Jan. 1–Dec. 1

Eligible population
18 years of age and older who have had an acute inpatient or observation stay.

Service required
The needed action is to avoid readmission within 30 days. The goal is that practices should follow the identified protocols of the TRC measures. Practices can identify patients who have been discharged from acute facilities using daily discharge reporting. Reach out to these patients to schedule follow-up care, and medication reconciliation, which could reduce the risk of readmission. PCR is a risk-adjusted measure.

Exclusions
During the measurement period:
- Stays with discharge dates of Dec. 2–31
- Patients who are pregnant
- Patients in hospice or using hospice services
- Patients who died
- Patients with four or more hospital stays (acute inpatient and observation) between Jan. 1 and Dec. 1
- For stays that included a direct transfer, excluding original admission's discharge date. Only the last discharge should be considered.

Note: Planned admissions for chemotherapy, rehabilitation, transplant, etc., are not included as readmissions. Rehabilitation exclusions are limited to fitting and adjustment of prosthesis and other medical devices, such as infusion pumps, neuropacemakers, etc.

Measure best practices
- Have processes to review daily discharge census.
- Have processes to accommodate scheduling appointments as close to the point of discharge as possible, ideally within seven days. If a patient cannot be seen within seven days, checking in with patient by telephone is highly encouraged.
- Have processes to conduct medication reconciliation during first post-discharge visit with the patient.
- Recommend appropriate health plan or community resources to patients to assist with any barriers to accessing resources necessary to prevent a readmission (i.e., ability to get the medications prescribed at discharge, transportation for follow-up appointments, family or community support, food services or in-home services).

The following situations are factored into risk adjustment:
- Co-morbidities, such as diabetes, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD)
- Surgeries – procedures performed prior to and during the current event
- Discharge condition – diagnoses made prior to and during the current event
- Age and gender – men have a higher risk, and risk increases with age

Care coordination

Transitions of Care (TRC)

Transitions of Care (TRC) MY26 | Weight = 1 (with four component measures)

The TRC measure assesses instances of admission and discharge information delivered to a patient's physician, as well as evaluating patient engagement provided within 30 days after an acute or nonacute discharge on or between Jan. 1 and Dec. 1 of the measurement year for patients 18 years of age and older.

The TRC measure organizes patient care and follow-up activities after a hospital admission and discharge. There are four components that contribute to the TRC score, and each requires engagement from the PCP within a certain period of time, as listed below.
• Notification of Inpatient Admission (TRC–NIA)
• Receipt of Discharge Information (TRC–RDI)
• Patient Engagement After Inpatient Discharge (TRC–PED)
• Medication Reconciliation Post-Discharge (TRC–MRP)

For all the components, take note if the patient is readmitted or transferred directly to an inpatient care setting within 30 days of discharge. In this event, use the first admission's admit date and the discharge date of the last discharge.

Exclusions
During the measurement period:
• Patients in hospice, using hospice services or receiving palliative care*
• Patients who died
• Discharges occurring after Dec. 1 of the measurement period**

Measure best practices
• Have processes in place with hospitals to facilitate sharing of admission and discharge information.
• Be aware of patients' inpatient stays and obtain timely discharge summaries.
• Review discharge summaries to ensure that the minimum required information is included.
• Have processes to accommodate scheduling appointments as close to the point of discharge as possible, ideally within seven days. If a patient cannot be seen within seven days, checking in with patients by telephone is highly encouraged.
• Ensure all notifications of admits or discharges are appropriately documented in patient charts and follow-up actions are conducted.

 * No palliative care exclusion for MRP
** Exclusion applies to RDI

Care coordination

Transitions of Care (TRC)

Notification of Inpatient Admission (TRC–NIA) MY26

Measurement period
Jan. 1–Dec. 31

Service required
• Documentation of the admission date must be noted in the patient's outpatient medical record on the day of admission or within the two following days (three days total).
• Evidence must include the date the documentation was received.

The following methods are compliant
Documentation in the patient's outpatient medical record of the admission communications:
• Between inpatient providers or staff and the PCP or ongoing care provider
• Between the emergency department (ED) and the PCP
• From a health information exchange or an automated admission, discharge and transfer (ADT) alert system
• Through a shared electronic health record (EHR) (received date is not required but must have been accessible to the PCP on the day of admission or within the two following days)
• From the patient's health plan

• There are no procedure codes that can be submitted via claims to address TRC–NIA. Information is collected via health plan medical record review only.
• If an observation stay turns into an inpatient admission, the admit notification must be documented as being received on the admit date of the observation stay or within the two following days.
• For planned admissions, documentation of a preadmission exam or advance admission notification is acceptable and:
  o Must clearly apply to the admission event and include a time frame for the planned inpatient admission
  o Is not limited to the admit date or the two following days

Note:
• Patients or family cannot report admission.
• Notification to the PCP must be given by the hospital or health plan.
• Any documentation that does not include a time frame or date stamp does not meet compliance criteria.

Receipt of Discharge Information (TRC–RDI) MY26

Measurement period
Jan. 1–Dec. 31

Service required
• Documentation of the discharge date must be noted in the patient's outpatient medical record on the day of discharge or within the two following days (three days total).
• Evidence must include a date stamp to show the date the when notice of discharge was received.

Service required
Documentation must include:
• Name and credentials of the physician or practitioner responsible for the patient's care during the inpatient stay
• Procedures or treatment provided
• Diagnoses at discharge

• Current medication list
• Testing results or documentation of pending tests or no tests pending
• Instructions for patient care post-discharge

If using a shared EHR system, evidence that the information was filed in the EHR and accessible to the patient's PCP on the day of discharge or within the two following days meets criteria. Documentation of a "received date" isn't required.

Note:
Discharge information may be included in, but is not limited to:
• A discharge summary or summary of care record
• Structured fields in the EHR

Care coordination

Transitions of Care (TRC)

Patient Engagement After Inpatient Discharge (TRC–PED) MY26

Measurement period
Jan. 1–Dec. 31

Eligible population
18 years of age and older who were discharged from an inpatient facility

Service required
- Documentation of patient engagement must take place within 30 days of discharge.
- Engagement may take place in any of the following ways:
  - o Outpatient visits, including office or home visits
  - o A telephone visit
  - o Transitional care management services
  - o A synchronous telehealth visit where real-time interaction occurred between the patient and his/her PCP with audio and video communication
  - o An e-visit or virtual check-in (asynchronous where two-way interaction, which was not real-time, occurred between the patient and the provider) such as via a patient portal
- The discharge date must be noted in the patient's outpatient medical record on the day of discharge or within the two following days (three days total).
- Evidence must include a date stamp to show when the date when the notice of discharge was received.
- If using a shared EHR system, evidence that the information was filed in the EHR and accessible to the patient's PCP on the day of discharge or within the two following days meets criteria—and "received date" isn't required.

Note: Documentation must include name and credentials of the physician or practitioner responsible for the patient's care during the inpatient stay; procedures or treatment provided; diagnoses at discharge; current medication list; testing results or documentation of pending tests or that no tests are pending; and instructions to the PCP or ongoing care provider for patient care.

Medication Reconciliation Post-Discharge (TRC–MRP) MY26

MRP calculates the annual percentage of adult patients whose medications were reconciled within 30 days of discharge from hospitalization. Medication reconciliation is defined as a review in which discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Measurement period
Jan. 1–Dec. 31

Eligible population
18 years of age and older who were discharged from an inpatient facility

Service required
Medications must be reconciled by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge up to 30 days after discharge (31 days total). However, follow up with patients as soon as possible after discharge to avoid duplication or dangerous reactions is encouraged.

- Licensed practical nurses (LPNs) and other non-licensed staff can perform the medication reconciliation, but it must be co-signed anytime in the measurement period by an approved provider.
- Medication reconciliation may be done via office, home or telehealth visit, including real-time, interactive audio/video visits and audio only.
- Medication name is required; dose, route and frequency are not but their inclusion is highly recommended.
- When patients are directly transferred to another facility, perform a reconciliation for final discharge and document all medication reconciliations with a dated notation in outpatient medical records.

Documentation in the medical record must include:
- Reference to current and discharge medications
- Evidence of medication reconciliation or that no medications were prescribed upon discharge
- National Provider Identifier (NPI) of appropriate practitioner conducting the reconciliation
- The date the service was performed
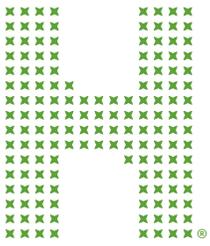
Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is an annual patient survey conducted for MA plans by a contracted CMS vendor. The goal of the survey is to assess the experiences of beneficiaries in MA plans, and the results of the survey are published in the "Medicare & You" handbook and on the Medicare website: www. medicare.gov. Nine areas of the patient survey are included in the Star measures reporting. The first six measures below directly correlate to patient experience with their physicians and other healthcare providers; the remaining three correlate to a patient's experience with their MA plan. CMS excludes enrollees who are under age 18, known to be deceased, known to reside in institutional settings or reside outside of the U.S. Additionally, CMS sample procedures do not allow for the selection of more than one enrollee per household.

