Health Plan of San Joaquin | Mountain Valley Health Plan

Medicare 2026 Star Measures

Session 2 of 3

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D-SNP Provider Network Training Series

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Introduction

- Second of a 3-part series for providers who care for Health Plan of San Joaquin/Mountain Valley Health Plan's Duals Special Needs Plan (D-SNP) members
- This session will cover 15 Medicare Stars measures and related best practices
- A Stars Pocket Guide (e-version) is also be available as a reference tool for practice staff

Overview of the Medicare Stars Program

CMS uses Stars ratings 1 to 5 to assess how well health plans perform, with 5 Stars being excellent.

- The Stars program measures quality of care, member experience, and plan operations for Medicare Advantage and Prescription Drug Plans
- Higher Stars ratings indicate better performance and lead to:
    - Increased member trust and enrollment
    - Access to CMS quality bonus payments
    - Improved member satisfaction and health outcomes
- Ratings are based on three main categories:
    1. Medical Care – Preventative and chronic condition management
    2. Patient Experience – Member satisfaction and communication
    3. Plan Administration – Accuracy, access, and service quality

Stars Domains that Overlap with Model of Care

The Stars program measures outcomes of the processes defined by the DSNP MOC. While MOC defines ***how care*** should be coordinated, Stars shows ***how well*** that care is delivered and experienced.

Domains:

- **Preventative and Chronic Care:** Delivery of timely screenings, follow-up, and chronic disease management directly drives Stars performance
- **Member Experience and Satisfaction:** Every interaction matters – clear communication, accessibility, and empathy improve member scores
- **Care Coordination and Follow-up:** Collaboration with the care team ensures members don't fall through the cracks during transitions or after hospitalization
- **Medication Adherence and Safety:** Reinforcing adherence and reviewing medication lists helps members stay on track and support safety measures

Why it matters: Strong performance in these areas improves member outcomes, builds trust, and strengthens overall Stars rating.

Provider Roles with Star Measures

Role	How to Use This Information
Care Providers (e.g., PCPs, NPs, PAs)	• Understand clinical care requirements • Know what coding/documentation needs to be submitted
Clinical Support Staff (e.g., Nurses, MAs)	• Understand clinical care requirements • Know what coding/documentation needs to be submitted
IT Staff (EHR builders)	• Incorporate into EHR visit templates
Pharmacy Staff	• Understand clinical care requirements • Understand roles w/external organizations (e.g., PBMs)
Care Managers	• Coordinate closing gaps in care for each measure

Today's Focus Measures

Staying Healthy: Screenings, Tests, and Vaccines

- C01- Breast Cancer Screening
- C02 - Colorectal Cancer Screening
- C03 - Annual Flu Vaccine

Managing Chronic (Long Term) Conditions

- C10 - Osteoporosis Management in Women who had a Fracture
- C11 - Diabetes Care – Eye Exam
- C12 - Diabetes Care – Blood Sugar Controlled
- C13 - Kidney Health Evaluation for Patients with Diabetes
- C14 - Controlling Blood Pressure
- C15 - Reducing the Risk of Falling
- C16 - Improving Bladder Control
- C17 - Medication Reconciliation Post-Discharge
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Let’s Begin!

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

- **C01- Breast Cancer Screening**
- C02 - Colorectal Cancer Screening
- C03 - Annual Flu Vaccine

C01 – Breast Cancer Screening

Description: Percent of female plan members aged 40-74 who had a mammogram.

Metric: Percentage of women MA enrollees 40 to 74 years of age (denominator) as of December 31 of the measurement year who had a mammogram to screen for breast cancer in the past two years (numerator).

HEDIS Label	Weighting Category	Weight
Breast Cancer Screening (BCS)	**Process Measure**	**1**

Provider Best Practices and Process Flows

- Implement standing orders
- Perform a care gap check at every clinical encounter
- Conduct proactive outreach to overdue members

Common BCS Codes

CPT: 77061 - 77063, 77065 - 77067

Codes for Mastectomies

CPT: 19180, 19200, 19240, 19303 - 19307
ICD-10: Z90.10 - Z90.13

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

- C01- Breast Cancer Screening
- **C02 - Colorectal Cancer Screening**
- C03 - Annual Flu Vaccine

C02 – Colorectal Cancer Screening

Description: Percent of plan members aged 50-75 who had appropriate screening for colorectal cancer.

Metric: Percentage of MA enrollees 50 to 75 (denominator) as of December 31 of the measurement year who had appropriate screenings for colorectal cancer (numerator).

HEDIS Label	Weighting Category	Weight
Colorectal Cancer Screening (COL)	**Process Measure**	**1**

Provider Best Practices and Process Flows

- Implement a standardized COL workflow, including colonoscopy, FIT, FOBT, or stool DNA testing options
- Manage abnormal results through closed-loop follow-up, with positive FIT results triggering colonoscopy scheduling within defined timeframes.

