CarePlus quality measure guide

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

CarePlus HEALTH PLANS

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Contents

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. CarePlus strives to support you in providing quality services and improving the health outcomes of your CarePlus-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 will also 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 may include 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 required, 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 CarePlus provider,

We are grateful for the high-quality care you deliver to our CarePlus-covered patients and are honored to partner with you in the Star Rating Program.

This guide is designed to help care teams understand and succeed in this program, with the primary objective of improving patient outcomes. A major focus of Star Ratings is ensuring patients receive the right care at the right time, including preventive and chronic care services.

This guide provides Star measure details for HEDIS, HOS, CAHPS and Patient Safety, as outlined by CMS. We explain measure specifications, evidence-based best practices and coding guidelines. Additionally, we highlight various CarePlus resources to help you, and your practice share pertinent data and receive action-oriented reporting.

In addition to this guide, we provide the following resources:

- Your CarePlus clinical advisor is happy to partner with you and provide resources to help you identify patients who are in the eligible population for Star and quality measures.
- Contact your CarePlus clinical advisor with Star-specific questions or direct inquiries to **CPHP.StarsDept@CarePlus-hp.com**.

Again, we are so appreciative of the high-quality care you provide and thank you for partnering in this program.

Sincerely,

Kevin Rojas
Director, Quality and Risk Adjustment
CarePlus Health Plans

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 and 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 Star Rating of a plan.

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 CarePlus 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 **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. Once established, a data feed automates the regular collection and submission of HEDIS measures 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 CarePlus membership.

2. Standard supplemental data

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 CarePlus membership.

3. Non-standard supplement data

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 CarePlus membership.

Tools you can use

Availity Essentials

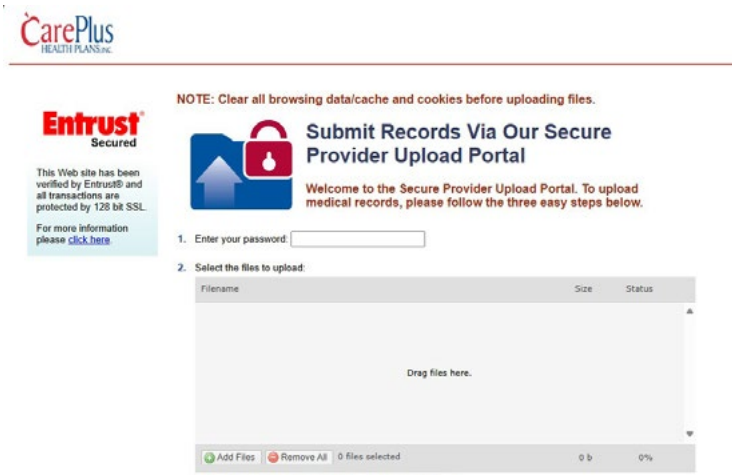
Availity® is a multi-payer digital application that is used to improve payer-provider collaboration. It can be used to submit preauthorization requests and view member benefits, eligibility information, claims status, and more with Availity Essentials™. For more information about Availity, go to **Availity Essentials**.

Submitting records manually

Although CarePlus has several platforms and tools to leverage for supplemental data, CarePlus does accept other types of submissions, including:

- Fax and physical mail
- Electronic upload via **CarePlus secure provider upload portal**

Learn more about these methods **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. CarePlus 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]

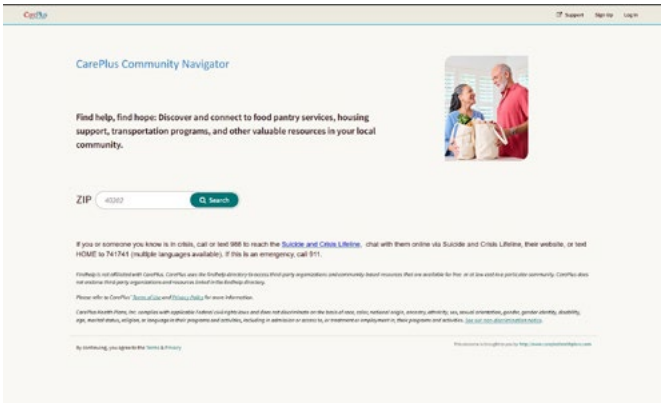
- Dual-eligible for Medicaid and Medicare (full or partial)
- Disabled
- Low Income Subsidy (LIS)

[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

CarePlus 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 (EHRs) have enhancements that integrate the HRSN screening tool as an assessment.
- The CarePlus 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 **211.org**.

CarePlus Community Navigator®



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:
  - Date and result of screening/test
  - Diagnosis codes for exclusions
  - 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 and Functional Status Assessment) if performed by a qualified provider and documented.
Colorectal Cancer Screening (COL–E)	Patient-reported screenings 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 an 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. Patient-reported results are not sufficient for this measure.