CAHPS (measured March to June of following year)	ABBR	Weight
Annual Flu Vaccine	FLU	1x
Care Coordination	CC	2x
Getting Needed Care	GNC	2x
Getting Appointments and Care Quickly	GAQC	2x
Getting Needed Prescription Drugs	GNRx	2x
Overall Rating of Health Care Quality	RHCQ	2x
Customer Service	CS	2x
Overall Rating of the Health Plan	RHP	2x
Overall Rating of Drug Plan	RDP	2x

Why surveys matter

Surveys provide insight into how our members/ your patients are experiencing aspects of their care. To learn more about surveys your patients may receive, please watch the video to the right.

Patient Experience (PE) surveys

▶ 0:00 / 7:46

Click above to learn more about PE surveys.

Humana.

Annual Flu Vaccine (FLU)

Annual Flu Vaccine (FLU) MY26 | Weight = 1

Overview

Percentage of sampled Medicare enrollees who received an influenza vaccination

Patient survey question

• Have you had a flu shot since July 1 (prior year)?

Measure best practices

• Talk to patients about getting vaccinated during regularly scheduled visits during flu season.
• Consider having office staff reach out to your patients who are at a higher risk of experiencing flu complications with a reminder to be vaccinated.
• Encourage patients to take advantage of vaccination opportunities at convenient locations, such as their local pharmacies.
• During their next office visit, confirm patients were vaccinated.

For more flu details and coding, please see the annual provider flu flyer.

Care Coordination (CC)

Care Coordination (CC) MY26 | Weight = 2

Overview

Assesses how well patient care is coordinated, including whether or not doctors had the records and information they needed about patients' care and how quickly patients got their test results

Patient survey questions

- In the last six months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
  Answer choices: Yes, definitely; Yes, somewhat; No
- In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists?
  Answer choices: Never; Sometimes; Usually; Always; I do not have a personal doctor; I have not talked with my personal doctor in the last six months; My personal doctor is a specialist

Measure best practices

- When sending out pre-appointment reminders, encourage patients to bring a list of all their current medications and supplements to their appointment.
- Have patients confirm their up-to-date medications and supplements at each appointment in their pre-appointment paperwork.
- Discuss medications in detail with patients to ensure they understand doctor instructions and any potential interactions, and inquire if patients are experiencing any side effects from medications and if they are struggling to pay for their medications.
- Include detailed medication instructions for patients in the after-visit summary, and consider using plain language when writing instructions.
- Ensure office staff has processes in place to assist with specialist referrals. Leverage referral center/ services where available. If specialist follow-up care cannot be scheduled when your patient is in your office, give him/her the names and phone numbers of specialists.
- Contact patients with the results of any screenings as soon as they are available, and schedule any necessary follow-up care.

Note: There are four HEDIS Star measures that are also referred to as care coordination measures. See Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC), Medication Reconciliation Post-Discharge (MRP), Plan All-Cause Readmissions (PCR) and Transitions of Care (TRC).

Getting Appointments and Care Quickly (GACQ)

Getting Appointments and Care Quickly (GACQ) MY26 | Weight = 2

Overview
Assesses how quickly the patients were able to get appointments and care

Patient survey question
- In the last six months, when you needed care right away, how often did you get care as soon as you needed?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, how often did you get an appointment for a checkup or routine care as soon as you needed?
  Answer choices: Never; Sometimes; Usually; Always

Measure best practices
- When possible, leave scheduling gaps for urgent appointments and have processes in place to help patients receive care from other providers (such as urgent care or other colleagues within your practice) when necessary.
- Leverage telehealth resources where appropriate.
- Utilize online appointment scheduling as an alternative to having patients call in to the office for scheduling.
- Consider implementing extended or flex office hours on certain days.
- If applicable, have office staff schedule any follow-up appointments for patients at the end of their current appointments.

Getting Needed Care (GNC)

Getting Needed Care (GNC) MY26 | Weight = 2

Overview
Assesses how easy it was for patients to get needed care and see specialists

Patient survey questions
- In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, how often was it easy to get the care, tests or treatment you needed?
  Answer choices: Never; Sometimes; Usually; Always

Measure best practices
- Ensure office staff has processes in place to assist with specialist referrals. Leverage referral center/services where available.
- If office staff is assisting with scheduling specialist appointments, consider using specialist reminder cards to give to the patients as part of the after-visit summary. If specialist follow-up care cannot be scheduled when your patient is in your office, provide the names and phone numbers to call for an appointment.
- Utilize interoperability or data-sharing functionality within your EHR to assist with real-time prior authorization.

Getting Needed Prescription Drugs (GNRx)

Getting Needed Prescription Drugs (GNRx) MY26 | Weight = 2

Overview
Assesses how easy it is for patients to get the medicines prescribed by their doctor

Patient survey questions
- In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
  Answer choices: Never; Sometimes; Usually; Always; I did not use my prescription drug plan to get any medicines in the last six months
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription by mail?
  Answer choices: Never; Sometimes; Usually; Always

Measure best practices
- Some medications require prior authorizations in order to be covered. Utilize interoperability or data-sharing functionality within your EHR to assist with formulary visibility and real-time prior authorization. You can also check the current preauthorization and notification list(s) at Humana.com/PAL to determine if a medication requires preauthorization before it can be dispensed or administered.
- Recommend patients switch to 90-day supplies from their community pharmacy or via a mail-order pharmacy.

Overall Rating of Health Care Quality (RHCQ)

Overall Rating of Health Care Quality (RHCQ) MY26 | Weight = 2

Overview
Patient's rating of health plan

Patient survey question
- Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your health care in the last six months?

Measure best practices
- Ensure office staff understands the importance of providing a welcoming atmosphere for patients.
- Monitor patient experience surveys for improvement opportunities, and keep tabs on online reviews and have a plan to act and follow up on poor experiences.
- Ask questions to gauge the patient's current experience and perception of the care they are receiving from your practice, specialists and other healthcare providers.
- Consider the teach-back method when giving patients instructions, as studies cite that 50% of patients leave appointments without fully understanding the provider's instructions.*

* Bodenheimer T. Teach-Back: A Simple Technique to Enhance Patients' Understanding. FPM. 2018 Jul/Aug; 25(4):20-22. PMID: 29989780.

The following CAHPS measures are related to a patient's experience with their MA plan. These measures are not provider-impacted.

Overall Rating of Drug Plan (RDP)

Overall Rating of Drug Plan (RDP) MY26 | Weight = 2

Overview
Patient's rating of drug plan

Patient survey question
- Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?

Overall Rating of the Health Plan (RHP)

Overall Rating of the Health Plan (RHP) MY26 | Weight = 2

Overview
Patient's rating of health plan

Patient survey question
- Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Customer Service (CS)

Customer Service (CS) MY26 | Weight = 2

Overview
Measures patient's satisfaction with specific customer service components of their health plan

Patient survey questions
- In the last six months, how often did your health plan's customer service give you the information or help you needed?
- In the last six months, how often did your health plan's customer service staff treat you with courtesy and respect?
- In the last six months, how often were the forms from your health plan easy to fill out?
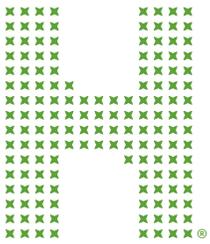
Health Outcomes Survey (HOS)

HOS is an annual patient-reported outcome survey conducted for MA plans by a vendor contracted by CMS. The goal of the survey is to gather valid and reliable health status data for use in quality improvement activities, public reporting, MA organization accountability and improving health outcomes. The survey contains questions regarding physical and mental health, chronic medical conditions, functional status (e.g., activities of daily living), clinical measures and other health status indicators. The survey is distributed annually between July and November.

HOS (measured July to November)	ABBR	Weight
Improving Bladder Control	IBC	1x
Improving or Maintaining Mental Health	IMMH	3x
Improving or Maintaining Physical Health	IMPH	3x
Monitoring Physical Activity in Older Adults	MPA	1x
Reducing the Risk of Falling	ROF	1x

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Patient Experience (PE) surveys

0:00 / 7:46

Click above to learn more about PE surveys.