Common COL Codes

CPT: 81528, 82274, 81528, 45330 - 45335, 74261 - 74263, 44388 - 44392
HCPCS: G0328, G0104, G0105, G0121

Codes for Exclusions

Colorectal Cancer: ICD-10: C18.0 - C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, X85.048
Total Colectomy: CPT: 44150 - 44153, 44155 - 44158, 44210 - 44212
ICD-10: 0DTE0ZZ, 0DTE7ZZ, 0DTE8ZZ

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

- C01- Breast Cancer Screening
- C02 - Colorectal Cancer Screening
- **C03 - Annual Flu Vaccine**

C03 – Annual Flu Vaccine

Description: Percent of plan members who got a vaccine (flu shot).

Metric: The percentage of sampled Medicare enrollees (denominator) who received an influenza vaccination (numerator).

HEDIS Label	Weighting Category	Weight
N/A	Process Measure	1

Provider Best Practices and Process Flows

- Implement standing orders for flu vaccines
- Offer vaccines opportunistically at every encounter during flu season
- Conduct proactive outreach for unvaccinated members
- Vaccinations administered externally must be confirmed and documented in the EHR

Note: This measure is based on CAHPS survey results that ask members whether they received their flu vaccine since July 1 of the previous year.

CAHPS Survey Question

Have you had a flu shot since July 1, 2025?

Domain 2 - Managing Chronic (Long Term) Conditions

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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

Provider Best Practices and Process Flows

- Fracture events should trigger an osteoporosis management pathway, including ordering a BMD test and/or initiating osteoporosis medication
- Post ED/hospital visits for fracture should include a standardized checklist
- Address members fall risk concurrently to reduce the risk of repeat fractures

Common OMW Codes

BMD CPT: 76977, 77080, 77081, 77085, 77086

Osteoporosis Medication HCPCS: J0897, J1740, J3110, J3111, J3489, J0897, J1740, J3489

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C11 – Diabetes Care - Eye Exam

Description: Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.

Metric: The percentage of diabetic MA enrollees age 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).

HEDIS Label	Weighting Category	Weight
Eye Exam for Patients with Diabetes (EED)	Process Measure	1

Provider Best Practices and Process Flows

- Partnerships with optometry and ophthalmology practices should be leveraged to improve access
- Digital eye exam, remote imaging, and fundus photography can count if the results are read by an eye care professional
- Prepare standing referrals to ophthalmologists, assist members in making appointments, and track referrals until the specialist report is obtained

Common EED Codes

DM Retinal Screening
CPT: 92002, 92012, 92137, 92227, 92228
HCPCS: S0620, S0621, S3000

Eye Exam with Evidence of Retinopathy
CPT-II: 2022F, 2024F, 2026F

Eye Exam without Evidence of Retinopathy:
CPT-II: 2023F, 2025F, 2033F
Fundus Photography CPT: 92250

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C12 – Diabetes Care - Blood Sugar Controlled

Description: Percent of plan members with diabetes who had an A1c lab test during the year that showed their average blood sugar is under control.

Metric: The percentage of diabetic MA enrollees age 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator)*.

HEDIS Label	Weighting Category	Weight
Glycemic Status Assessment for Patients with Diabetes (GSD) - Poor >9%	Intermediate Outcome Measure	3

Provider Best Practices and Process Flows

- Ensure all diabetic members receive at least one hA1c annually
- Members with A1c values greater than 9% should receive intensified management
- Barriers such as medication affordability, adherence challenges, food insecurity, and health literacy should be proactively addressed

Common GSD Codes

HbA1c less than 7.0% CPT-II: 3044F

HbA1c ≥ 7.0% and < 8.0% CPT-II: 3051F

HbA1c > 9.0% CPT-II: 3046F

HbA1c ≥ 8.0% and ≤ 9.0% CPT-II: 3052F

*This measure for public reporting is reverse-scored, so higher scores are better.

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C13 – Kidney Health Evaluation for Patients with Diabetes

Description: Percent of plan members with diabetes who received a kidney health evaluation during the year.

Metric: The percentage of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

HEDIS Label	Weighting Category	Weight
Kidney Health Evaluation for Patients with Diabetes (KED)	Process Measure	1

Provider Best Practices and Process Flows

- Order annual diabetes kidney health bundles, including estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (uACR)
- Abnormal results should trigger standardized protocols, including ACE inhibitor or ARB optimization and nephrology referral when indicated.
- Patients should receive education on chronic kidney disease risk and follow-up plans.

Common KED Codes

eGFR
CPT: 80047, 80050, 80069, 82565
LOINC: 50044-7, 50210-4, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6
uACR
LOINC: 13705-9, 14958-3, 30000-4, 44292-1, 59159-4, 76401-9, 77252-3, 77254-1, 89998-9, 9318-7

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C14 – Controlling Blood Pressure

Description: Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.

Metric: The percentage of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose blood pressure (BP) was adequately controlled (less than 140/90 mm Hg) (numerator).