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.[3] Our goal is to provide the highest level of care and service to the MA members enrolled in CarePlus plans.

CarePlus 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.

CarePlus 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 CarePlus' 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 CarePlus 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 MY26 Star reporting. The Patient Experience Survey (PXS) thresholds represented are created by CarePlus, driven by CarePlus' Patient Experience Survey.

- CarePlus' PXS 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 CarePlus?

Similar to Medicare's Star Rating Program cycle, thresholds become available on an annual basis and are integrated into CarePlus' reporting when they are published. Based on the time of year, CarePlus reporting will show MY performance data and finalized thresholds.

[3] 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

There are two key milestones for data updates:

1. April: MY data flips from the previous year to the current year. CarePlus creates its own thresholds to account for industry performance trends. CarePlus' thresholds are not the same as CMS' Medicare 2026 Part C and D Star Ratings Technical Notes cut points but are modeled to resemble them in many ways.

2. October: CMS releases Star Ratings results prior to the Annual Election Period (AEP), along with the latest thresholds.

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 any measure in Medicare's Star Rating Program, 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.

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.[4]
- 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.

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).

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 via phone.

CarePlus 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

[4] https://www.wellsource.com/health-risk-assessments

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)	Completion of an annual comprehensive HRA ensures CarePlus' 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.

*Eligibility for some activities is based on clinical triggers.

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 and D–SNP Medicare patients

Preventive activities

Eligible screenings may include:

- Annual Wellness Visit
- Bone mineral density test
- Colonoscopy (45+)
- Mammogram
- 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).

Educational activities

Attend a health education or art class, participate in an athletic event, go to a social club or attend a religious gathering. Activity and reward values vary by plan.

In accordance with the federal requirements of the Centers for Medicare & Medicaid Services (CMS), no amounts on the gift cards shall be redeemable for cash and no amount may be applied toward the purchase of any prescription drug under under your patient's plan. Rewards (gift cards) must be earned and redeemed in the same plan year.

Rewards not redeemed by Dec. 31 will be forfeited.

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

CarePlus' goal

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

Provider-facing CarePlus clinical advisors

- 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)
- CarePlus Quality Reports

How is success measured?

CarePlus

Evaluates member care and awards incentives to providers annually

CMS

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

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

Healthcare Effectiveness Data and Information Set (HEDIS)

Developed by 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

Stating Therapy for Patients With Cardiovascular Disease (SPC–E)

- Moves from 1x measure to a display measure

Thresholds

Follow this icon in future pages to review measure thresholds.

Coding

Follow this icon in future pages to review measure coding.

Healthcare Effectiveness Data and Information Set (HEDIS)

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-E**	**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**	**–**

The Transitions of Care score is achieved by averaging it's four components. (TRC–NIA, TRC–RDI, TRC–PED and TRC–MRP)

* Measures apply only to Special Needs Plans (SNP)

** The TRC score is achieved by averaging four components

Preventive screenings

Breast Cancer Screening (BCS-E)

Coding

Thresholds

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

Measurement period

January–December

Eligible population

Women 40*–74 years of age who are recommended to complete a routine breast cancer screening and had a mammogram to screen for breast cancer.

Include patients recommended for routine breast cancer screening with any of the following criteria:

- Administrative gender of female anytime 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 year and Dec. 31 of the measurement year (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:
  - 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)
- Patient 66 years of age and with **frailty and advanced illness**

* Women must be 42 years of age in the measurement period. However, since the measure has a "look-back" period of two years, the patient may have been 40years of age at the time of screening.

Healthcare Effectiveness Data and Information Set (HEDIS)

Preventive screenings

Breast Cancer Screening (BCS-E)

Coding

Thresholds

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

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.

Supplemental data accepted

Preventive screenings

Colorectal Cancer Screening (COL-E)

Coding

Thresholds

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

Measurement period

January–December

Eligible population

Patients 45–75 years of age who had appropriate screening for colorectal cancer

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

Healthcare Effectiveness Data and Information Set (HEDIS)

Preventive screenings

Colorectal Cancer Screening (COL-E)

Coding

Thresholds

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

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.
- Submit supplemental data to communicate historical evidence of testing and colon cancer screenings completed.
- Encourage patients to complete a colon cancer screening. Eligible patients may receive an at-home test kit. Encourage patients with an at-home test kit to complete and return the test kit. Consult your clinical advisor for a list of eligible patients.
- Cologuard® is the only sDNA with FIT test approved for measure closure.
- Shield™ is a blood-based biomarker test used to screen for colon cancer but is not an acceptable screening for this measure.

Supplemental data accepted

Preventive screenings

Coding

Thresholds

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 of prior year to June 30 of the measure year

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 and older 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.