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Improving Bladder Control (IBC)

Improving Bladder Control (IBC) MY26 | Weight = 1

Overview
Percentage of surveyed patients 65 years of age and older who reported having any urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a provider

Patient survey questions
- Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?
  Answers: Yes; No
- During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?
  Answers: A lot; Somewhat; Not at all
- Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine?
  Answers: Yes; No
- There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other healthcare provider about any of these approaches?
  Answers: Yes; No

Exclusion
- Patients in hospice

Measure best practices
- Discuss bladder control issues and symptoms with your older patients, including during telehealth visits, and consider ways to destigmatize the topic.
- Consider having questions on this topic in questionnaires, as these allow the patient to note potential issues that can be brought up to the doctor to discuss.
- Determine if exercise or other treatment options such as medications, bladder control products or surgery may help.
- If recommending specific bladder exercises, write down clear instructions along with informational pamphlets demonstrating the exercises.

Monitoring Physical Activity in Older Adults (MPA)

Monitoring Physical Activity in Older Adults (MPA) MY26 | Weight = 1

Overview
Percentage of sampled Medicare patients 65 years of age and older who have had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level of exercise or physical activity

Patient survey questions
- In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.
  Answers: Yes; No; I had no visits in the past 12 months
- In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.
  Answers: Yes; No; I had no visits in the past 12 months

Exclusions
- Patients in hospice
- Patients responding, "I had no visits in the past 12 months"

Measure best practices
- Determine if it is appropriate for your patients to start, maintain or increase the level of physical activity based on their overall health and have relevant discussions with the patient.
- Include any recommended activity with frequency and duration in the patient after-visit summary and ensure they have a physical copy of the goals/plan for maintaining or increasing activity.
- Share handouts or items patients can keep or have in their homes to help them remember the conversation for the survey.

Improving or Maintaining Physical Health (IMPH)

Improving or Maintaining Physical Health (IMPH) MY26 | Weight = 3

Overview
Percentage of sampled Medicare patients 65 years of age and older whose physical health status was the same or better than expected after two years

Patient survey questions
- In general, would you say your health is:
  Answers: Excellent; Very good; Good; Fair; Poor
- The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
  - o Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?
  - o Climbing several flights of stairs?
  Answers: Yes, limited a lot; Yes, limited a little; No, not limited at all
- During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
  - o Accomplished less than you would like as a result of your physical health?
  - o Were limited in the kind of work or other activities as a result of your physical health?
  Answers: No, none of the time; Yes, a little of the time; Yes, some of the time; Yes, most of the time; Yes, all of the time
- During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
  Answers: Not at all; A little bit; Moderately; Quite a bit; Extremely
- Compared to one year ago, how would you rate your physical health in general now?
  Answers: Much better; Slightly better; About the same; Slightly worse; Much worse

Measure best practices
- Develop a plan for preventive screenings and services for patients.
- Determine an exercise or physical therapy program that is appropriate for patients' needs and abilities.
- Perform a pain assessment to determine if a pain management or treatment plan is needed.
- If recommending specific exercises, write down clear instructions and any goals specific to the patient, and include informational pamphlets demonstrating the exercises.

Improving or Maintaining Mental Health (IMMH)

Improving or Maintaining Mental Health (IMMH) MY26 | Weight = 3

Overview
Percentage of sampled Medicare enrollees 65 years of age and older whose mental health status was the same or better than expected after two years

Patient survey questions
- During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
    - o Accomplished less than you would like as a result of any emotional problems
    - o Didn't do work or other activities as carefully as usual as a result of any emotional problems?
    Answers: No, none of the time; Yes, a little of the time; Yes, some of the time; Yes, most of the time; Yes, all of the time
- How much of the time during the past four weeks:
    - o Have you felt calm and peaceful?
    - o Did you have a lot of energy?
    - o Have you felt downhearted and blue?
    Answers: All of the time; Most of the time; A good bit of the time; Some of the time; A little of the time; None of the time
- During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
    Answers: All of the time; Most of the time; Some of the time; A little of the time; None of the time
- Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed, or irritable) in general now?
    Answers: Much better; Slightly better; About the same; Slightly worse; Much worse

Measure best practices
- Administer PHQ-2 and PHQ-9 Mental Health Assessments.
- Check in with the patient's mental/emotional health at each visit, asking about stress, loneliness or any big life changes that have occurred and may be causing uneasiness.
- Provide written materials regarding mental well-being and identify local resources.
- Connect patients to resources that may be able to assist (e.g., Humana Community Navigator).

Reducing the Risk of Falling (ROF)

Reducing the Risk of Falling (ROF) MY26 | Weight = 1

Overview
Percentage of Medicare patients 65 years of age and older who have had a fall or had problems with balance or walking, 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

Patient survey questions
- A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?
  Answers: Yes; No; I had no visits in the past 12 months
- Did you fall in the past 12 months?
  Answers: Yes; No
- In the past 12 months, have you had a problem with balance or walking?
  Answers: Yes; No
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:
  - o Suggest that you use a cane or walker
  - o Suggest that you do an exercise or physical therapy program
  - o Suggest a vision or hearing test

Answers: Yes; No; I had no visits in the past 12 months

Exclusions
- Patients in hospice
- Patients responding, "I had no visits in the past 12 months"

Measure best practices
- Take advantage of, and share, the Centers for Disease Control and Prevention's (CDC) "Stopping Elderly Accidents, Deaths and Injuries" (STEADI) online training and materials.
- Consider having questions on this topic in questionnaires, as these allow the patient to note potential issues that can be brought up to the doctor to discuss.
- If recommending exercises specific to fall risk, write down clear instructions and give the patient informational pamphlets demonstrating the exercises.
- Assess patients' risk factors and share information and resources that might assist in reducing the risk of falls in their homes and daily lives.
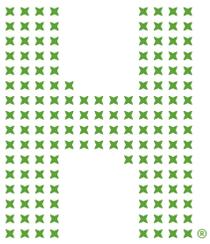
Humana Patient Experience (PE) Survey*

The Humana Patient Experience (PE) Survey is a voice-automated phone call to Humana members after an in-person visit with their healthcare provider. Its questions align with the intent of CMS-administered CAHPS and HOS surveys for MA members but with a key difference: CMS surveys are measured at the contract level, and individual response data is not available as it relates to provider-specific performance.

To address this gap, Humana's PE Survey uses questions informed by CMS standards but phrased, organized and implemented differently—focusing on measures providers can directly influence. The goal is to give providers actionable insights and support collaboration with Humana to improve the overall patient experience.

Humana PE Survey (measured January–December)	ABBR	Weight
Coordination of Care	CC	5.5x**
Getting Needed Care	GNC	5.5x**
Getting Care Quickly	GCQ	5.5x**
Patient Discussion		4.5x**
Monitoring Physical Activity	MPA	1x**
Improving or Maintaining Mental Health	IMMH	1.5x**
Reducing the Risk of Falls	ROF	1x**
Improving Bladder Control	IBC	1x**

Note: Humana's Patient Experience (PE) Survey is informed by CAHPS and HOS but focuses on measures Humana has identified as provider-influenced. Unlike CAHPS and HOS—which ask members to evaluate their overall care over a set time frame—the PE Survey centers on a single, recent visit. Because the Humana PE Survey emphasizes specific CAHPS and HOS measures and a different aspect of experience, its weighting does not align with CMS's weighting for CAHPS and HOS.

 * Not included as part of CMS Star Ratings, applicable for provider performance

** Humana-established weights, not CMS-established

If interested in learning more about Humana's Patient Experience Survey, please register for one of our live-session webinars with the following link:
https://humana.zoom.us/webinar/register/WN_aO1-aVvxSL6rx3VQjqTEYA

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Coordination of Care (CC)

Humana PE Survey Weight = 5.5

Overview
Assesses how well patient care is coordinated, including whether or not doctors had conversations about a patient's medicines as well as how informed personal doctors are about any specialist care their patients received

Humana PE survey questions
- Did your personal doctor talk about all the prescription medicines you were taking?
  Answers: Yes; No; Doesn't apply
- Did your personal doctor seem informed and up to date about the care you got from specialists?
  Answers: Yes; No; Doesn't apply

Measure best practices
- When sending out pre-appointment reminders, encourage patients to bring a list of all their current medications and supplements to their appointment.
- Have patients confirm their up-to-date medications and supplements at each appointment in their pre-appointment paperwork.
- Discuss medications in detail with patients to ensure they understand doctor instructions and any potential interactions, and inquire if patients are experiencing any side effects from medications and if they are struggling to pay for their medications.
- Include detailed medication instructions for patients in the after-visit summary, and consider using plain language when writing instructions.
- Ensure office staff has processes in place to assist with specialist referrals. Leverage referral center/services where available. If specialist follow-up care cannot be scheduled when your patient is in your office, give him/her the names and phone numbers of specialists.
- Contact patients with the results of any screenings as soon as they are available, and schedule any necessary follow-up care.

