Health Plan of San Joaquin

Mountain Valley Health Plan

Medicare 2026 Star Measures

Session 3 of 5

HPSJ/MVHP Quality Department

March 25, 2025

Introduction

- Third 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

Health Outcomes Survey (HOS)

- C04 Improving or Maintaining Physical Health
- C05 Improving or Maintaining Mental Health
- C06 Monitoring Physical Activity

Care for Older Adults -

- C08 Care for Older Adults – Medication Review
- C09 Care for Older Adults – Pain Assessment

Domain 1 - Staying Healthy: Screenings, Tests, and Vaccines

C04 – Improving or Maintaining Physical Health

Description: Percent of plan members whose physical health was the same or better than expected after two years.

Metric: The percentage of sampled Medicare enrollees 65 years of age or older (denominator) whose physical health status was the same or better than expected (numerator).

HEDIS Label	Weighting Category	Weight*
N/A	Outcome Measure	1

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

C04 – Improving or Maintaining Physical Health

Provider Best Practices and Process Flows

- Providers should conduct systematic functional status assessments during Annual Wellness Visits and chronic care visits, including mobility, activities of daily living, pain, and fatigue.
- Early referrals to physical therapy, occupational therapy, cardiac rehabilitation, or fall prevention programs should be made when indicated, with follow-up on adherence.
- Chronic symptom control for conditions such as heart failure, chronic obstructive pulmonary disease, and arthritis should be supported through structured care plans and regular check-ins.
- Providers should reinforce care experience drivers, including shared decision-making, clear next steps, and proactive follow-up.

C04 – Improving or Maintaining Physical Health

Provider Data and Technology Expectations

- Functional status assessments should be captured in standardized, structured EHR fields.
- Referral management systems should support closed-loop tracking for therapy and community-based programs.
- Patient engagement tools should support symptom tracking and outreach documentation.
- Experience-of-care analytics should link CAHPS drivers to provider panels.

C04 – Improving or Maintaining Physical Health

Knowledge Check

Which of the following actions would most effectively help improve the measure of members whose physical health is the same or better than expected after two years?

A. Focusing only on acute visit documentation and coding accuracy

B. Limiting care management to members with recent hospitalizations only

C. Relying on claims data alone to monitor patient progress

D. Conducting structured functional status assessments, initiating early refers (e.g., PT/OT), and tracking follow-up through closed-loop systems

C05 – Improving or Maintaining Mental Health

Description: Percent of plan members whose mental health was the same or better than expected after two years.

Metric: The percentage of sampled Medicare enrollees 65 years of age or older (denominator) whose mental health status was the same or better than expected (numerator).

HEDIS Label	Weighting Category	Weight
N/A	Outcome Measure	1

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

C05 – Improving or Maintaining Mental Health

Provider Best Practices and Process Flows

- Providers should routinely screen for depression and anxiety using validated tools such as PHQ-2, PHQ-9, and GAD-7.
- Positive screenings should trigger stepped-care pathways and warm handoffs to behavioral health services.
- Medication initiation or adjustment should include follow-up within two to four weeks.
- Providers should normalize mental health discussions, ensure privacy, and reinforce access options to reduce stigma.

C05 – Improving or Maintaining Mental Health

Provider Data and Technology Expectations

- Behavioral health screening results should be captured discretely in the EHR with automated follow-up tasks for positive results.
- Referral workflows should track behavioral health access and attendance.
- Tele-behavioral health integration should be used to expand access where appropriate.
- Provider dashboards should track screening rates and follow-up completion.

C05 – Improving or Maintaining Mental Health

Knowledge Check

Which of the following strategies would most effectively improve the measure of members whose mental health is the same or better than expected after two years?

A. Screening for depression only when patients report symptoms

B. Using validated screening tools routinely, initiating timely follow-u and referrals, and tracking engagement through EHR workflows

C. Referring patients to behavioral health only after multiple positive screenings

D. Focusing only on medication management without follow-up

C06 – Monitoring Physical Activity

Description: Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.

Metric: The percentage of sampled Medicare members 65 years of age or older who had a doctor's visit in the past 12 months (denominator) and who received advice to start, increase, or maintain their level of exercise or physical activity (numerator).