Preventive screenings

Coding

Thresholds

Osteoporosis Management in Women Who Had a Fracture (OMW)

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

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.

Supplemental data accepted

Condition management – cardio

Controlling High Blood Pressure (CBP)

Coding

Thresholds

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

Measurement period

January–December

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

Healthcare Effectiveness Data and Information Set (HEDIS)

Condition management – cardio

Controlling High Blood Pressure (CBP)

Coding

Thresholds

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

Measure best practices

- In-office measurement: Ensure accurate measurement by implementing and maintaining office practices such as:
  - Providing at least five minutes of quiet rest prior to reading
  - Using correct cuff size
  - 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):
  - Assess for adherence barriers; consider simplified medication options, such as 90- or 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.
  - Recommend at-home monitoring of blood pressure and provide supporting materials
  - Consider follow-up in approximately a month; offer virtual options where appropriate/convenient

Supplemental data accepted

Condition management – cardio

Coding

Thresholds

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

Statin Therapy for Patients With Cardiovascular Disease (SPC-E)
MY26 | Weight = 1

Measurement period

January–December

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:

- Only outpatient visits can include telehealth
- With a diagnosis of ischemic vascular disease (IVD)
- In an inpatient or outpatient setting
- 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.

Exclusions

Some SPC–E 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)
- Patients 66 years of age and older with **frailty and advanced illness**

Condition management – cardio

Coding

Thresholds

Statin Therapy for Patients With Cardiovascular Disease (SPC)

Statin Therapy for Patients With Cardiovascular Disease (SPC)
MY26 | **Weight = 1**

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.

Supplemental data accepted

Condition management – cardio

Eye Exam for Patients With Diabetes (EED)

Coding

Thresholds

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

Measurement period

January–December

Eligible population

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

Service required

- A retinal or dilated eye exam performed by an eye care professional (optometrist or ophthalmologist) during the current measurement year 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.

Note: 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.

Healthcare Effectiveness Data and Information Set (HEDIS)

Condition management – cardio

Coding

Thresholds

Eye Exam for Patients With Diabetes (EED)

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

Measure best practices

- Ask specifically about retinal eye exam history.
- Review diabetes services needed at each office visit and refer patients to see an eye care professional for a comprehensive dilated or retinal eye exam during the current 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 year through supplemental data.
- Ensure processes exist when referring patients to eye specialists to follow up with specialist or patient to obtain records and result of exam.
- Submit claims with appropriate CPT Category II codes to indicate 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 year.)

Supplemental data accepted

Condition management – diabetes

Coding

Thresholds

Glycemic Status Assessment for Patients With Diabetes (GSD)

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

Measurement period

January–December

Eligible population

Patients 18–75 years of age who have been diagnosed (twice) with type 1 or type 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.

Note: 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**

Healthcare Effectiveness Data and Information Set (HEDIS)

Condition management – diabetes

Coding

Thresholds

Glycemic Status Assessment for Patients With Diabetes (GSD)

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

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 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.
- Execute processes to monitor patients with greater than 9% HbA1c levels and encourage the appropriate follow-up 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.

Supplemental data accepted

Condition management – diabetes

Coding

Thresholds

Kidney Health Evaluation for Patients With Diabetes (KED)

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

Measurement period

January–December

Eligible population

Patients 18–85 years of age with type 1 or type 2 diabetes who meet either of the following criteria during the measurement year or the year prior to the measurement year:

- Two diagnoses of diabetes on different dates of service
- Pharmacy data showing one dispensed insulin or hypoglycemic/antihyperglycemic and at least one diagnosis of diabetes

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:
  - One must contain a quantitative urine albumin test
  - One must contain a urine creatinine test
  - 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**

Healthcare Effectiveness Data and Information Set (HEDIS)

Condition management – diabetes

Coding

Thresholds

Kidney Health Evaluation for Patients With Diabetes (KED)

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

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 period 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 period 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 appropriate time frame for measure compliance.

Supplemental data accepted

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

Coding

Thresholds

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

Measurement period

January–December

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

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:
  - 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
  - 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
  - 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 any time during the measurement year

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

Coding

Thresholds

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

Measure best practices

- Perform a comprehensive functional status assessment with older patients as a part of an annual wellness 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 be submitted as supplemental data.

Supplemental data accepted

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

Coding

Thresholds

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

Measurement period

January–December

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.

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

Note: Do not include medication lists or medication reviews performed in an outpatient setting. If the patient is not taking medication, this must be notated in the patient's 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 any time during the measurement year

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

Coding

Thresholds

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

Measure best practices

- Complete medication review annually.
- Ensure clinician review and reconciliation of medications. Documentation of the review must include the date of 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 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 year.