Getting Needed Care (GNC)

Humana PE Survey Weight = 5.5

Overview
Assesses how easy it was for patients to get a referral to see a specialist from their personal doctor (if necessary)

Humana PE Survey questions
- Did you have any trouble getting a referral from your personal doctor to see a specialist?
  Answers: Yes; No; Doesn't Apply

The following questions are asked to gauge Humana members' experience with their health plan and prescription drug plan. These questions are not included in a provider's Patient Experience Rating (PER) received from Humana.
- Did you have trouble with your prescription drug plan covering any medication your doctor prescribed?
  Answers: Yes; No; Doesn't Apply
- Did you have problems getting approval through your health plan for any tests, care or treatment your doctor said you needed?
  Answers: Yes; No; Doesn't Apply

Measure best practices
- Ensure office staff has processes in place to assist with specialist referrals. Leverage referral center/services where available.
- If office staff is assisting with scheduling specialist appointments, consider using specialist reminder cards to give to the patients as part of the after-visit summary. If specialist follow-up care cannot be scheduled when your patient is in your office, give him/her the names and phone numbers to call for an appointment.
- Utilize interoperability or data-sharing functionality within your EHR to assist with real-time prior authorization.

Getting Care Quickly (GCQ)

Humana PE Survey Weight = 5.5

Overview
Assesses how quickly the patients were able to get appointments and care

Humana PE Survey questions
- Did you experience any difficulty scheduling your appointment?
  Answers: Yes; No; Doesn't apply
- How long after your scheduled appointment time did you wait in the waiting room and exam room to see the person you came to see?
  Answers: 0-15 minutes; 15-30 minutes; 30-60 minutes; 60 or more minutes

Measure best practices
- If possible, schedule a patient's follow-up visit before the patient leaves their appointment.
- Utilize online appointment scheduling as an alternative to having patients call in to the office for scheduling.
- Consider adding extended or flex office hours on certain days to accommodate patients with difficulties being seen during normal business hours.
- 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.

Monitoring Physical Activity (MPA)

Patient Discussion • Humana PE Survey Weight = 1

Overview
Patients are asked if they received advice from their doctor to start, increase or maintain their level of exercise or physical activity

Humana PE Survey question
- Did your doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity?
  Answers: Yes; No

Measure best practices
- Determine if it is appropriate for your patients to start, maintain or increase their level of physical activity based on their overall health, and have relevant discussions with the patient.
- Include any recommended activity with frequency and duration in the patient after-visit summary and ensure they have a physical copy of the goals/plan for maintaining or increasing activity.
- Share handouts or items patients can keep or have in their homes to help them remember the conversation for the survey.

Improving or Maintaining Mental Health (IMMH)

Patient Discussion • Humana PE Survey Weight = 1.5

Overview

Patients are asked if they've talked to their doctors about how to manage their mental health. Patients are asked an introductory question that allows them to identify if they've had any recent mental health struggles. If they answer "yes," they will be asked the Humana PE Survey question. If they answer "no," it will skip the question.

Humana PE Survey question

- Has your doctor or other health provider talked to you about how to manage your mental or emotional health?
  Answers: Yes; No

Measure best practices
- Administer PHQ-2 and PHQ-9 Mental Health Assessments.
- Check in with patients' mental/emotional health at each visit, asking about stress, loneliness or any big life changes that have occurred and may be causing uneasiness.
- Provide written materials regarding mental well-being and identify local resources.
- Connect patients to resources that may be able to assist (e.g., Humana Community Navigator).

Improving Bladder Control (IBC)

Patient Discussion • Humana PE Survey Weight = 1

Overview
Patients are asked about conversations with their provider about urine leakage. If patients answer that this is not an applicable topic for them, the second question will be skipped.

Humana PE survey questions
- Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine?
  Answers: Yes; No; Doesn't apply
- Has your doctor, nurse or other healthcare provider talked to you about ways to control or manage leaking urine, including bladder training exercises, medication and surgery?
  Answers: Yes; No

Measure best practices
- Discuss bladder control issues and symptoms with your older patients, including during telehealth visits, and consider ways to destigmatize the topic.
- Consider having questions on this topic in questionnaires, as these allow the patient to note potential issues that can be brought up to the doctor to discuss.
- Determine if exercise or other treatment options such as medications, bladder control products or surgery may help.
- If recommending specific bladder exercises, write down clear instructions along with informational pamphlets demonstrating the exercises.

Reducing the Risk of Falls (ROF)

Patient Discussion • Humana PE Survey Weight = 1

Overview
Patients are asked about conversations with their provider about fall risk. They are asked an initial gatekeeper question about balance, and the two questions below are skipped if the member answers "No."

Humana PE survey questions
- Did your doctor or other health provider talk to you about falling or problems with balance or walking?
  Answers: Yes; No; Doesn't apply
- Did your doctor or other health provider suggest any treatment, such as using a cane or walker, having your blood pressure checked or having regular vision or hearing tests?
  Answers: Yes; No

Measure best practices
- Take advantage of, and share, the CDC's "Stopping Elderly Accidents, Deaths and Injuries" (STEADI) online training and materials.
- Consider having questions on this topic in questionnaires, as these allow the patient to note potential issues that can be brought up to the doctor to discuss.
- If recommending exercises specific to fall risk, write down clear instructions informational pamphlets demonstrating the exercises.
- Assess patients' risk factors and share information and resources that might assist in reducing the risk of falls in their homes and daily lives.
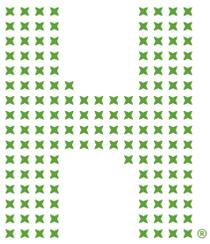
Patient Safety

Patient Safety includes measures to assess prescription drug plan (Part D) quality and performance in the Star Rating Program. The Patient Safety measures monitor Part D services to ensure the safety of MA enrollees. These measures are developed and endorsed by the PQA. They apply to both Medicare Advantage prescription drug (MAPD) plan and prescription drug-only plans (PDP). When a prescription is filled under a Medicare Part D plan, a prescription drug event (PDE) is submitted to CMS by MA organizations, such as Humana. Only PDE information is used by CMS to evaluate these measures; therefore, no quality reporting is required by physicians.

Patient Safety (measured January–December)	ABBR	Weight
Medication Adherence		
Cholesterol (statins)	MAC	3x
Diabetes Medication	MAD	3x
Hypertension (ACE/ARB)	MAH	3x
Statin Use in Persons with Diabetes	SUPD	1x
Concurrent Use of Opioids and Benzodiazepines	COB	1x
Use of Multiple Anticholinergic (ACH) Medications in Older Adults	POLY–ACH	1x
Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults	POLY–CNS	Display

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Medication Adherence (MA)

CMS uses a metric called proportion of days covered, or PDC, to determine medication adherence. 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.

If a patient's PDC is greater than or equal to 80%, the patient is deemed adherent. A rate lower than 80% is considered nonadherent. The PDC threshold of 80% is the level above which the medication has a reasonable likelihood of achieving the most clinical benefit based on clinical evidence.*

Measure best practices
- Ask patients if they are taking medication and if they missed doses during the past week or month to identify and resolve patient-specific adherence barriers.
- Ask whether patients forgot to refill or have trouble getting medications from their pharmacy—transportation to the pharmacy can be an issue. Retail or mail pharmacy 90-day fills may offer less frequent trips to the pharmacy or eliminate them altogether in the case of mail delivery.
- If appropriate, prescribe 90- or 100-day supplies for maintenance medications and encourage patients to ask the pharmacy to auto-refill their medications. Encourage adherence by providing a 90-day prescription for maintenance drugs.
- Give patient materials—such as a medication instruction sheet, covering common side effects, reasons why and how to take medication, and tips for remembering doses.
- Evaluate individual health-related social needs (HRSN). These are conditions patients are born with, working and living conditions, and age, which may impact adherence. If HRSN are a concern, refer patients to Humana Community Navigator at Humana.findhelp.com.
- Refer Humana patients to Humana.com/TakeMyMedicine for adherence tips and tools.

Note: Changes for this measure in 2026 include the measure being moved to a 1x weight by CMS but will stay at 3x weight for Humana. CMS calculations will be risk adjusted, but Humana's provider reporting/incentives will not include any risk-adjustment methodologies. In 2025, there was an adjustment made for CMS calculations related to individuals who are in-patient at skilled nursing facilities (SNF); that adjustment was removed for 2026.

* www.cms.gov

Medication Adherence (MA)

Medication Adherence for Cholesterol Medication (MAC) MY26 | Weight = 3

Measurement period
Jan. 1–Dec. 31

Service required
• Patients must have two or more fills of cholesterol medication (a statin drug of any intensity) on record and at least 91 days of part D coverage to be in the denominator.
• Eligible patients must fill prescriptions for at least 80% of the measurement period.

