Health Plan of San Joaquin

Mountain Valley Health Plan

Medicare 2026 Star Measures

Session 4 of 5

HPSJ/MVHP Quality Department

April 8, 2026

Introduction

- 4th 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 covers 6-7 Medicare Stars measures and related best practices
- Stars Pocket Guide (e-version) coming soon

Today's Focus Measures

Managing Chronic (Long Term) Conditions

- C10 Osteoporosis Management in Women Who Had a Fracture
- C19 Statin Therapy for Patients with Cardiovascular Disease

Drug Safety & Accuracy of Drug Pricing

- D08 Medication Adherence for Diabetes Medications
- D09 Medication Adherence for Hypertension (RAS Antagonists)
- D10 Medication Adherence for Cholesterol (Statins)
- D12 Statin Use in Persons with Diabetes (SUPD)

Medicare Part C

Domain 2 - Managing Chronic (Long Term) Conditions

C10 – Osteoporosis Management in Women Who Had a Fracture

Description: Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months.

Metric: The percentage of women MA enrollees 67 -85 who suffered a fracture (denominator) and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture (numerator).

HEDIS Label	Weighting Category	Weight
Osteoporosis Management in Women Who Had a Fracture (OMW)	Process Measure	1

C10 – Osteoporosis Management in Women Who Had a Fracture

Provider Best Practices and Process Flows

- A fracture event should trigger an osteoporosis management pathway, including ordering a DXA scan and/or initiating osteoporosis medication within six months.
- Post-emergency department or post-hospital fracture follow-up appointments should include a standardized checklist.
- Clear responsibility for DXA ordering and medication initiation should be established between primary care and orthopedic providers.
- Fall risk should be addressed concurrently to reduce the risk of repeat fractures.

C10 – Osteoporosis Management in Women Who Had a Fracture

Provider Data and Technology Expectations

- Fracture events should be identified through claims or ADT feeds.
- Registries should track eligible women aged 67–85 with fractures and monitor timelines for DXA completion or medication initiation.
- Imaging results and medication prescribing should be ingested into the EHR.
- Care coordination tasks should route to the appropriate clinician or care team.

C10 – Osteoporosis Management in Women Who Had a Fracture

Knowledge Check

A 72-year-old female patient is seen in your office 3 months after a wrist fracture treated in the emergency department. What actions should be taken to meet quality measure requirements for osteoporosis management?

A. Wait until the patient reports symptoms of osteoporosis before taking action

B. Order a DXA scan or initiate osteoporosis medication within 6 months of the fracture

C. Refer the patient only to physical therapy for fall prevention

D. No additional follow-up is needed if the fracture has healed

C19 – Statin Therapy for Patients with Cardiovascular Disease

Description: This rating is based on the percent of plan members with heart disease who get the right type of cholesterol-lowering drugs.

Metric: The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high or moderate-intensity statin medication during the measurement year (numerator).

HEDIS Label	Weighting Category	Weight
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Process Measure	1

C19 – Statin Therapy for Patients with Cardiovascular Disease

Provider Best Practices and Process Flows

- Providers should identify members with atherosclerotic cardiovascular disease and standardize statin prescribing at appropriate intensity.
- Statin intolerance should be addressed through structured approaches, including rechallenge or alternative dosing, with documentation.
- At least one statin dispensing during the measurement year must be confirmed to avoid fill-related leakage.

C19 – Statin Therapy for Patients with Cardiovascular Disease

Provider Data and Technology Expectations

- Claims data should identify eligible cardiovascular disease populations.
- Prescribing alerts should notify providers when eligible members lack active statin therapy.
- Pharmacy claims data should confirm medication dispensing.
- Provider dashboards should support outreach to close gaps.

C19 – Statin Therapy for Patients with Cardiovascular Disease

Knowledge Check

A 65-year-old male patient with a history of myocardial infarction is seen for a routine visit. His chart shows no active statin prescription, and there is no record of a statin fill this year. What is the most appropriate next step to meet quality measure requirements?

A. Document lifestyle counseling only, and reassess next year

B. Prescribe a moderate- or high-intensity statin and ensure it is dispensed

C. Wait for the patient to request cholesterol treatment

D. Order cholesterol labs before considering any treatment

Medicare Part D

Domain 4 - Drug Safety and Accuracy of Drug Pricing

D08 – Medication Adherence For Diabetes Medications

Description: The percentage of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are taking the medication.

Metric: This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy across any of the classes of diabetes medications.

HEDIS Label	Weighting Category	Weight
Prescription Drug Event (PDE) Data	Intermediate Outcome Measure	3

D08 – Medication Adherence For Diabetes Medications

Provider Best Practices and Process Flows

- Early refill gaps should trigger pharmacist or nurse outreach.
- Regimens should be simplified and affordability barriers addressed.
- Ninety-day fills and medication synchronization should be promoted.