Supplemental data accepted

Care coordination

Coding

Thresholds

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

January–December

Applicable data collection method

Administrative only

Eligible population

Patients 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 the day of ED visit). 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

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

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.

Care coordination

Coding

Thresholds

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**

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.

Supplemental data accepted

Care coordination

Thresholds

Plan All-Cause Readmissions (PCR)

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

Measurement period

January–December

Eligible population

For individuals aged 18 and older, this measure calculates the risk-adjusted ratio of actual to expected unplanned acute readmissions (including both inpatient and observation stays) for any diagnosis within 30 days following discharge from an acute hospitalization (either inpatient or observation stay).

Service required

The needed action is to avoid readmission within 30 days. 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
- Pregnancy-related admission
- Patients in hospice or using hospice services
- Patients who died during stay
- Patients with four or more hospital stays (acute inpatient and observation) between Jan. 1 and Dec. 1
- For stays that included a direct transfer, exclude 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.

Care coordination

Thresholds

Plan All-Cause Readmissions (PCR)

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

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 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)

Coding

Thresholds

Transitions of Care (TRC) MY26 | **Weight = 1**

The Transitions of Care (TRC) measure assesses instances of admission and discharge information delivered to a patient's physician and evaluates patient engagement provided within 30 days after an acute or nonacute discharge on or between Jan. 1 and Dec. 1 of the measurement period 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 are excluded for the TRC–RDI component

*Palliatve care is not an exclusion for the TRC–MRP component

Care coordination

Transitions of Care (TRC)

Coding

Thresholds

Transitions of Care (TRC) MY26 | **Weight = 1**

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.

Supplemental data accepted

Care coordination

Transitions of Care (TRC)

Coding

Thresholds

Notification of Inpatient Admission (TRC–NIA) MY26

Measurement period

January–December

Applicable data collection method

Medical record review only

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:
  - Must clearly apply to the admission event and include a time frame for the planned inpatient admission
  - Is not limited to the admit date or the two following days

Note: Patient 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.

Care coordination

Transitions of Care (TRC)

Coding

Thresholds

Receipt of Discharge Information (TRC–RDI) MY26

Measurement period

January–December

Applicable data collection method

Medical record review only

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 the date the documentation was received.

The following methods are compliant

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)

Coding

Thresholds

Patient Engagement After Inpatient Discharge (TRC–PED) MY26

Measurement period

January–December

Applicable data collection method

Administrative and hybrid

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:

- Outpatient visits, including office or home visits
- A telephone visit
- Transitional care management services
- A synchronous telehealth visit where real-time interaction occurred between the patient and his/her PCP with audio and video communication
- 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.

Care coordination

Transitions of Care (TRC)

Coding

Thresholds

Medication Reconciliation Post-Discharge (TRC–MRP) MY26

Measurement period

January–December

Applicable data collection method

Administrative and hybrid

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.

Medication reconciliation may be performed in any of the following ways:

- 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 the age of 18, known to be deceased, known to reside in an institutional setting or reside outside of the U.S.

Additionally, CMS sample procedures do not allow for the selection of more than one enrollee per household and includes members who have been enrolled in an MA/MAPD plan for six months or more. The survey is distributed annually between March and June.

CAHPS (measured February–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 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 consult your CarePlus Patient Experience Program educator.

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.

Care Coordination (CC)

Care Coordination (CC) MY26 | **Weight = 2**

Overview

Assesses how well patient care is coordinated, including whether doctors had the records and information they needed about patients' care and how quickly patients got their test results

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

Note: There are three 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), Plan All-Cause Readmissions (PCR) and Transitions of Care (TRC).

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Care Coordination (CC)

Care Coordination (CC) MY26 | **Weight = 2**

Measure best practices

- Talk to patients about getting vaccinated during regularly scheduled visits during flu season.
- When sending out 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 the patient 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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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 questions

- 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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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.

Note: As of January 1, 2026, CMS requires prior authorization decisions within seven calendar days for standard (non-urgent) requests for medical items and services. CarePlus is committed to meeting the timeframe for prior authorization decisions in accordance with this rule. To prevent unnecessary denials or barriers to care, please ensure supporting clinical documentation is submitted with each request. For more information, click **here**.

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
- 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; I did not use my prescription drug plan to fill a prescription at my local pharmacy 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 by mail?
  Answer choices: Never; Sometimes; Usually; Always; I did not use my prescription drug plan to fill a prescription by mail in the last six months; I am not sure if my drug plan offers prescriptions by mail

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 CarePlusHealthPlans.com/PAL to determine if a medication requires preauthorization before it can be dispensed or administered.
- Recommend patients switch to 90- or 100-day supplies from their community pharmacy or via a mail-order pharmacy.

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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

Rating of Drug Plan (RDP)

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?

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

Rating of Health Plan (RHP)

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?