HEDIS Label	Weighting Category	Weight
Controlling High Blood Pressure (CBP)	Intermediate Outcome Measure	3

Provider Best Practices and Process Flows

- Follow standard measurement protocols, including appropriate rest time, cuff size selection, and repeat measurements when elevated
- Rapid follow-up visits should be scheduled within two to four weeks for uncontrolled blood pressure
- Medication adherence and lifestyle counseling should be provided to members

Common CBP Codes

Systolic BP

CPT-II: 3074F, 3075F, 3077F

Diastolic BP

CPT-II: 3078F, 3079F, 3080F

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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

Provider Best Practices and Process Flows

- 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.

HOS 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?
- Did you fall in the past 12 months?
- In the past we months, have you had a problem with balance or walking?
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?

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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

Provider Best Practices and Process Flows

- Routinely screen older adults for urinary incontinence
- Document discussions of treatment options, including pelvic floor therapy, behavioral strategies, and medications when appropriate
- Persistent symptoms should trigger referrals to pelvic floor physical therapy or urology

HOS Survey Questions

- Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking or urine?
- There are many ways to control or manage the leaking or 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?

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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

Provider Best Practices and Process Flows

- Hospital discharge notifications should trigger medication reconciliation within seven to fourteen days
- 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

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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

Provider Best Practices and Process Flows

- 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

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C19 – Statin Therapy for Patients with Cardiovascular Disease

Description: This rating is based on the percentage of plan members with heart disease who receive that appropriate 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
Plan All-Cause Readmissions (PCR)	Outcome Measure	3

Provider Best Practices and Process Flows

- Identify members with atherosclerotic cardiovascular disease and standardize statin prescribing at appropriate intensity
- Statin intolerance should be addressed and documented
- At least one stain dispensing during the measurement year must be confirmed to avoid fill-related leakage
- Encourage members to obtain 90-day supplies at their pharmacy

Common SPC Codes

Other revascularization
CPT: 37220, 37221, 37224 - 37231

PCI
CPT: 92920, 92924, 92933, 92937, 92941, 92943
HCPCS: C9600, C9602, C960

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- **C20 - Transitions of Care**
- C21 - Follow-Up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

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

Provider Best Practices and Process Flows

- Implement end-to-end transition of care bundle, including notification, discharge information, engagement, and medication reconciliation
- Follow-up appointments should be scheduled prior to discharge whenever possible

Common TRC Codes

Medication Reconciliation Encounter CPT: 99483, 99496
Medication Reconciliation Intervention CPT: 99605, 99606
Outpatient and Telehealth CPT: 98000 - 98016, 98966 - 98968, 98970 - 98972, 98980, 98981, 99202 - 99205
HCPCS: G0071, G0402, G0438, G0463, G2010, G2012, G2250
Transitional Care Management Service CPT: 99495, 99496

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- **C21 - Follow-Up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**

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

Provider Best Practices and Process Flows

- ED events should trigger outreach within 24-72 hours and follow-up services within 7 days
- Telehealth follow-up by nurses or care managers should be used when appointment availability is limited
- Follow-up encounters should include medication review

Common FMC Codes

Case Management Encounter CPT: 99366, **HCPCS:** T1016, T1017, T2022, T2023
Complex Care Management Service CPT: 99439, 99487, 99489, 99490, 99491, **HCPCS:** G0506
Outpatient and Telehealth CPT: 98000 - 98016, 98966 - 98968, **HCPCS:** G0071, G0438, G0439, G0463, G2010, G2012, G2250

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
- **BMD**: Bone Mineral Density test
- **BH**: Behavioral Health
- **CMR**: Comprehensive Medication Review
- **CAHPS**: Consumer Assessment of Healthcare Providers and Systems
- **ASCVD**: Atherosclerotic Cardiovascular Disease
- **SNP**: Special Needs Plan

Upcoming Resources

Future Look and Learns

- Part 3: October 7, 2026

Stars Pocket Guide

- Quick reference for in-clinic operations
- Measure definitions, best practices, documentation requirements
- Available as a PDF or printed

Provider Next Steps

- Ensure all clinical and operational support staff become familiar with the Stars measure definitions and best practices
- Print and distribute copies of the Stars Pocket Guide
- Incorporate Stars measures into EHR visit templates
- Train clinical staff on corresponding process changes
- Send feedback to HPSJ on the effectiveness of Stars trainings or potential enhancements to the Stars Pocket Guide

Measures Covered Next Session:

Health Outcomes Survey (HOS) Measures
C04 - Improving or Maintaining Physical Health
C05 - Improving or Maintaining Mental Health
C06 - Monitoring Physical Activity
C08 - Care for Older Adults - Medication Review
C09 - Care for Older Adults - Pain Assessment

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey 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

Drug Safety and Accuracy of Drug Pricing Measures
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)

THANK YOU!

Health Plan of San Joaquin

Mountain Valley Health Plan

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

San Joaquin

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Stanislaus

1025 J Street
Modesto, CA 95354

El Dorado

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Placerville, CA 95667