Note: Prescriber tools are available to identify current and at-risk non-adherent patients

Exclusions
• Patients in hospice or using hospice services
• Patients with ESRD or on dialysis

Medication Adherence for Diabetes Medications (MAD) MY26 | Weight = 3

Measurement period
Jan. 1–Dec. 31

Service required
• Patients must have two or more fills of diabetes medication on record and at least 91 days of part D coverage to be in the denominator
• Eligible patients must fill prescriptions for at least 80% of the measurement period.
• Drug therapy across these classes of diabetes medications are included in this measure: biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase (DPP)-IV inhibitors, incretin mimetics, meglitinides and sodium glucose cotransporter 2 (SGLT2) inhibitors.

Note: Prescriber tools are available to identify current and at-risk non-adherent patients

Exclusions
• Patients in hospice or using hospice services
• Patients with ESRD or on dialysis
• Patients who had filled a prescription for insulin after measure eligibility

Medication Adherence for Hypertension (ACE/ARB) (MAH) MY26 | Weight = 3

Measurement period
Jan. 1–Dec. 31

Service required
• Patients must have at least two high blood pressure 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.
• Blood pressure medication therapy programs for these renin angiotensin system (RAS) antagonists are included in this measure: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB) or direct renin inhibitor medications.

Exclusions
• Patients in hospice or using hospice services
• Patients with ESRD or on dialysis
• Prescription(s) filled for Entresto® (sacubitril/valsartan) after measure eligibility

Concurrent Use of Opioids and Benzodiazepines (COB)

Concurrent Use of Opioids and Benzodiazepines (COB) MY26 | Weight = 1

Measurement period
Jan. 1–Dec. 31

Eligible population
18 years of age and older and enrolled in a Part D plan:
- Having had two or more fills for opioids on different dates of service (claims can be for same or different opioids)
- With 15 or more cumulative days' supply during measurement period
  - o With no more than one gap in enrollment of up to 31 days during the measurement year
  - o The earliest date of service can be no more than 30 days from the last day of the measurement year (Jan. 1–Dec. 2)

Only paid, irreversible prescription claims are included in the data set to calculate the measure.

Service required
- If the number of fills remains at less than 30 days, there is no action at all.
- If the number of fills is two or more and has an overlapping supply for 30 days, the patient will be included in the numerator.

Notes
- The more patients in the numerator, the worse the performance.
- A lower rate indicates better performance.
- Failing patients cannot be salvaged.
- Unlike adherence measures, patients who enter the COB measure stay in the numerator and are considered failing for the rest of the measurement period.

Exclusions
During the measurement period:
- Patients with cancer or sickle cell disease
- Patients in hospice, using hospice services or receiving palliative care
- Patients who died

For a full list of medications, please review the COB flyer.

Measure best practices
- Review patient medications regularly, especially those that utilize specialists and receive care through other facilities such as hospitals and urgent care clinics.
- Utilize standard criteria, such as the Beers Criteria, to identify medications that should not be taken together.
- 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.
- Ensure patient records include clear documentation and that patients have a strong understanding of the directions given to them on discontinuing medications.
- Work with the patient's pharmacy to ensure no additional refills are available on discontinued medications.
- Educate patients and healthcare providers about the medications included in this measure and the risk of taking these medications in combination.
- Recommend at least one of these medications be changed to a safer medication or discontinued and tapered to prevent further decline or adverse events.
- Patients should be reminded not to accept additional opioid or benzodiazepine prescriptions without the prescribing healthcare provider conferring with the PCP before prescribing.

Statin Use in Persons with Diabetes (SUPD)

Statin Use in Persons with Diabetes (SUPD) MY26 | Weight = 1

Measurement period
Jan. 1–Dec. 31

Eligible population
40–75 years of age with diabetes who were:
- Dispensed at least two diabetic prescription fills on unique dates during the measurement period
- Dispensed a statin medication fill during the measurement period

Service required
- At least one fill for a statin medication of any intensity in the measurement period

Exclusions
During the measurement period or prior year:
- Patients with end-stage renal disease (ESRD)
- Patients with rhabdomyolysis or myopathy
- Patients who are pregnant or lactating or undergoing therapy for fertility (clomiphene)
- Patients with cirrhosis
- Patients with prediabetes
- Patients with polycystic ovary syndrome (PCOS)
- Patients utilizing a PCSK9 inhibitor or bempedoic acid

During the measurement period:
- Patients in hospice or using hospice services
- Patients who died

Measure best practices
- Ensure a comprehensive review of new to practice/new to Medicare patients who have been diagnosed with diabetes to evaluate their current statin therapy.
- Ensure the practice has a process to conduct reviews of patients' records when dispensed two diabetes medications on two separate dates of service
- Ensure there is a process for evaluating current statin therapy and ensuring the patient is on any intensity statin.

For a full list of medications, please review the SUPD flyer.

Polypharmacy

Use of Multiple Anticholinergic Medications in Older Adults (POLY–ACH)

Use of Multiple Anticholinergic Medications in Older Adults (POLY–ACH)
MY26 | Weight = 1

Measurement period
Jan. 1–Dec. 31

Eligible population
65 years of age and older who are enrolled in a Part D plan and have had two or more fills of a unique* anticholinergic (ACH) medication with different dates of service.

Service required
- One of the medications should be changed to a safer medication or discontinued to enhance the patient's safety.
- Only paid, non-reversed prescription claims are included in the data set to calculate the measure

Patients should not take two or more unique ACH medications that have overlapping days' supply for 30 or more cumulative days during the measurement period. If the number of fills remains at less than two, there is no action at all. If the number of fills is two or more and has an overlapping supply, the patient will be included in the numerator.
- The more patients in the numerator, the worse the performance.
- A lower rate indicates better performance.
- Failing patients cannot be salvaged.

Unlike with adherence measures, patients who enter the numerator of the POLY–ACH measure stay in the numerator and are considered failing for the rest of the measure year.

Exclusions
During the measurement period:
- Patients in hospice, using hospice services or receiving palliative care

Measure best practices
- Review all patients' medication lists at every visit and specifically review patient medical records when they are taking a medication that falls on the POLY–ACH measure drug list.
- Ensure there are not other medications that should not be taken with the polypharmacy medication. If there is a conflict, work with the patient to ensure one medication is discontinued.
- Before prescribing a new medication, review all patient-reported medications as well as those noted in any of the patient's records. If new medications are needed, review the POLY–ACH measure drug list prior to prescribing.
- Minimize negative outcomes when POLY–ACH medications cannot be avoided by utilizing the lowest dose and frequency.
- Ensure medications have limits to supply and/or duration.
- Document risks in the patient's chart and discuss. Ensure the patient has written documentation of the concern and the potential harmful effects.
- Review medications at each visit for polypharmacy and consider removal or replacement with a clinical alternative.
- Some medications in this measure may require a prior authorization approval to be covered by the patient's plan. Please note even if the medications are deemed medically necessary and the prior authorization is approved, the patient may still fail the POLY–ACH measure.

For a full list of medications, please review the POLY-ACH flyer.

 * Unique is defined at the active ingredient level.

Polypharmacy

Use of Multiple Central Nervous System-Active Medications in Older Adults (POLY–CNS)

Use of Multiple Central Nervous System-Active Medications in Older Adults (POLY–CNS) MY26 | Weight = Display

Measurement period
Jan. 1–Dec. 31

Eligible population
65 years of age and older who have three or more fills of unique* CNS medications with an overlapping days' supply for 30 or more cumulative days during the measurement period.

Service required
One of the medications should be changed to a safer medication or discontinued to enhance the patient's safety. Only paid, non-reversed prescription claims are included in the data set to calculate the measure.

Three or more unique CNS medications should not be taken that have overlapping days' supply for 30 or more cumulative days during the measurement period. If the number of fills for each unique CNS drug remains less than two, there is no action at all. If the number of fills for each unique CNS drug is two or more with unique dates of service, the patient will be included in the numerator.
• The more patients in the numerator, the worse the performance.
• A lower rate indicates better performance.
• Failing patients cannot be salvaged.

Unlike with adherence measures, patients who enter the numerator of the POLY–CNS measure stay in the numerator and are considered failing for the rest of the measurement period.