Health Outcomes Survey (HOS)

The 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–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

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 consult your CarePlus Patient Experience Program educator.

Improving Bladder Control (IBC)

Improving Bladder Control (IBC) MY26 | **Weight = 1**

Overview

Percentage of sampled Medicare 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?
  Answer choices: Yes; No
- During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?
  Answer choices: A lot; Somewhat; Not at all
- Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine?
  Answer choices: 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?
  Answer choices: 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 healthcare provider may ask if you exercise regularly or take part in physical exercise.
  Answer choices: Yes; No; I had no visits in the past 12 months
- In the past 12 months, did a doctor or other healthcare 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 healthcare 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.
  Answer choices: Yes; No; I had no visits in the past 12 months

Exclusion

- 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:
  Answer choices: 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?
  - Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?
    Answer choices: Yes, limited a lot; Yes, limited a little; No, not limited at all
  - Climbing several flights of stairs?
    Answer choices: 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?
  - Accomplished less than you would like as a result of your physical health?
    Answer choices: 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
  - Were limited in the kind of work or other activities as a result of your physical health?
    Answer choices: 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)?
  Answer choices: 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?
  Answer choices: 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 (IMPH) MY26 | **Weight = 3**

Overview

Percentage of sampled Medicare patients 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)?
  - Accomplished less than you would like as a result of any emotional problems
    Answer choices: 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
  - Didn't do work or other activities as carefully as usual as a result of any emotional problems?
    Answer choices: 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:
  - Have you felt calm and peaceful?
    Answer choices: 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
  - Did you have a lot of energy?
    Answer choices: 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
  - Have you felt downhearted and blue?
    Answer choices: 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.)?
  Answer choices: 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?
  Answer choices: 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 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., CarePlus Community Navigator®).
- If a patient reports issues with emotional/mental health/isolation, understand how this may impact physical activity regimen for a holistic approach to care.

Reducing the Risk of Falling (ROF)

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

Overview

Percentage of sampled 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?
  Answer choices: Yes; No; I had no visits in the past 12 months
- Did you fall in the past 12 months?
  Answer choices: Yes; No
- In the past 12 months, have you had a problem with balance or walking?
  Answer choices: 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:
  - Suggest that you use a cane or walker
  - Suggest that you do an exercise or physical therapy program
  - Get a vision or hearing test

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.

Exclusions

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

CarePlus Patient Experience Survey (PXS)*

The CarePlus Patient Experience Survey is a voice-automated telephone call to CarePlus members following an in-person visit with their healthcare provider.

The survey questions are similar to the content of the CAHPS survey and the HOS administered by CMS to MA members. The CMS surveys for health plans are measured at the contract level and individual response data is not available as it relates to provider performance. Because of this, the PXS questions are informed by the CMS surveys but are phrased, organized and implemented differently to provide more focus on measures that can be impacted by providers.

The overall purpose of the PXS is to help providers gain insights into how they can partner with CarePlus on strategies to improve the overall experience of patients.

CarePlus PXS (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**

* Not included as part of CMS Star Ratings, applicable for provider performance
** CarePlus-established weights, not CMS-established. CarePlus creates its own thresholds and weights to account for industry performance trends

Note: CarePlus' Patient Experience Survey is shaped by CAHPS and HOS, but the questions are specific to CAHPS and HOS measures that CarePlus has deemed provider-influenced.

Unlike CAHPS and HOS—which ask members to evaluate their overall care over a set time frame—the PXS centers on a single, recent visit. Because the CarePlus PXS 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

If interested in learning more about CarePlus' Patient Experience Survey, contact your CarePlus Patient Experience Program educator or email CPHP.StarsDept@careplus-hp.com.

Coordination of Care (CC)

Coordination of Care (CC) CarePlus PXS Weight = 5.5

Overview

Assesses how well patient care is coordinated, including whether doctors had conversations about a patient's medicines as well as how informed personal doctors are about any specialist care their patients received.

CarePlus PXS questions

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

Measure best practices

- When sending out 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 the patient 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)

Getting Needed Care (GNC) CarePlus PXS 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).

CarePlus PXS questions

- Did you have any trouble getting a referral from your personal doctor to see a specialist?
  Answer choices: Yes; No; Doesn't Apply

The following questions are asked to gauge CarePlus 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 CarePlus.

- Did you have trouble with your prescription drug plan covering any medication your doctor prescribed?
  Answer choices: 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?
  Answer choices: 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)

Getting Care Quickly (GCQ) CarePlus PXS Weight = 5.5

Overview

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

CarePlus PXS questions

- Did you experience any difficulty scheduling your appointment?
  Answer choices: 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?
  Answer choices: 0-15 minutes; 15-30 minutes; 30-60 minutes; 60 or more minutes

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.
- 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 | Monitoring Physical Activity (MPA) CarePlus PXS 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.

