Health Plan of San Joaquin

Mountain Valley Health Plan

Medicare 2026 Star Measures

Session 2 of 5

HPSJ/MVHP Quality Department

March 4, 2025

Introduction

- Second of a 5-part series for providers who care for Health Plan of San Joaquin/Mountain Valley Health Plan's Duals Special Needs Plan (D-SNP) members
- Each session will dive into 6-7 Medicare Stars measures and related best practices
- A Stars Pocket Guide (e-version) will also be available soon as a reference tool for practice staff

Today's Focus Measures

- C15 – Reducing the Risk of Falling
- C16 – Improving Bladder Control
- C17 – Medication Reconciliation Post-Discharge
- C18 – Plan All-Cause Readmissions
- C20 – Transitions of Care
- C21 – Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Medicare Part C

Domain 2 - Managing Chronic (Long Term) Conditions

C15 – Reducing the Risk of Falling

Description: Percent of plan members with a problem falling, walking, or balancing who discussed it with their doctor and received a recommendation for how to prevent falls during the year.

Metric: The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months (denominator) and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner (numerator).

HEDIS Label	Weighting Category	Weight
Fall Risk Management (FRM)	Process Measure	1

C15 – Reducing the Risk of Falling

Provider Best Practices and Process Flows

- Providers should conduct annual fall risk screenings for members aged 65 and older and after any fall-related encounter.
- Documented recommendations should include exercise or physical therapy, home safety interventions, vision review, and medication review.
- High-risk members should receive multi-factorial fall risk management.

C15 – Reducing the Risk of Falling

Provider Data and Technology Expectations

- Structured EHR templates should capture fall risk assessments and interventions.
- Referral workflows should track physical therapy, home safety evaluations, and vision services.
- High-risk medications should be flagged, and orthostatic vital sign prompts should be enabled.
- Population lists should identify members reporting falls or balance issues.

C15 – Reducing the Risk of Falling

Knowledge Check

A 72-year-old Medicare member reports feeling unsteady when walking and says they nearly fell last month. The provider documents the concern during the visit. Which action is necessary for this encounter to count toward the fall prevention measure?

A. Document the patient's fall risk and schedule a follow-up visit next year

B. Provide and document a recommendation to prevent falls, such as exercise, physical therapy, home safety changes, vision review, or medication review

C. Order imaging to evaluate balance problems

D. Refer the patient to the emergency department for evaluation

C16 – Improving Bladder Control

Description: Percent of plan members with a urine leakage problem in the past 6 months who discussed treatment options with a provider.

Metric: The percentage of Medicare members 65 years of age or older who reported having any urine leakage in the past six months (denominator) and who discussed treatment options for their urinary incontinence with a provider (numerator).

HEDIS Label	Weighting Category	Weight
Management of Urinary Incontinence in Older Adults (MUI)	Process Measure	1

C16 – Improving Bladder Control

Provider Best Practices and Process Flows

- Providers should routinely screen older adults for urinary incontinence.
- Discussions of treatment options, including pelvic floor therapy, behavioral strategies, and medications when appropriate, must be documented.
- Persistent symptoms should trigger referrals to pelvic floor physical therapy or urology.

C16 – Improving Bladder Control

Provider Data and Technology Expectations

- EHR tools should support structured screening and counseling documentation.
- Referral and follow-up tracking should ensure continuity of care.
- Patient education resources should be delivered after visits.
- Care gap reports should identify members with positive screenings lacking documented discussions.

C16 – Improving Bladder Control

Knowledge Check

A 70-year-old Medicare member reports experiencing urine leakage over the past several months during a routine visit. The provider documents the symptom in the medical record. Which action is required for this visit to count toward the urinary incontinence discussion measure?

A. Document the urine leakage and advise the patient to monitor symptoms

B. Document the urine leakage and order diagnostic imaging

C. Discuss and document treatment options such as pelvic floor therapy, behavioral strategies, or medications when appropriate

D. Refer the patient to urology without discussing treatment options

Pausing to Process...

C17 – Medication Reconciliation Post-Discharge

Description: The percentage of plan members whose medication records were updated within 30 days after leaving the hospital.

Metric: The percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled on the date of discharge through 30 days after discharge (31 total days).