Exclusions
During the measurement period:
• Patients with a seizure disorder diagnosis
• Patients in hospice, using hospice services or receiving palliative care

Measure best practices
• Review all medication lists at every visit and specifically review patient medical records when they are taking a medication that falls on the POLY–CNS measure drug list. Ensure there are no other medications that should not be taken with the POLY medication. If there is a conflict, work with the patient to ensure one medication is discontinued.
• Before prescribing a new medication, check to see if it falls on the POLY–CNS measure drug list and review all patient-reported medications and what is notated in the patient charts.
• Minimize negative outcomes when polypharmacy medications cannot be avoided by utilizing the lowest dose and frequency.
• Ensure medications have limits to supply and/ or duration.
• Discuss risks with the patient, and document in their chart. Ensure the patient has written documentation of the concern and the potential harmful effects.
• Consider reducing use of other CNS-active medications.
• Consider tapering to avoid symptom recurrence and discontinuation syndromes.

For a full list of medications, please review the POLY–CNS flyer.

 * Unique is defined at the active ingredient level.
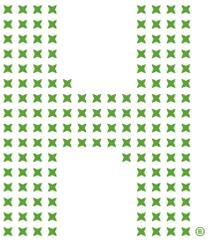
Additional operational categories*

Improvement quantifies how a plan's performance has improved from one year to the next. Improvement measures, unlike other Star measures, are not based on a data set of their own. Rather, improvements are determined by comparing the current year performance of eligible Star measures against the prior year. Eligible measures will be rated only if there is enough data to determine significant improvement or a decline of 50% or greater.

Improvement	ABBR	Weight
Part C Improvement	HPQI	5x
Part D Improvement	DPQI	5x

The Independent Review Entity (IRE) is an independent entity (currently Maximus) contracted by CMS to review Medicare health and drug plans' response to appeals and denials. These measures review the timeliness of responses on appeals as well as whether the IRE agrees with the carrier decision to deny claims.

IRE	ABBR	Weight
Timely Decisions About Appeals	PTD	2x
Reviewing Appeals Decisions	RAD	2x

Operational categories are tied to specific information that is used by CMS to measure quality or performance. For example, prescription claims data is used to determine drug safety.

CMS	ABBR	Weight
Medicare Plan Finder Accuracy	MPF	1x
Call Center-Foreign Language Interpreter and TTY/TDD Part C	FLIC	2x
Call Center-Foreign Language Interpreter and TTY/TDD Part D	FLID	2x
Complaints about the Health/Drug Plan	CHPC/CHPD	2x
Comprehensive Medication Review	CMR	Display
Special Needs Care Management	SNP	1x
Members Choosing to Leave the Plan	MLPC/MLPD	2x

* Measures are a part of the MA plan Star Rating but not influenced by providers.

Humana®

Glossary

Baseline survey
For the Health Outcomes Survey (HOS), the baseline survey is the first of two surveys performed to assess the patient's perception of their own health. The same population, or cohort, of patients will receive a follow-up survey two years later.

Bonus year (BY)
Bonus year is the year in which CMS pays bonuses for currently enrolled patients based on the prior calendar year's rating.

CAHPS
CAHPS® is the Consumer Assessment of Healthcare Providers and Systems. It is conducted on behalf of CMS. CAHPS is a survey that assesses consumers' experiences with the quality of healthcare and plan services and is focused on Medicare Advantage and prescription drug plans.

CMS
The Centers for Medicare & Medicaid Services.

Composite measures
Composite measures are only applicable to the CAHPS survey. The pass rate for these measures is determined by the responses to multiple questions. The rate for each question is calculated and those rates are averaged into a combined, or composite, score for the measure.

CPT
Current Procedural Terminology (CPT®) codes are developed by the American Medical Association (AMA). CPT Category I codes are used to communicate a procedure or service administered to a patient. CPT Category II codes are supplemental codes used for quality performance measurement.

Cut points
Cut points—also known as thresholds—are established to determine performance based on the percentage of patients that must be in compliance to achieve a certain Star Rating. Thresholds are established by CMS for each year and are updated to reflect significant changes in industry performance and distribution of scores.

Denominator
Denominator includes the eligible population or events being assessed via a measure.

Discussion measures
Discussion measures apply to the HOS and assess how well physicians are doing in initiating discussion of certain health topics and addressing them with their patients.

Display measures
Display measures do not currently impact a Medicare Advantage plan's Star Rating. In some cases, these are former Star measures that have been transitioned to display. However, most of them are new measures being tested before they are designated as a Star measure, or they are on display for informational purposes only. If they become a Star measure, they would then be assigned one of the Star measure types (outcome or intermediate outcome).

Exclusions
Exclusions are the CMS-determined criteria that exempt a Medicare Advantage patient or an event from being included when determining pass rate of a measure.

Follow-up survey
For HOS, the follow-up survey is the second of two surveys performed to assess the patient's perception of their own health. Patients who completed a baseline survey two years prior and remained on the same MA contract will receive the follow-up survey.

HCPCS
HCPCS is the Healthcare Common Procedure Coding System used by CMS and maintained by the AMA.

HEDIS
Healthcare Effectiveness Data and Information Set is a registered trademark of the National Committee for Quality Assurance (NCQA). It is a set of standardized performance measures designed to help compare the performance of health plans on an "apples-to-apples" basis. The details of its measures can change annually. It is governed by NCQA. HEDIS measure performance is used to determine clinical quality performance.

HOS
Health Outcomes Survey is an annually reported outcome survey conducted on behalf of CMS. It assesses the ability of a Medicare Advantage organization (MAO) to maintain or improve its patients' physical and mental health, as well as ascertain if physicians are having meaningful discussions with patients on certain health topics.

ICD-10-CM
ICD-10-CM is the International Classification of Diseases, Tenth Revision, Clinical Modification developed by the World Health Organization and provided by CMS and the National Center for Health Statistics (NCHS).

Improvement measures
Improvement measures, unlike other Star measures, are not based on a data set of their own, but rather are determined by comparing the current year performance of eligible Star measures against the prior year. Eligible measures will be rated only if there is enough data to determine significant improvement or decline of ≥ 50%. There are two measures—one for Part C and one for Part D. These measures both have a weight of five.

Improvement survey measures
Improvement survey measures apply to the HOS and are used to assess whether a patient's self-reported physical and/or mental health has improved or declined between the two survey periods: baseline and follow-up.

IRE
IRE is an Independent Review Entity. Currently CMS' IRE is Maximus.

MAO
Medicare Advantage organization

MAPD
Medicare Advantage prescription drug plan

Measure year (MY)
Measure year or measurement year is the period of time when patients are receiving their screenings, filling prescriptions and responding to surveys. Information regarding this activity is being exchanged with CMS or the IRE.

Metric
Metric is the methodology used to assess a particular measure as it pertains to Medicare Advantage members.

Numerator
Numerator includes the patients or events for a specific test, screening or survey that are used to determine measure compliance or pass rates.

Operational categories
Operational categories are tied to specific information that is used by CMS to measure quality or performance. For example, prescription claims data is used to determine drug safety.

Outcome measures
Outcome measures reflect improvements in a patient's health and are central to assessing quality of care. These measures are all triple-weighted. Improving or Maintaining Physical Health and Improving or Maintaining Mental Health are both outcome measures.

Overall rating
The overall rating of a plan is calculated using the weighted average Star Ratings of the included measures. It is not an aggregate of the summary rating. This is the rating that will be visible on Medicare Plan Finder when patients are choosing their plan.

Part C
Part C measures evaluate the health or medical portion of an MAPD plan and make up the Part C summary rating.

Part D
Part D relates to prescription drug plan services. Part D measures are used when assessing both prescription drug plan (PDP) and Medicare Advantage prescription drug (MAPD) plans. These measures make up the Part D summary rating for these plans. In the case of a PDP, these measures make up both the Part D summary rating and the overall rating of the plan.

Pass rate
Pass rate is the resulting percentage of a measure when assessed and is also referred to as a compliance rate. For most measures, a higher rate indicates better performance. However, there are inverse measures, such as Plan All-Cause Readmissions, for which a lower rate indicates better performance.

Patient Safety
Patient Safety is the operational category used to assess quality and performance of drug plan services. The Pharmacy Quality Alliance (PQA) oversees the Patient Safety category.

PDP
Prescription drug plan

PQA
Pharmacy Quality Alliance

Process measures
Most Star measures are process measures. These measures must have a process in place to gather information—primarily from healthcare providers—that will be reported to CMS to demonstrate services are being provided to improve, maintain or monitor the health of Medicare Advantage patients. Process measures are single-weighted.

Quality bonus
Quality bonuses are earned on plans rated four stars or higher and are invested back into Medicare Advantage plans to provide more benefits and services to members.

Rating year
Rating year is the plan year (Jan. 1–Dec. 31) for which a Star Rating is in effect. MAOs learn their plans' Star Ratings in October of the prior year, just before AEP, which is the Annual Election Period (AEP) for MA patients.

Reporting year
Reporting year is when data from all plan administrators is being submitted to and collected by CMS.