CarePlus PXS question

- Did your doctor or other healthcare provider advise you to start, increase or maintain your level of exercise or physical activity?
  Answer choices: 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 | Improving or Maintaining Mental Health (IMMH)
CarePlus PXS 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 CarePlus PXS question. If they answer "No," it will skip the question.

CarePlus PXS question

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

Measure best practices

- Administer PHQ-2 and PHQ-9 Mental Health Assessments.
- Check in with 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., CarePlus Community Navigator®).
- If a patient reports issues with emotional/mental health or isolation, understand how this may impact physical activity regimen for a holistic approach to care.

Improving Bladder Control (IBC)

Patient Discussion | Improving Bladder Control (IBC) CarePlus PXS 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.

CarePlus PXS questions

- Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine?
  Answer choices: 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?
  Answer choices: 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 | **Reducing the Risk of Falls CarePlus PXS 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."

CarePlus PXS questions

- Did your doctor or other healthcare provider talk to you about falling or problems with balance or walking?
  Answer choices: 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?
  Answer choices: Yes; No

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 along with 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 Pharmacy Quality Alliance. They apply to both Medicare Advantage prescription drug (MAPD) plans 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 CarePlus. 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

*CarePlus-established weights, not CMS-established. CarePlus creates its own thresholds and weights to account for industry performance trends.

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.[5]

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 CarePlus. CMS calculations will be risk adjusted, but CarePlus' 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.

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- or 100-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- or 100-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 **CarePlus Community Navigator®**.
- Refer patients to **Medication Management | CarePlus Health Plans** for adherence tips and tools.

Medication Adherence (MA)

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

Measurement period

January–December

Overview

Proportion of days covered: Statins (PDC–STA/MAC)

Percentage of patients 18 years of age and older with Part D benefits with at least two cholesterol medication (a statin drug) prescription fills on unique service dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Exclusions

- Patients in hospice or using hospice services
- Patients with ESRD or on dialysis

Medication Adherence for Diabetes Medications MY26 | Weight = 3

Measurement period

January–December

Overview

Proportion of days covered: Diabetes all-class rate (PDC–DR/MAD)

Percentage of patients 18 years of age and older with Part D benefits with at least two diabetes medication prescription fills on unique dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication

- 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.

Exclusions

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

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

Measurement period

January–December

Overview

Proportion of days covered: renin angiotensin system antagonists (PDC–RASA/MAH)

Percentage of patients 18 years of age and older with Part D benefits with 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 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

January–December

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
  - With no more than one gap in enrollment of up to 31 days during the measurement year
  - 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

CMS wants to ensure patients are not taking opioids and benzodiazepines together with overlapping days' supply for 30 or more cumulative days during the measurement period.

- A patient moves into the numerator if there are two or more claims of any benzodiazepine on different dates of service and concurrent use of opioids and benzodiazepines for 30 or more cumulative days.
- The patient does not enter the numerator if:
  - The number of fills for each drug is less than two, or
  - The number of overlapping days' supply is less than 30 cumulative days

Exclusions

- Patients with cancer, sickle cell disease or palliative care during the measure year if there is at least one claim in the primary diagnosis or other diagnosis fields during the measure year
- Patients in hospice or using hospice services

Concurrent Use of Opioids and Benzodiazepines (COB)

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

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.
- Patients should be reminded not to accept additional opioid or benzodiazepine prescriptions without the prescribing healthcare provider conferring with the PCP before prescribing.
- Recommend at least one of these medications be changed to a safer medication or discontinued and tapered to prevent further decline or adverse events.

Statin Use in Persons with Diabetes (SUPD)

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

Measurement period

January–December

Eligible population

Patients 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 year

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

- Use noncompliant patient lists to review medications and evaluate addition of statin therapy to regimen.
- Ensure a comprehensive review of new to practice/Medicare patients who have been diagnosed with diabetes to evaluate their current statin therapy.
- Ensure the practice has process to conduct reviews if patient records when dispensed two diabetes medications on unique dates of service.
- Inform patients that statin therapy may reduce the risk of heart attack and stroke.
- For patients beginning statin therapy, discuss common side effects such as muscle weakness and advise them to contact your practice to discuss options before discontinuing.
- To minimize potential side effects, select the appropriate dose based on patient's health factors and any drug-to-drug interactions with current medications.

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

January–December

Eligible population

Patients 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

CMS wants to ensure patients are not taking two or more unique ACH medications and have an overlapping days' supply for 30 or more cumulative days during the measurement period.

- One of the medications should be changed to a safer medication or discontinued to enhance the patient's safety.

The patient does not enter the numerator if the number of fills for each unique ACH drug is less than two or the number of overlapping days' supply is less than 30 cumulative days.