HEDIS Label	Weighting Category	Weight
Medication Reconciliation Post-Discharge (MRP)	Process Measure	1

C17 – Medication Reconciliation Post-Discharge

Provider Best Practices and Process Flows

- Hospital discharge notifications should trigger medication reconciliation within seven to fourteen days, either by phone or in person.
- Discharge medications should be compared to pre-admission medications, discrepancies resolved, and patients educated.
- Providers should close the loop with pharmacies by canceling outdated prescriptions and confirming new fills.

C17 – Medication Reconciliation Post-Discharge

Provider Data and Technology Expectations

- ADT feeds should support timely identification of discharges.
- Medication reconciliation templates should align with measure specifications.
- Tasking systems should ensure reconciliation completion within required timeframes.
- Pharmacy integration should confirm medication fills and identify duplications or confusion.

C17 – Medication Reconciliation Post-Discharge

Knowledge Check

A 66-year-old Medicare member is discharged from the hospital on June 10. The primary care provider reviews the hospital discharge medications, compares them to the member's pre-admission medications, updates the medication list in the EHR, and resolves discrepancies on July 20. Does this encounter count toward the Medication Reconciliation Post-Discharge measure?

A. Yes, because medication reconciliation was completed after discharge

B. Yes, because the medication list was updated during the same calendar year

C. No, because medication reconciliation must occur within 30 days after discharge

D. No, because medication reconciliation must occur on the same day as discharge

Pausing to Process...

C18 – Plan All-Cause Readmissions

Description: Percent of plan members aged 18 and older discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.

Metric: The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 years of age and older.

HEDIS Label	Weighting Category	Weight
Plan All-Cause Readmissions (PCR)	Outcome Measure	3

C18 – Plan All-Cause Readmissions

Provider Best Practices and Process Flows

- Providers should perform post-discharge risk stratification and tailor intervention intensity accordingly.
- Outreach should occur within forty-eight to seventy-two hours, with follow-up visits within seven days.
- Interventions should address medication access, durable medical equipment, caregiver support, and social needs.
- Standardized care pathways should be used for common readmission drivers such as heart failure, chronic obstructive pulmonary disease, and pneumonia.

C18 – Plan All-Cause Readmissions

Provider Data and Technology Expectations

- Readmission risk dashboards should support population monitoring.
- Real-time hospitalization alerts should be enabled through ADT feeds and HIE connectivity.
- Care management platforms should document all outreach and outcomes.
- Shared care plans should be accessible across care settings.

C18 – Plan All-Cause Readmissions

Knowledge Check

A 59-year-old patient is discharged from the hospital after treatment for pneumonia. Ten days later, the patient is admitted to the hospital again for worsening heart failure. How is this event counted in the Plan All-Cause Readmissions measure?

A. It does not count because the readmission diagnosis is different from the original hospitalization

B. It counts only if the second admission is related to pneumonia

C. It counts because any unplanned acute readmission within 30 days is included, regardless of diagnosis

D. It does not count because the patient is under age 65

Pausing to Process...

C20 – Transitions of Care

Description: This rating is based on the percent of plan members who got follow-up care after a hospital stay. Follow-up care includes getting information about their health problem and what to do next, having a visit or call with a doctor, and having a doctor or pharmacist make sure the plan member's medication records are up to date.

Metric: Discharge, Transitions of Care -Notification of Inpatient Admission, Transitions of Care -Patient Engagement After Inpatient Discharge, and Transitions of Care -Receipt of Discharge Information.

HEDIS Label	Weighting Category	Weight
Transitions of Care (TRC)	Process Measure	1

C20 – Transitions of Care

Provider Best Practices and Process Flows

- Providers should implement an end-to-end transition of care bundle, including notification, discharge information, engagement, and medication reconciliation.
- Standardized scripts and checklists should be used for outreach calls.
- Follow-up appointments should be scheduled prior to discharge whenever possible.
- Each discharge episode should have a single accountable owner.

C20 – Transitions of Care

Provider Data and Technology Expectations

- ADT and discharge data should be integrated into care management workflows.
- Care management platforms should support all transition subcomponents.
- Structured documentation templates should align with composite measure requirements.
- Reporting should identify subcomponent drop-off points.