HEDIS Label	Weighting Category	Weight
Physical activity in Older Adults (PAO)	Process Measure	1

C06 – Monitoring Physical Activity

Provider Best Practices and Process Flows

- Providers should complete annual exercise counseling for members aged 65 and older and document that counseling occurred.
- Counseling should include assessment of current activity, barriers, recommendations, and a follow-up plan.
- Referrals to evidence-based programs such as SilverSneakers, walking groups, or physical therapy should be made when appropriate.
- Medical assistant rooming workflows should initiate physical activity screening to support provider efficiency.

C06 – Monitoring Physical Activity

Provider Data and Technology Expectations

- EHR templates should include structured fields for documenting physical activity counseling.
- Registries should identify missed documentation, which is a common source of STARS leakage.
- Referral tracking should monitor community programs and physical therapy engagement.
- Patient education resources should be delivered via patient portals or text messaging.

C06 – Monitoring Physical Activity

Knowledge Check

Which of the following approaches would best improve performance on the measure of seniors receiving exercise counseling?

A. Discussing physical activity only when patients bring it up

B. Providing general advice without documenting the conversation

C. Routinely assessing physical activity, documenting counseling in structured EHR fields, and offering referrals with follow-up plans

D. Referring patients to exercise programs without discussing their current activity level

Medicare Part C

Domain 2 - Managing Chronic (Long Term) Conditions

C08 – Care for Older Adults - Medication Review

Description: Percent of plan members whose doctor or clinical pharmacist reviewed a list of everything they take (prescription medications, OTC medications, herbal or supplemental remedies) at least once a year.

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).

HEDIS Label	Weighting Category	Weight
Care for Older Adults (COA) - Medication Review	Process Measure	1

C08 – Care for Older Adults - Medication Review

Provider Best Practices and Process Flows

- Providers should complete an annual comprehensive medication review conducted by a pharmacist or qualified clinician.
- The medication review should confirm completeness of the medication list, including prescription medications, over-the-counter drugs, and supplements.
- Medication duplications, interactions, and high-risk medications should be identified and addressed.
- Documentation of the medication review and maintenance of a current medication list in the EHR are required to meet measure criteria.

C08 – Care for Older Adults - Medication Review

Provider Data and Technology Expectations

- Medication lists should be integrated across EHR data, pharmacy claims, and patient-reported information.
- Structured documentation templates should align with medication review and medication list value sets.
- High-risk medications, including those identified by Beers Criteria, should be flagged for pharmacist outreach.
- External medication data should be ingested and reconciled into the active medication list.

C08 – Care for Older Adults - Medication Review

Knowledge Check

Which of the following actions is required to meet the measure for annual medication review?

A. Reviewing only prescription medication during acute visits

B. Completing a comprehensive medication review and maintaining an up-to-date medication list that includes prescriptions, OTCs, and supplements

C. Updating the medication list only when a new prescription is written

D. Relying on pharmacy claims data without documenting in the EHR

C09 – Care for Older Adults - Pain Assessment

Description: Percent of plan members who had a pain screening at least once during the year.

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator).

HEDIS Label	Weighting Category	Weight
Care for Older Adults (COA) - Pain Screening	Process Measure	1

C09 – Care for Older Adults - Pain Assessment

Provider Best Practices and Process Flows

- Providers should perform at least one standardized pain assessment annually, capturing both pain intensity and functional impact.
- Documented protocols should guide next steps, including non-pharmacologic interventions, physical therapy referrals, medication adjustments, or specialty referrals.
- Pain assessment documentation must be discrete and clearly meet the measure definition.
- Reassessment should occur after interventions to support continuity of care.

C09 – Care for Older Adults - Pain Assessment

Provider Data and Technology Expectations

- Pain assessments should be captured using structured EHR tools that include numeric scales and functional interference measures.
- Care gap reports should identify members missing an annual pain assessment.
- Referral tracking should support pain-related physical therapy, occupational therapy, and specialty care.
- Clinical decision support should promote safe prescribing practices in older adults.

C09 – Care for Older Adults - Pain Assessment

Knowledge Check

Which of the following best supports compliance with the annual pain assessment measure?

A. Completing a standardized pain assessment that includes intensity and functional impact, and documenting it in structured EHR fields

B. Asking patients about pain only if they report symptoms

C. Documenting pain only in free-text notes without follow-up

D. Referring paints to pain management without completing an assessment

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%

*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.

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

www.hpsj-mvhp.org | 1-888-936-PLAN (7526)

San Joaquin

HPSJ/MVHP Headquarters
7751 South Manthey Road
French Camp, CA 95231

Stanislaus

1025 J Street
Modesto, CA 95354

El Dorado

4237 Golden Circle Drive
Placerville, CA 95667