



# Medicare 2026 Star Measures

Session 5 of 5

HPSJ/MVHP Quality Department

April 22, 2026



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# Introduction

- Final session in 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
- Slides from past sessions are posted at <https://www.hpsj.com/look-and-learn/>



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# Stars Pocket Guide now available!



## Medicare 2026 Star Measures Pocket Guide

The 2026 Medicare Stars Pocket Guide is a practical, provider-facing resource designed to simplify and operationalize the CMS Star measures that directly impact quality performance. It brings together key measure definitions, performance expectations, and clear, actionable best practices into one streamlined reference that can be used in day-to-day clinical workflows. It reinforces the connection between clinical care, documentation, and Star ratings, helping provider teams close care gaps, improve patient outcomes, and align with health plan quality goals.



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# Today's Focus Measures

C22 – Getting Needed Care

C23 – Getting Appointments and Care Quickly

C25 – Rating of Health Care Quality

C27 – Care Coordination

D06 – Getting Needed Prescription Drugs



Medicare  
Part C

## **Domain 3 – Member Experience with Health Plan**



# C22 – Getting Needed Care

**Description:** The percent of the best possible score the plan earned on how easy it is for members to get needed care, including care from specialists.

**Metric:** This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Primary Data Source	Weighting Category	Weight
CAHPS	Patients' Experience and Complaints Measure	2



# C22 – Getting Needed Care

## Provider Best Practices and Process Flows

- Providers should reduce friction for specialty access through referral turnaround time standards and dedicated referral support.
- Prior authorization and documentation assistance should be provided proactively.
- Navigation support and warm handoffs should be used to guide members through care.



# C22 – Getting Needed Care

## Provider Data and Technology Expectations

- Referral management systems should provide status transparency.
- Access analytics should track specialty wait times and referral cycle times.
- Patient communication tools should deliver updates and instructions.
- CAHPS driver analytics should be monitored by practice site.



## C22 – Getting Needed Care

### Knowledge Check

**A provider office wants to improve its performance on the “Getting Needed Care” CAHPS measure. Which of the following actions would most directly support improvement in this measure?**

- A. Increasing the number of annual wellness visits completed
- B. Reducing referral turnaround times and providing proactive support for prior authorizations
- C. Expanding office hours for routine primary care visits only
- D. Focusing solely on medication adherence outreach



# C23 – Getting Appointments and Care Quickly

**Description:** The percent of the best possible score the plan earned on how quickly members get appointments and care.

**Metric:** This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Primary Data Source	Weighting Category	Weight
CAHPS	Patients' Experience and Complaints Measure	2



# C23 – Getting Appointments and Care Quickly

## Provider Best Practices and Process Flows

- Same-day and next-day appointment capacity should be expanded using urgent slots, nurse visits, and telehealth.
- Standardized triage protocols should guide appropriate routing.
- Scheduling backlogs should be monitored using third-next-available metrics.



# C23 – Getting Appointments and Care Quickly

## Provider Data and Technology Expectations

- Scheduling analytics should track time-to-appointment and abandonment rates.
- Demand and capacity dashboards should support intervention.
- Automated waitlists and recall systems should be used.
- Patient self-scheduling should be enabled with appropriate guardrails.



## C23 – Getting Appointments and Care Quickly

### Knowledge Check

**A clinic is trying to improve its performance on the “Getting Appointments and Care Quickly” CAHPS measure. Which of the following strategies would have the greatest impact?**

- A. Increasing the number of preventive care reminders sent to patients
- B. Expanding same-day and next-day appointment availability and using standardized triage protocols
- C. Focusing only on improving specialist referral workflows
- D. Reducing documentation time for providers without changing scheduling practices



# C25 – Rating of Health Care Quality

**Description:** The percent of the best possible score the plan earned from members who rated the quality of the health care they received.

**Metric:** This case-mix adjusted measure is used to assess members' view of the quality of care received from the health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Primary Data Source	Weighting Category	Weight
CAHPS	Patients' Experience and Complaints Measure	2



# C25 – Rating of Health Care Quality

## Provider Best Practices and Process Flows

- Providers should focus on visit experience fundamentals, including listening, clarity, and shared decision-making.
- Test results should be communicated reliably and promptly.
- Continuity with preferred providers should be supported when possible.



# C25 – Rating of Health Care Quality

## Provider Data and Technology Expectations

- Experience surveys should support provider-level feedback loops.
- Result notification workflows should track completion.
- Care coordination tools should reduce fragmented experiences.
- CAHPS dashboards should highlight key drivers



# C25 – Rating of Health Care Quality

## Knowledge Check

**A provider group wants to improve its performance on the CAHPS “Rating of Health Care Quality” measure. Which of the following actions would most directly influence members’ ratings?**

- A. Increasing the number of patients enrolled in care management programs
- B. Expanding the number of contracted specialists in the network
- C. Ensuring providers consistently listen to patients, communicate clearly, and follow up promptly with test results
- D. Focusing only on reducing emergency department utilization



## C27 – Care Coordination

**Description:** The percent of the best possible score the plan earned on how well the plan coordinates members' care. (This includes whether doctors had the records and information they needed about members' care and how quickly members got their test results.)