C20 – Transitions of Care

Knowledge Check

A 68-year-old member is discharged from the hospital after treatment for pneumonia. The provider's office receives notification of the admission, obtains discharge information, contacts the patient after discharge to review next steps, and performs medication reconciliation. Why is completing all of these steps important for the Transitions of Care measure?

A. Because the measure only evaluates medication reconciliation after discharge

B. Because the measure is based on multiple components including notification of admission, patient engagement after discharge, and receipt of discharge information

C. Because the measure only requires a follow-up office visit within 30 days

D. Because the measure only evaluates hospital discharge documentation

Pausing to Process...

C21 – Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Description: This rating is based on the percent of plan members with 2 or more chronic conditions who got follow-up care within 7 days after they had an emergency department (ED) visit. Depending on the person's needs this might be a visit with a health care provider, an appointment with a case manager, or a home visit.

Metric: The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

HEDIS Label	Weighting Category	Weight
Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	Process Measure	1

C21 – Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Provider Best Practices and Process Flows

- Emergency department events should trigger outreach within twenty-four to seventy-two hours and follow-up services within seven days.
- Telehealth follow-up by nurses or care managers should be used when appointment availability is limited.
- Follow-up encounters should include medication review and symptom action planning.

C21 – Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Provider Data and Technology Expectations

- Emergency department alerts should be received through ADT feeds or claims data.
- High-risk cohorts should be identified through multi-chronic condition registries.
- Automated scheduling workflows should support timely follow-up.
- Analytics should track seven-day follow-up completion rates.

C21 – Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Knowledge Check

A 64-year-old member with diabetes and heart failure visits the emergency department for shortness of breath and is discharged home. Which action would help ensure this ED visit meets the Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measure?

A. Schedule a routine follow-up visit within 30 days

B. Conduct a follow-up service such as an office visit, telehealth encounter, case management contact, or home visit within 7 days of the ED visit

C. Wait for the member to request a follow-up appointment

D. Schedule a follow-up only if the member returns to the ED again

Pausing to Process...

Appendix

Star Cut Points - Part C - Domain 1

Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C01 - Breast Cancer Screening	< 58%	≥ 58% to < 71%	≥ 71% to < 76%	≥ 76% to < 84%	≥ 84%
C02 - Colorectal Cancer Screening	< 48%	≥ 48% to < 60%	≥ 60% to < 70%	≥ 70% to < 78%	≥ 78%
C03 - Annual Flu Vaccine*	< 57	≥ 57 to < 61	≥ 61 to < 68	≥ 68 to < 73	≥ 73
C04 - Improving or Maintaining Physical Health	< 66%	≥ 66% to < 70%	≥ 70% to < 72%	≥ 72% to < 75%	≥ 75%
C05 - Improving or Maintaining Mental Health	< 81%	≥ 81% to < 83%	≥ 83% to < 85%	≥ 85% to < 88%	≥ 88%
C06 - Monitoring Physical Activity	< 41%	≥ 41% to < 47%	≥ 47% to < 53%	≥ 53% to < 59%	≥ 59%

*C03 - Annual Flu Vaccine is not measured by stars but instead by base groups 1-5

Star Cut Points - Part C - Domain 2

Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C07 - Special Needs Plan (SNP) Care Management	< 42%	≥ 42% to < 60%	≥ 60% to < 73%	≥ 73% to < 88%	≥ 88%
C08 - Care for Older Adults - Medication Review	< 58%	≥ 58% to < 85%	≥ 85% to < 93%	≥ 93% to < 98%	≥ 98%
C09 - Care for Older Adults - Pain Assessment	< 65%	≥ 65% to < 86%	≥ 86% to < 95%	≥ 95% to < 99%	≥ 99%
C10 - Osteoporosis Management in Women who had a Fracture	< 32%	≥ 32% to < 41%	≥ 41% to < 53%	≥ 53% to < 68%	≥ 68%
C11 - Diabetes Care - Eye Exam	< 60%	≥ 60% to < 72%	≥ 72% to < 80%	≥ 80% to < 86%	≥ 86%