Thresholds
Thresholds—also known as cut points—are established to determine performance based on the percentage of patients that must be in compliance to achieve a certain star level. Thresholds are established by CMS for each year and are updated to reflect significant changes in industry performance and distribution of scores.

Humana's MY2026 provider thresholds

Humana strives to support a different kind of healthcare for Medicare members by setting new and higher targets for performance improvement that bridge the gap between the last CMS published thresholds and current performance needs. Humana incorporates historical CMS Star data, internal performance data and industry data into our analytics to project future thresholds for the measures within the Star Rating Program. Additional analysis identifies the provider thresholds required to compliment Humana's improvement initiatives and meet overall performance objective

HEDIS		BY26		CMS	Humana
Measure	3 star	4 star	5 star	Weight	Weight
Breast Cancer Screening (BCS-E)	75%	79%	87%	1x	1x
Care for Older Adults – Functional Status Assessment (COA–FSA)	71%	87%	98%	1x	1x
Care for Older Adults – Medication Review (COA–MDR)	89%	94%	99%	1x	1x
Colorectal Cancer Screening (COL-E)	63%	72%	80%	1x	1x
Eye Exam for Patients With Diabetes (EED)	71%	79%	85%	1x	1x
Kidney Health Evaluation for Patients With Diabetes (KED)	57%	67%	80%	1x	1x
Glycemic Status Assessment for Patients With Diabetes (GSD)	87%	91%	93%	3x	3x
Controlling High Blood Pressure (CBP)	78%	83%	89%	3x	3x
Osteoporosis Management in Women Who Had a Fracture (OMW)	43%	56%	71%	1x	1x
Plan All-Cause Readmissions (PCR)	9%	8%	6%	3x	3x
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	63%	72%	84%	1x	1x
Transitions of Care – Composite (TRC)	60%	74%	81%	5x	5x
Patient Safety: Medicare Advantage prescription drug (MAPD) plan values					
Medication Adherence for Diabetes Medications (MAD)	87%	90%	93%	1x	3x*
Medication Adherence for Hypertension (MAH)	90%	93%	95%	1x	3x*
Medication Adherence for Cholesterol (MAC)	90%	92%	96%	1x	3x*
Statin Use in Persons with Diabetes (SUPD)	85%	90%	95%	1x	1x
Concurrent Use of Opioids and Benzodiazepines (COB)	13%	9%	6%	1x	1x
Use of Multiple Anticholinergic Medications in Older Adults (POLY–ACH)	8%	6%	4%	1x	1x

* Changes for this measure in 2026 include the measure being moved to a 1x weight by CMS but will stay at 3x weight for Humana. CMS calculations will be risk adjusted, but Humana's provider reporting/incentives will not include any risk-adjustment methodologies. In 2025, there was an adjustment made for CMS calculations related to individuals who are in-patient at a skilled-nursing facilty (SNF); that adjustment was removed for 2026.

Centers for Medicare & Medicaid Services (CMS) Part C and D threshold trends for Star measures

CMS: Medicare Advantage prescription drug (MAPD) plan values	BY25		BY26		BY27	
MTM Program Completion Rate for Comprehensive Medication Review (CMR)	85%	92%	89%	93%	92%	95%
CAHPS						
Annual Flu Vaccine (FLU)	74%	78%	71%	76%	68%	73%
Care Coordination (CC)	86%	87%	87%	88%	88%	89%
Customer Service (CS)	90%	92%	91%	92%	91%	92%
Getting Appointments and Care Quickly (GACQ)	78%	80%	84%	86%	84%	86%
Getting Needed Care (GNC)	81%	83%	82%	83%	82%	84%
Getting Needed Prescription Drugs (GNRx)	90%	91%	90%	91%	90%	91%
Overall Rating of Drug Plan (RDP)	87%	89%	87%	89%	88%	89%
Overall Rating of Health Care Quality (RHCQ)	87%	88%	87%	88%	87%	88%
Overall Rating of the Health Plan (RHP)	88%	89%	88%	89%	87%	89%
HOS						
Improving/Maintaining Physical Health (IMPH)	N/A	N/A	N/A	N/A	72%	75%
Improving/Maintaining Mental Health (IMMH)	N/A	N/A	N/A	N/A	85%	88
Monitoring Physical Activity (MPA)	53%	58%	52%	60%	53%	59%
Improving Bladder Control (IBC)	47%	51%	48%	52%	49%	53%
Reducing the Risk of Falling (ROF)	60%	70%	63%	73%	62%	71%

Coding

BCS-E coding

Code	Code type	Definition
77061–77063	CPT	Breast, mammography
77065	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067	CPT	Screening mammography, bilateral (two-view study of each breast), including computer-aided detection (CAD) when performed

CBP coding

Code	Code type	Definition
3074F	CPT II	Systolic: blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD)
3075F	CPT II	Systolic: blood pressure 130–139 mm Hg (DM)
3077F	CPT II	Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM)
3078F	CPT II	Diastolic: blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)
3079F	CPT II	Diastolic: blood pressure 80–89 mm Hg (HTN, CKD, CAD) (DM)
3080F	CPT II	Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)
99457	CPT	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

COL-E coding

Code	Code type	Definition
82270, 82274	CPT	**Pathology/laboratory codes:** Fecal occult blood test between Jan. 1 and Dec. 31 of the current year
G0328	HCPCS	**Pathology/laboratory codes:** Fecal occult blood test between Jan. 1 and Dec. 31 of the current year
81528	CPT	Cologuard (FIT-DNA) test between Jan. 1 two years prior and Dec. 31 of the current year
0464U	CPT	Cologuard (FIT-DNA) test between Jan. 1 two years prior and Dec. 31 of the current year
45330–45335, 45337, 45338, 45340–45342, 45346, 45347, 45349, 45350	HCPCS	**Surgery/hospital codes:** Flexible sigmoidoscopy between Jan. 1 four years prior and Dec. 31 of the current year

COL-E coding

G0104	CPT	**Surgery/hospital codes:** Flexible sigmoidoscopy between Jan. 1 four years prior and Dec. 31 of the current year
45378, 45380, 45381, 45384, 45388	CPT	CT colonography between Jan. 1 four years prior and Dec. 31 of the current year
74262–74263	CPT	CT colonography between Jan. 1 four years prior and Dec. 31 of the current year
60515-4, 72531-7, 79069-1, 79071-7, 9101-2, 82688-3	LOINC	CT colonography between Jan. 1 four years prior and Dec. 31 of the current year
77353-1	LOINC	Noninvasive colorectal cancer DNA and occult blood screening (interpretation) in stool narrative
77354-9	LOINC	Noninvasive colorectal cancer DNA and occult blood screening (presence) in stool
G0105, G0121	HCPCS	Colonoscopy between Jan. 1 nine years ago and Dec. 31 of the current year
708699002	SNOMED	Colorectal cancer detected by DNA-based stool screening (finding)
841000119107	SNOMED	History of flexible sigmoidoscopy (situation)
851000119109	SNOMED	History of colonoscopy (situation)
119771000119101	SNOMED	History of total colectomy (situation)

EED coding

Code type	Code
Most common CPT codes for diabetic retinal screening	
CPT	92002, 92004, 92012, 92014, 92018, 92019, 92134, 92137, 92201, 92202, 92230, 92235, 99213–99215, 99242–99245, 99204, 99205, 99213–99215, 99242, 99243, 99245
Other CPT codes for diabetic retinal screening	
CPT	67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92018, 92019, 92201, 92202, 92229, 92235, 92240, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
CPT code for automated eye exam	
CPT	92229
Without evidence of retinopathy**	
CPT II	2023F, 2025F, 2033F, 3072F
With evidence of retinopathy	
CPT II	2022F, 2024F, 2026F
HCPCS	S0620, S0621, S3000
ICD-10-CM to report diabetes mellitus without complications	
ICD-10-CM	E10.9, E11.9, E13

** When negative retinopathy results are reported for a patient, he or she will be compliant for the measurement year in which the testing occurred through the end of the following measurement year.

GSD coding

Code	Code type	Definition
3044F, 3046F*, 3051F, 3052F	CPT II	Physician codes. **Note:** These codes count for both the HbA1c test and HbA1c level
83036, 83037	CPT	Pathology/laboratory codes. **Note:** Pathology/laboratory codes count for the HbA1c test measure. They must include the result value to count for the HbA1c poor control measure.
97506-0	LOINC	Glucose management indicator

* Code indicates results that do not meet Star measure control levels and will not fully address care opportunities. However, this code should be used to verify that the test was performed and for monitoring/reporting of results.