**Metric:** This case-mix adjusted composite measure is used to assess Care Coordination. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale of 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Primary Data Source	Weighting Category	Weight
CAHPS	Patients' Experience and Complaints Measure	2



# C27 – Care Coordination

## Provider Best Practices and Process Flows

- Primary care providers should have specialist notes available before follow-up visits.
- Closed-loop referral and test result management should be implemented.
- Medication and problem lists should be maintained accurately to prevent fragmentation.



# C27 – Care Coordination

## Provider Data and Technology Expectations

- HIE connectivity via Manifest MedEx or Carequality should support specialist and hospital data exchange.
- Referral and results management systems should track completion.
- Shared care plans should support high-risk members.
- Panel-level dashboards should monitor coordination metrics.



## C27 – Care Coordination

### Knowledge Check

**A clinic is working to improve its performance on the CAHPS “Care Coordination” measure. Which of the following actions would most directly improve member experience in this area?**

- A. Ensuring specialist notes and test results are available to the primary care provider before follow-up visits
- B. Increasing the number of preventive screenings completed annually
- C. Expanding telehealth services for routine visits only
- D. Reducing appointment wait times for urgent care visits



Medicare  
Part D

## **Domain 3 – Member Experience with the Drug Plan**



# D06 – Getting Needed Prescription Drugs

**Description:** The percent of the best possible score the plan earned on how easy it is for members to get the prescription drugs they need using the plan.

**Metric:** This case-mix adjusted measure is used to assess the ease with which a beneficiary gets the medicines their doctor prescribed. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

Primary Data Source	Weighting Category	Weight
CAHPS	Patients' Experience and Complaints Measure	2



# D06 – Getting Needed Prescription Drugs

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## Provider Best Practices and Process Flows

- Medication access playbooks should guide formulary alternatives, step therapy, and prior authorization.
- Refill synchronization and ninety-day fills should be encouraged.
- Pharmacist outreach should support new starts and high-risk medications.



# D06 – Getting Needed Prescription Drugs

## Provider Data and Technology Expectations

- Electronic prior authorization cycle times should be monitored.
- Pharmacy claims data should identify delayed starts.
- Adherence dashboards should track refill gaps.



## D06 – Getting Needed Prescription Drugs

### Knowledge Check

**A provider office wants to improve its performance on the CAHPS measure for “Getting Needed Prescription Drugs.” Which of the following actions would most directly improve member experience?**

- A. Scheduling more frequent follow-up visits for chronic conditions
- B. Focusing only on reducing hospital readmissions
- C. Proactively assisting with prior authorizations and offering formulary alternatives when medications are not covered
- D. Increasing the number of annual medication reviews completed