Star Cut Points - Part C -Domain 2 Continued

Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C12 - Diabetes Care - Blood Sugar Controlled	< 54%	≥ 54% to < 77%	≥ 77% to < 87%	≥ 87% to < 91%	≥ 91%
C13 - Kidney Health Evaluation for Patients with Diabetes	< 34%	≥ 34% to < 51%	≥ 51% to < 62%	≥ 62% to < 74%	≥ 74%
C14 - Controlling Blood Pressure	< 67%	≥ 67% to < 75%	≥ 75% to < 80%	≥ 80% to < 86%	≥ 86%
C15 - Reducing the Risk of Falling	< 51%	≥ 51% to < 57%	≥ 57% to < 62%	≥ 62% to < 71%	≥ 71%
C16 - Improving Bladder Control	< 41%	≥ 41% to < 45%	≥ 45% to < 49%	≥ 49% to < 53%	≥ 53%

Star Cut Points - Part C -Domain 2 Continued

Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C17 - Medication Reconciliation Post-Discharge	< 40%	≥ 40% to < 60%	≥ 60% to < 74%	≥ 74% to < 87%	≥ 87%
C18 - Plan All-Cause Readmission	> 12%	> 10% to ≤ 12%	> 9% to ≤ 10%	> 7% to ≤ 9%	≤ 7%
C19 - Statin Therapy for Patients with Cardiovascular Disease	< 81%	≥ 81% to < 85%	≥ 85% to < 88%	≥ 88% to < 91%	≥ 91%
C20 - Transitions of Care	< 44%	≥ 44% to < 56%	≥ 56% to < 69%	≥ 69% to < 79%	≥ 79%
C21 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	< 50%	≥ 50% to < 59%	≥ 59% to < 67%	≥ 67% to < 78%	≥ 78%

Base Group Cut Points - Part C -Domain 3

Measure	Base Group 1	Base Group 2	Base Group 3	Base Group 4	Base Group 5
C22 - Getting Needed Care	< 78	≥ 78 to < 80	≥ 80 to < 82	≥ 82 to < 84	≥ 84
C23 - Getting Appointments and Care Quickly	< 80	> 80 to ≤ 82	> 82 to ≤ 84	> 84 to ≤ 86	≥ 86
C24 - Customer Service	< 88	≥ 88 to < 89	≥ 89 to < 91	≥ 91 to < 92	≥ 92
C25 - Rating of Health Care Quality	< 84	≥ 84to < 86	≥ 86 to < 87	≥ 87 to < 88	≥ 88
C26 - Rating of Health Plan	< 84	≥ 84 to < 85	≥ 85 to < 87	≥ 87 to < 89	≥ 89
C27 - Care Coordination	< 85	≥ 85 to < 86	≥ 86 to < 88	≥ 88 to < 89	≥ 89

Star Cut Points - Part C -Domain 4

Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C28 - Complaints about the Health Plan	> 1.34	> 0.71 to ≤ 1.34	> 0.32 to ≤0.71	> 0.11 to ≤ 0.32	≤ 0.11
C29 - Members Choosing to Leave the Plan	> 39%	> 28% to ≤ 39%	> 17% to ≤28%	> 8% to ≤ 17%	≤ 8%
C30 - Health Plan Quality Improvement	< -0.121368	≥ -0.121368 to < 0	≥ 0 to < 0.202884	≥ 0.202884 to < 0.391253	≥ 0.391253

Star Cut Points - Part C -Domain 5

Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
C31 - Plan Makes Timely Decisions About Appeals	< 74%	≥ 74% to < 90%	≥ 90% to < 99%	≥ 99% to < 100%	≥ 100%
C32 - Reviewing Appeals Decisions	< 83%	≥ 83% to < 96%	≥ 96% to < 96%	≥ 98% to < 100%	≥ 100%
C33 - Call Center - Foreign Language Interpreter and TTY Availability	< 51%	≥ 51% to < 74%	≥ 74% to < 97%	≥ 97% to < 00%	≥ 100%