D08 – Medication Adherence For Diabetes Medications

Provider Data and Technology Expectations

- Proportion of days covered dashboards should generate gap alerts.
- Pharmacy claims integration should provide near-real-time refill status.
- Outreach workflows should document interventions.

D08 – Medication Adherence for Diabetes Medications

Knowledge Check

A 58-year-old patient with diabetes has a proportion of days covered (PDC) of 72% of their oral diabetes medication. What is the most appropriate action to improve adherence and meet quality measure requirements?

A. Wait until the next annual visit to reassess adherence

B. Discontinue the medication and reassess treatment options

C. Initiate outreach to address refill gaps and consider 90-day fills or medication synchronization

D. Order additional lab work before addressing adherence

D09 – Medication Adherence for Hypertension (RAS antagonists)

Description: The percentage of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% o r more of the time they are taking the medication.

Metric: This measure is defined as the percentage of Medicare Part D beneficiaries aged 18 and older who adhere to their prescribed drug therapy for renin-angiotensin system (RAS) antagonists: ACEI, ARB, or direct renin inhibitor medications.

HEDIS Label	Weighting Category	Weight
Prescription Drug Event (PDE) Data	Intermediate Outcome Measure	3

D09 – Medication Adherence for Hypertension (RAS antagonists)

Provider Best Practices and Process Flows

- Adherence outreach should occur promptly after refill gaps.
- Medication tolerability and side effects should be addressed.

D09 – Medication Adherence for Hypertension (RAS antagonists)

Provider Data and Technology Expectations

- Proportion of days covered monitoring should support alerts.
- Pharmacy and EHR data should be reconciled.

D09 – Medication Adherence for Hypertension (RAS antagonists)

Knowledge Check

A 70-year-old patient prescribed an ACE inhibitor for hypertension has a proportion of days covered (PDC) of 75%. Pharmacy data shows delayed refills over the past two months. What is the most appropriate next step?

A. Wait until the next scheduled visit to address adherence

B. Discontinue the medication due to non-adherence

C. Initiate outreach to assess barriers, address side effects, and encourage timely refills

D. Order additional labs before addressing medication use

D10 – Medication Adherence for Cholesterol (Statins)

Description: The percentage of plan members with a prescription for a cholesterol medication (a *statin drug*) who fill their prescription often enough to cover 80% or more of the time they are taking the medication.

Metric: This measure is defined as the percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed drug therapy for statin cholesterol medications.

Primary Data Source	Weighting Category	Weight
Prescription Drug Event (PDE) data	Intermediate Outcome Measure	3

D10 – Medication Adherence for Cholesterol (Statins)

Provider Best Practices and Process Flows

- Early statin discontinuation should trigger outreach and intolerance management.
- Shared decision-making should reinforce cardiovascular risk reduction.
- Ninety-day fills and refill synchronization should be promoted.

D10 – Medication Adherence for Cholesterol (Statins)

Provider Data and Technology Expectations

- Statin adherence dashboards should monitor refill gaps.
- Documentation pathways should support intolerance management.

D10 – Medication Adherence for Cholesterol (Statins)

Knowledge Check

A 67-year-old patient with hyperlipidemia was started on a statin 4 months ago. Pharmacy data shows they stopped refilling the medication after the first fill, and their proportion of days covered (PDC) is now 60%. What is the most appropriate next step?

A. Document non-adherence and take no further action

B. Initiate outreach to discuss barriers, assess statin intolerance, and restart therapy if appropriate

C. Wait until the next annual visit to reassess cholesterol levels

D. Switch to a non-statin medication without further discussion

D12 – Statin Use in Persons with Diabetes (SUPD)

Description: To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of plan members with diabetes who take the most effective cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled.

Metric: This measure is defined as the percentage of Medicare Part D beneficiaries, 40-75 years old, who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period.

Primary Data Source	Weighting Category	Weight
Prescription Drug Event (PDE) data	Process Measure	1

D12 – Statin Use in Persons with Diabetes (SUPD)

Provider Best Practices and Process Flows

- Eligible members aged forty to seventy-five with diabetes should be identified and prescribed statins by default unless contraindicated.
- Providers must confirm at least one statin fill occurs during the measurement year.
- Intolerance should be managed and documented using structured approaches.

D12 – Statin Use in Persons with Diabetes (SUPD)

Provider Data and Technology Expectations

- Eligibility lists should combine diabetes medication fills and statin dispensing data.
- Prescribing alerts should prompt action.
- Pharmacy claims integration should confirm dispensing.

D12 – Statin Use in Persons with Diabetes (SUPD)

Knowledge Check

A 62-year-old patient with diabetes has filled their diabetes medications twice this year, but has no statin prescription fill on record. What is the most appropriate next step to meet quality measure requirements?

A. Prescribe a statin and confirm that at least one fill occurs during the measurement year

B. Continue diabetes treatment only and reassess next year

C. Wait until cholesterol levels worsen before initiating therapy

D. Refer the patient to a specialist without starting treatment

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

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