# Appendix



# Star Cut Points - Part C - Domain 1

Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<b>C01 - Breast Cancer Screening</b>	< 58%	≥ 58% to < 71%	≥ 71% to < 76%	≥ 76% to < 84%	≥ 84%
<b>C02 - Colorectal Cancer Screening</b>	< 48%	≥ 48% to < 60%	≥ 60% to < 70%	≥ 70% to < 78%	≥ 78%
<b>C03 - Annual Flu Vaccine*</b>	< 57	≥ 57 to < 61	≥ 61 to < 68	≥ 68 to < 73	≥ 73
<b>C04 - Improving or Maintaining Physical Health</b>	< 66%	≥ 66% to < 70%	≥ 70% to < 72%	≥ 72% to < 75%	≥ 75%
<b>C05 - Improving or Maintaining Mental Health</b>	< 81%	≥ 81% to < 83%	≥ 83% to < 85%	≥ 85% to < 88%	≥ 88%
<b>C06 - Monitoring Physical Activity</b>	< 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
<b>C07 - Special Needs Plan (SNP) Care Management</b>	< 42%	≥ 42% to < 60%	≥ 60% to < 73%	≥ 73% to < 88%	≥ 88%
<b>C08 - Care for Older Adults - Medication Review</b>	< 58%	≥ 58% to < 85%	≥ 85% to < 93%	≥ 93% to < 98%	≥ 98%
<b>C09 - Care for Older Adults - Pain Assessment</b>	< 65%	≥ 65% to < 86%	≥ 86% to < 95%	≥ 95% to < 99%	≥ 99%
<b>C10 - Osteoporosis Management in Women who had a Fracture</b>	< 32%	≥ 32% to < 41%	≥ 41% to < 53%	≥ 53% to < 68%	≥ 68%
<b>C11 - Diabetes Care - Eye Exam</b>	< 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
<b>C12 - Diabetes Care - Blood Sugar Controlled</b>	< 54%	≥ 54% to < 77%	≥ 77% to < 87%	≥ 87% to < 91%	≥ 91%
<b>C13 - Kidney Health Evaluation for Patients with Diabetes</b>	< 34%	≥ 34% to < 51%	≥ 51% to < 62%	≥ 62% to < 74%	≥ 74%
<b>C14 - Controlling Blood Pressure</b>	< 67%	≥ 67% to < 75%	≥ 75% to < 80%	≥ 80% to < 86%	≥ 86%
<b>C15 - Reducing the Risk of Falling</b>	< 51%	≥ 51% to < 57%	≥ 57% to < 62%	≥ 62% to < 71%	≥ 71%
<b>C16 - Improving Bladder Control</b>	< 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
<b>C17 - Medication Reconciliation Post-Discharge</b>	< 40%	≥ 40% to < 60%	≥ 60% to < 74%	≥ 74% to < 87%	≥ 87%
<b>C18 - Plan All-Cause Readmission</b>	> 12%	> 10% to ≤ 12%	> 9% to ≤ 10%	> 7% to ≤ 9%	≤ 7%
<b>C19 - Statin Therapy for Patients with Cardiovascular Disease</b>	< 81%	≥ 81% to < 85%	≥ 85% to < 88%	≥ 88% to < 91%	≥ 91%
<b>C20 - Transitions of Care</b>	< 44%	≥ 44% to < 56%	≥ 56% to < 69%	≥ 69% to < 79%	≥ 79%
<b>C21 - Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions</b>	< 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
<b>C22 - Getting Needed Care</b>	< 78	≥ 78 to < 80	≥ 80 to < 82	≥ 82 to < 84	≥ 84
<b>C23 - Getting Appointments and Care Quickly</b>	< 80	> 80 to ≤ 82	> 82 to ≤ 84	> 84 to ≤ 86	≥ 86
<b>C24 - Customer Service</b>	< 88	≥ 88 to < 89	≥ 89 to < 91	≥ 91 to < 92	≥ 92
<b>C25 - Rating of Health Care Quality</b>	< 84	≥ 84to < 86	≥ 86 to < 87	≥ 87 to < 88	≥ 88
<b>C26 - Rating of Health Plan</b>	< 84	≥ 84 to < 85	≥ 85 to < 87	≥ 87 to < 89	≥ 89
<b>C27 - Care Coordination</b>	< 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
<b>C28 - Complaints about the Health Plan</b>	> 1.34	> 0.71 to ≤ 1.34	> 0.32 to ≤ 0.71	> 0.11 to ≤ 0.32	≤ 0.11
<b>C29 - Members Choosing to Leave the Plan</b>	> 39%	> 28% to ≤ 39%	> 17% to ≤ 28%	> 8% to ≤ 17%	≤ 8%
<b>C30 - Health Plan Quality Improvement</b>	< - 0.1213 68	≥ -0.121368 to < 0	≥ 0 to < 0.202884	≥ 0.202884 to < 0.391253	≥ 0.3912 53



# Star Cut Points - Part C - Domain 5

Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<b>C31 - Plan Makes Timely Decisions About Appeals</b>	< 74%	≥ 74% to < 90%	≥ 90% to < 99%	≥ 99% to < 100%	≥ 100%
<b>C32 - Reviewing Appeals Decisions</b>	< 83%	≥ 83% to < 96%	≥ 96% to < 96%	≥ 98% to < 100%	≥ 100%
<b>C33 - Call Center - Foreign Language Interpreter and TTY Availability</b>	< 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
<b>D01 - Call Center - Foreign language Interpreter and TTY Availability</b>	< 45%	≥ 45% to < 79%	≥ 79% to < 95%	≥ 95% to < 100%	≥ 100%
<b>D02 - Complaints about the Drug Plan</b>	> 1.34	> 0.71 to ≤ 1.34	> 0.32 to ≤ 0.71	> 0.11 to ≤ 0.32	≤ 0.11
<b>D03 - Members Choosing to Leave the Plan</b>	> 39%	> 28% to ≤ 39%	> 17% to ≤ 28%	> 8% to ≤ 17%	≤ 8%
<b>D04 - Drug Plan Quality Improvement</b>	< -0.233766	≥ -0.233766 to < 0	≥ 0 to < 0.320439	≥ 0.320439 to < 0.579545	≥ 0.579545
<b>D05 - Rating of Drug Plan</b>	< 85	≥ 85 to < 86	≥ 86 to < 88	≥ 88 to < 89	≥ 89
<b>D06 - Getting Needed Prescription Drugs</b>	< 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
<b>D07 - MPF Price Accuracy</b>	< 92	≥ 92 to < 93	≥ 93 to < 94	≥ 94 to < 99	≥ 99
<b>D08 - Medication Adherence for Diabetes Medications</b>	< 83%	≥ 83% to < 86%	≥ 86% to < 89%	≥ 89% to < 92%	≥ 92%
<b>D09 - Medication Adherence for Hypertension (RAS antagonists)</b>	< 84%	≥ 84% to < 88%	≥ 88% to < 91%	≥ 91% to < 93%	≥ 93%
<b>D10 - Medication Adherence for Cholesterol (Statins)</b>	< 84%	≥ 84% to < 88%	≥ 88% to < 90%	≥ 90% to < 93%	≥ 93%
<b>D11 - MTM Program Completion Rate for CMR</b>	< 62%	≥ 62% to < 82%	≥ 82% to < 91%	≥ 91% to < 96%	≥ 96%
<b>D12 - Statin Use in Persons with Diabetes (SUPD)</b>	< 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!



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### 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