Note: Only paid, non-reversed prescription claims are included in the data set to calculate the measure.

Exclusions

During the measurement period:

- Patients in hospice, using hospice services or receiving palliative care

* Unique is defined at the active ingredient level.

Polypharmacy

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

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

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 no 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.

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

January–December

Eligible population

Patients 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

CMS wants to ensure patients are not taking three or more unique CNS medications that have overlapping days' supply for 30 or more cumulative days during the measurement period.

- One of the medications should be changed to a safer medication or discontinued to enhance the patient's safety.

The patient does not enter the numerator if the number of fills for each unique CNS drug is less than three or the number of overlapping days' supply is less than 30 cumulative days.

Note: Only paid, non-reversed prescription claims are included in the data set to calculate the measure.

Exclusions

During the measurement period:

- Patients with a seizure disorder diagnosis
- Patients in hospice, using hospice services or receiving palliative care

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**

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.

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.

Appendix

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®

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 Medicare Advantage and prescription drug plans.

CMS

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.

Appendix

Glossary

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.

Appendix

Glossary

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.

Appendix

Glossary

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.

Appendix

CarePlus BY29/MY26 provider thresholds

CarePlus 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.

CarePlus 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 CarePlus' improvement initiatives and meet overall performance objective.

HEDIS	BY29			CMS	CarePlus
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
Controlling High Blood Pressure (CBP)	78%	83%	89%	3x	3x
Eye Exam for Patients With Diabetes (EED)	71%	79%	85%	1x	1x
Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	63%	72%	84%	1x	1x
Glycemic Status Assessment for Patients With Diabetes (GSD)	87%	91%	93%	3x	3x
Kidney Health Evaluation for Patients With Diabetes (KED)	57%	67%	80%	1x	1x
Osteoporosis Management in Women Who Had a Fracture (OMW)	43%	56%	71%	1x	1x
Plan All-Cause Readmissions (PCR)	9%	8%	6%	3x	3x
Transitions of Care – Composite (TRC)†	60%	74%	81%	1x	1x

Appendix

CarePlus BY29/MY26 provider thresholds

Patient Safety: Medicare Advantage prescription drug (MAPD) plan values					
Concurrent Use of Opioids and Benzodiazepines (COB)*	13%	9%	6%	1x	1x
Medication Adherence for Cholesterol (MAC)	90%	92%	96%	1x	3x*
Medication Adherence for Diabetes Medications (MAD)	87%	90%	93%	1x	3x*
Medication Adherence for Hypertension (MAH)	90%	93%	95%	1x	3x*
Statin Use in Persons with Diabetes (SUPD)	85%	90%	95%	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 CarePlus. CMS calculations will be risk adjusted, but CarePlus' 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.

† TRC composite score is determined by averaging the scores of its four components (TRC–NIA, TRC–RDI, TRC–PED and TRC–MRP). TRC–MRP and TRC–PED are each 1x for CarePlus' provider reporting/incentives.

Appendix

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

HEDIS	BY25[6]		BY26[7]		BY27[8]	
Measure	**4 star**	**5 star**	**4 star**	**5 star**	**4 star**	**5 star**
Breast Cancer Screening (BCS-E)	71%	79%	75%	82%	76%	84%
Care for Older Adults – Functional Status Assessment (COA–FSA)	Display		Display		Display	
Care for Older Adults – Medication Review (COA–MDR)	93%	98%	92%	98%	93%	98%
Care for Older Adults – Pain Screening (COA–PNS)	91%	96%	92%	96%	95%	99%
Colorectal Cancer Screening (COL-E)	71%	80%	75%	83%	70%	78%
Controlling High Blood Pressure (CBP)	74%	82%	80%	85%	80%	86%
Eye Exam for Patients With Diabetes (EED)	73%	81%	77%	83%	80%	86%
Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	60%	68%	60%	69%	67%	78%
Glycemic Status Assessment for Patients With Diabetes (GSD)	80%	87%	84%	90%	87%	91%
Kidney Health Evaluation for Patients With Diabetes (KED)	Display		Display		62%	74%
Osteoporosis Management in Women Who Had a Fracture (OMW)	55%	71%	52%	71%	53%	68%
Plan All-Cause Readmissions (PCR)	10%	8%	10%	8%	9%	7%
Statin Therapy for Patients With Cardiovascular Disease (SPC–E)	86%	90%	88%	92%	88%	91%
Transitions of Care – Composite (TRC)†	64%	78%	63%	77%	69%	79%