KED coding

Blood test	AND	Urine test (must include both quantitative albumin and urine creatinine)		
		Option 1	**Option 2**	
Estimated glomerular filtration rate lab test (eGFR)		Urine albumin-creatinine ratio (uACR)	Quantitative urine albumin lab test	Urine creatinine lab test
CPT: 80047, 80048, 80050*, 80053, 80069, 82565		LOINC: 102097-3, 50044-7, 98979-8, 98980-650210-4, 50384-7, 62238-1, 69405-9, 70969-1,	CPT code 82043	CPT code 82570
			If submitting two urine tests: • One must be quantitative urine albumin lab test • The other must be urine creatinine lab test • The two test dates must be within the measurement year and the test dates must be within four days of each other	

* 80050 is a general health panel; providers must share the components of the panel for Humana to pay.

COA Coding

Code	Code type	Definition
COA – Functional Status Assessment (FSA)		
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on care-giving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
1170F	CPT II	Functional status assessed
G0438	HCPCS	Annual Wellness Visit, includes a personalized prevention plan of service (PPS), initial visit
G0439	HCPCS	Annual Wellness Visit, includes a personalized prevention plan of service (PPS), subsequent visit

COA coding

COA – Medication Review (MDR)		
90863	CPT	Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on care-giving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
99495	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of at least moderate complexity during the service period, face-to-face visit within 14 calendar days of discharge
99496	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of high complexity during the service period, face-to-face visit within seven calendar days of discharge
99605	CPT	Medication therapy management service(s) provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided, initial 15 minutes, new patient
99606	CPT	Medication therapy management service(s) provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided, initial 15 minutes, established patient
1159F	CPT II	Medication list documented in medical record
1160F	CPT II	Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record
G8427	HCPCS	List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route

OMW coding

Code	Code type	Definition
76977	CPT	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
77078	CPT	Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77080	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77081	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77085	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment
77086	CPT	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)
BP48ZZ1	ICD-10-PCS	Ultrasonography of right shoulder, densitometry
BP49ZZ1	ICD-10-PCS	Ultrasonography of left shoulder, densitometry
BP4GZZ1	ICD-10-PCS	Ultrasonography of right elbow, densitometry
BP4HZZ1	ICD-10-PCS	Ultrasonography of left elbow, densitometry
BP4LZZ1	ICD-10-PCS	Ultrasonography of right wrist, densitometry
BP4MZZ1	ICD-10-PCS	Ultrasonography of left wrist, densitometry
BP4NZZ1	ICD-10-PCS	Ultrasonography of right hand, densitometry
BP4PZZ1	ICD-10-PCS	Ultrasonography of left hand, densitometry
BQ00ZZ1	ICD-10-PCS	Plain radiography of right hip, densitometry
BQ01ZZ1	ICD-10-PCS	Plain radiography of left hip, densitometry
BQ03ZZ1	ICD-10-PCS	Plain radiography of right femur, densitometry
BQ04ZZ1	ICD-10-PCS	Plain radiography of left femur, densitometry
BR00ZZ1	ICD-10-PCS	Plain radiography of cervical spine, densitometry
BR07ZZ1	ICD-10-PCS	Plain radiography of thoracic spine, densitometry
BR09ZZ1	ICD-10-PCS	Plain radiography of lumbar spine, densitometry
BR0GZZ1	ICD-10-PCS	Plain radiography of whole spine, densitometry

SPC coding – ICD-10-CM

Code	Definition
G72.0	Drug-induced myopathy
G72.2	Myopathy due to other toxic agents
G72.9	Myopathy, unspecified
M60.80	Other myositis, unspecified site
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.819	Other myositis, unspecified shoulder
M60.821	Other myositis, right upper arm
M60.822	Other myositis, left upper arm
M60.829	Other myositis, unspecified upper arm
M60.831	Other myositis, right forearm
M60.832	Other myositis, left forearm
M60.839	Other myositis, unspecified forearm
M60.841	Other myositis, right hand
M60.842	Other myositis, left hand
M60.849	Other myositis, unspecified hand
M60.851	Other myositis, right thigh

Code	Definition
M60.852	Other myositis, left thigh
M60.859	Other myositis, unspecified thigh
M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.869	Other myositis, unspecified lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.879	Other myositis, unspecified ankle and foot
M60.88	Other myositis, other site
M60.89	Other myositis, multiple sites
M60.9	Myositis, unspecified
M62.82	Rhabdomyolysis
M79.1	Myalgia
M79.10	Myalgia, unspecified site
M79.11	Myalgia of mastication muscle
M79.12	Myalgia of auxiliary muscles, head and neck
M79.18	Myalgia, other site

FMC coding

Code type	Code
Outpatient visits	
CPT/CPT II	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483
HCPCS	G0402, G0438, G0439, G0463, T1015
SNOMED	185463005, 185464004, 185465003, 281036007, 30346009, 3391000175108, 37894004, 439740005, 444971000124105, 77406008, 84251009
UBREV	0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
Telephone visits	
CPT/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002
Transitional care management	
CPT	99495, 99496
Case management services encounter	
CPT	99366
HCPCS	T1016, T1017, T2022, T2023
Complex care management services	
CPT	T1016, T1017, T2022, T2023
HCPCS	G0506
Outpatient or telehealth behavioral health visit	
CPT	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
HCPCS	G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
SNOMED	185465003, 281036007, 3391000175108, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 444971000124105, 77406008, 84251009
Intensive outpatient visit or partial hospitalization–with POS code 52 (Psychiatric Facility–Partial Hospitalization) or POS code 53 (Community Mental Health Center visit)	
CPT/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

FMC coding

Code type	Code
Intensive outpatient visit or partial hospitalization	
CPT	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
UBREV	0905, 0907, 0912, 0913
SNOMED	305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000, 7133001
Electroconvulsive therapy with POS code 24 (Ambulatory Surgical Center); POS code 52 (Psychiatric Facility–Partial Hospitalization); POS code 53 (Community Mental Health Center visit)	
CPT	90870
ICD-10-PCS	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
SNOMED	1010696002, 1010697006, 10470002, 11075005, 231079005, 231080008, 23835007, 284468008, 313019002, 313020008
Telehealth visit with POS 02 (Telehealth Provided Other than in Patient's Home) or POS 10 (Telehealth Provided in Patient's Home)	
CPT	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
Substance use disorder service or substance abuse counseling and surveillance	
CPT	99408, 99409
HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
UBREV	0906, 0944, 0945
SNOMED	182969009, 20093000, 23915005, 266707007, 310653000, 370776007, 70854007, 384742004, 385989002, 386449006, 386450006, 386451005, 414054004, 414056002, 414283008, 414501008, 415662004, 424589009, 428211000124100, 445628007, 445662007, 450760003, 56876005, 61480009, 64297001, 67516001, 704182008, 707166002, 710081004, 711008001, 713106006, 713107002, 713127001, 713700008, 720174008, 720175009, 720176005, 720177001, 763104007, 763233002, 763302001, 772813001, 774090004, 774091000, 792901003, 792902005, 827094004, 865964007, 87106005

TRC–PED coding

Code	Definition
98966, 98967, 98968, 99441, 99442, 99443, 99483	Telehealth visit (audio only)
99495, 99496	Transitional care management service
98969, 98970, 98971, 98972	Online assessments

Medication Reconciliation Post-Discharge	
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: • Cognition-focused evaluation, including a pertinent history and examination • Medical decision-making of moderate or high complexity • Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity • Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]) • Medication reconciliation and review for high-risk medications • Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s) • Evaluation of safety (e.g., home), including motor vehicle operation • Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on care-giving tasks • Development, updating or revision, or review of an advance care plan • Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups), shared with the patient and/or caregiver with initial education and support Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
99496 (Days 1–7 post-discharge)	Transitional care management services with the following required elements: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge • Medical decision-making of high complexity during the service period • Face-to-face visit within seven calendar days of discharge
99495 (Days 8–14 post-discharge)	Transitional care management services with the following required elements: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge • Medical decision-making of at least moderate complexity during the service period • Face-to-face visit within 14 calendar days of discharge
1111F (Within 30 days post-discharge*)	Discharge medications reconciled with the current medication list in outpatient medical record * The 30-day limit relates to the measure specifications, not to a time limit on when the code can be used. **Note:** NPI required in addition to CPT II code to close care opportunity.

Links

- Humana's Quality Resources webpage:
  https://provider.humana.com/working-with-us/quality-resources
- CMS Part C and D Star Ratings:
  https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data
- www.availity.com
- www.submitrecords.com/Humana
- For Humana's Patient Experience Survey, please register for one of our live-session webinars with the following link:
  https://humana.zoom.us/webinar/register/WN_yN_nm09OQZGaizTA1y7tjw
- Humana's medical and pharmacy coverage policies:
  Humana.com/CoveragePolicies
- Humana's claims payment policies:
  Humana.com/ClaimPaymentPolicies
- Humana's claims processing edits:
  Humana.com/Edits

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