Star Cut Points - Part D -Domains 1-3

Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D01 - Call Center - Foreign language Interpreter and TTY Availability	< 45%	≥ 45% to < 79%	≥ 79% to < 95%	≥ 95% to < 100%	≥ 100%
D02 - Complaints about the Drug Plan	> 1.34	> 0.71 to ≤ 1.34	> 0.32 to ≤ 0.71	> 0.11 to ≤ 0.32	≤ 0.11
D03 - Members Choosing to Leave the Plan	> 39%	> 28% to ≤ 39%	> 17% to ≤ 28%	> 8% to ≤ 17%	≤ 8%
D04 - Drug Plan Quality Improvement	< -0.233766	≥ -0.233766 to < 0	≥ 0 to < 0.320439	≥ 0.320439 to < 0.579545	≥ 0.579545
D05 - Rating of Drug Plan	< 85	≥ 85 to < 86	≥ 86 to < 88	≥ 88 to < 89	≥ 89
D06 - Getting Needed Prescription Drugs	< 87	≥ 87 to < 88	≥ 88 to < 90	≥ 90 to < 91	≥ 91

*Health Plan is an MA-PD, which is a Medicare Advantage organization that offers Medicare prescription drug coverage and Part A and Part B benefits in one plan.

Star Cut Points - Part D -Domain 4

Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
D07 - MPF Price Accuracy	< 92	≥ 92 to < 93	≥ 93 to < 94	≥ 94 to < 99	≥ 99
D08 - Medication Adherence for Diabetes Medications	< 83%	≥ 83% to < 86%	≥ 86% to < 89%	≥ 89% to < 92%	≥ 92%
D09 - Medication Adherence for Hypertension (RAS antagonists)	< 84%	≥ 84% to < 88%	≥ 88% to < 91%	≥ 91% to < 93%	≥ 93%
D10 - Medication Adherence for Cholesterol (Statins)	< 84%	≥ 84% to < 88%	≥ 88% to < 90%	≥ 90% to < 93%	≥ 93%
D11 - MTM Program Completion Rate for CMR	< 62%	≥ 62% to < 82%	≥ 82% to < 91%	≥ 91% to < 96%	≥ 96%
D12 - Statin Use in Persons with Diabetes (SUPD)	< 81%	≥ 81% to < 85%	≥ 85% to < 89%	≥ 89% to < 93%	≥ 93%

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Acronyms

- **MA: Medicare Advantage**
- **EHR**: Electronic Health Record
- **HIE**: Health Information Exchange
- **AWV**: Annual Wellness Visit
- **ADT**: Admission, Discharge, and Transfer
- **FIT**: Fecal Immunochemical Test
- **FOBT**: Fecal Occult Blood Test
- **DXA**: Dual-Energy X-ray Absorptiometry
- **BH**: Behavioral Health
- **CMR**: Comprehensive Medication Review
- **CAHPS**: Consumer Assessment of Healthcare Providers and Systems
- **ASCVD**: Atherosclerotic Cardiovascular Disease
- **SNP**: Special Needs Plan

Health Information Exchange Expectations

Providers are strongly encouraged to participate in and routinely use a Health Information Exchange (HIE) to support care gap closure, care coordination, and data completeness. For this program, preferred HIEs include **Manifest MedEx** and **Carequality**. Providers should use these platforms to retrieve external clinical data, including hospitalizations, imaging, laboratory results, immunizations, and specialty care documentation.

Care Gap Identification

The health plan will provide suspected care gaps via **Inovalon**. Providers are expected to reconcile Inovalon-identified gaps with EHR or population health tool data and notify the health plan of discrepancies.

Supplemental Data

Value of Supplemental Data

Supplemental data closes gaps left by claims by capturing services that are delivered but not reliably billed, improving timeliness, accuracy, and numerator capture. When properly documented, it reduces false care gaps, supports more equitable measurement, and strengthens audit defensibility.

Guidance on Use

- Submit supplemental data using the standard supplemental data template to ensure consistency, validation, and audit readiness.
- Submit test files for any new value set or data source before production use. Testing allows validation, troubleshooting, and confirmation that values map correctly to the measure logic. Data that is not tested may be rejected or excluded from final rates.
- High-yield measures include well-child and well-care visits, immunizations, screenings, and select lab-based measures not reliably captured in claims.
- Ensure all supplemental records meet documentation requirements, including accurate member identifiers, service dates, provider information, and valid codes or values aligned to current specifications.
- Monitor supplemental data throughout the measurement year.
- Submit data early and periodically to identify trends, resolve data quality issues, and avoid last-minute submission risks.
- Use supplemental data as a precision tool to improve accuracy and confidence in reported performance.

THANK YOU!

Health Plan of San Joaquin

Mountain Valley Health Plan

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