Appendix

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

Patient Safety: Medicare Advantage prescription drug (MAPD) plan values	BY25[6]		BY26[7]		BY27[8]	
Measure	**4 star**	**5 star**	**4 star**	**5 star**	**4 star**	**5 star**
Medication Adherence for Cholesterol (MAC)	88%	91%	89%	93%	90%	93%
Medication Adherence for Diabetes Medications (MAD)	88%	90%	87%	91%	89%	92%
Medication Adherence for Hypertension (MAH)	89%	91%	90%	92%	91%	93%
Statin Use in Persons with Diabetes (SUPD)	88%	92%	89%	93%	89%	93%
CMS: Medicare Advantage prescription drug (MAPD) values						
MTM Program Completion Rate for Comprehensive Medication Review (CMR)	85%	92%	89%	93%	91%	96%
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 Health Plan (RHP)	88%	89%	88%	89%	87%	89%

Appendix

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

HOS	BY25[6]		BY26[7]		BY27[8]	
Measure	**4 star**	**5 star**	**4 star**	**5 star**	**4 star**	**5 star**
Improving or Maintaining Physical Health (IMPH)	Display		Display		72%	75%
Improving or Maintaining Mental Health (IMMH)	Display		Display		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%

Sources:
[6] Medicare 2024 Part C & D Star Ratings Technical Notes
[7] Medicare 2025 Part C & D Star Ratings Technical Notes
[8] Medicare 2026 Part C & D Star Ratings Technical Notes

Appendix

Coding

BCS-E coding

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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

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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	Diastolic: blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)
3079F	CPT	Diastolic: blood pressure 80–89 mm Hg (HTN, CKD, CAD) (DM)
3080F	CPT	Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)

Appendix

COL-E coding

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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	HCPCS	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	CPT	**Surgery/hospital codes:** Flexible sigmoidoscopy between Jan. 1 four years prior and Dec. 31 of the current year
G0104	CPT	**Surgery/hospital codes:** Flexible sigmoidoscopy between Jan. 1 four years prior and Dec. 31 of the current year
74261–74263	CPT	CT colonography between Jan. 1 four years prior and Dec. 31 of the current year
44388–44392, 44394, 44401–44408, 45378–45982, 45384–45386, 45388–45393, 45398	CPT	Colonoscopy between Jan. 1 nine years ago and Dec. 31 of the current year
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)

Appendix

EED coding

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Code type	Code
Most common CPT codes for diabetic retinal screening	
CPT	92002, 92004, 92012, 92014, 92134, 92225, 92228, 92230, 92250, 92260
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, 92137, 92201, 92202, 92227, 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, E13.9

** 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 year.

Appendix

GSD coding

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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

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<table>
<tr><th rowspan="2">Blood test</th><th rowspan="2">AND</th><th colspan="3">Urine test
(must include both quantitative albumin and urine creatinine)</th></tr>
<tr><th>Option 1</th><th colspan="2">Option 2</th></tr>
<tr><td>Estimated glomerular filtration rate lab test (eGFR)</td><td>Urine albumin-creatinine ratio (uACR)</td><td>Quantitative urine albumin lab test</td><td>Urine creatinine lab test</td></tr>
<tr><td rowspan="2">CPT: 80047, 80048, 80050*, 80053, 80069, 82565

* 80050 is a general health panel; providers must share the components of the panel for CarePlus to pay.</td><td rowspan="2">LOINC: 13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7</td><td>CPT code 82043</td><td>CPT code 82570</td></tr>
<tr><td colspan="2">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</td></tr>
</table>

Appendix

COA coding

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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 – 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

Appendix

COA coding cont.

Return to COA page →

Code	Code type	Definition
COA – Medication Review (MDR)		
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

Appendix

OMW coding

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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

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OMW coding cont. Return to OMW page →

Code	Code type	Definition
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
J0897	HCPCS	Injection, denosumab, 1 mg
J1740	HCPCS	Injection, ibandronate sodium, 1 mg
J3110	HCPCS	Injection, teriparatide, 10 mcg
J3111	HCPCS	Injection, romosozumab-aqqg, 1 mg
J3489	HCPCS	Injection, zoledronic acid, 1 mg
Q5136	HCPCS	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg

Appendix

SPC-E coding – ICD-10-CM

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Required exclusions

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
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

Appendix

FMC coding

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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

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FMC coding cont.

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Code type	Code
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
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

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FMC coding cont.

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Code type	Code
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

Appendix

TRC–MRP coding

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Code	Code type	Definition
1111F	CPT II	Discharge medications reconciled with the current medication list in outpatient medical record
99483	CPT	Assessment of and care planning for a patient
99495, 99496	CPT	Transitional care management service
99605, 99606	CPT	Medication therapy management service

TRC–PED coding

Return to TRC page →

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

Links

- CarePlus's Quality Resources webpage:
  Quality Resources for Providers | CarePlus Health Plans
- CMS Part C and D Star Ratings:
  CMS.gov/medicare/health-drug-plans/part-c-d-performance-data
- **Availity Essentials™**
- **SubmitRecords.com/careplus**