



**Total Care Advantage  
(HMO D-SNP)  
Quality Measures:  
HEDIS and the  
CMS 5 Star Quality  
Rating System**

**Part 2 of 2**

**2026**

# Course Objectives

1. Understand CMS 5 Star Quality Measurement
2. Understand HEDIS and its role in D-SNP Quality Measurement/Performance
3. Understand the Provider Role in Quality Measure Performance

# What is the CMS 5 Star Rating System?

**The 5 Star Rating System:** The primary method Medicare uses to measure quality and performance of Medicare Advantage (Part C) and Prescription Drug (Part D) plans

- Rating is a 1-5 scale (1 = Poor, 5 = Excellent)
- Uses 40+ clinical, patient experience, operational measures

**Core Focus:** Enhancing care outcomes, increasing patient safety and improving patient experience

45

33 Part C measures and 12 Part D measures from various data sources including HEDIS, CAHPS, HOS, administrative data. Raw scores are converted into a Star equivalent based on cut points that change every year.



Categorical Adjustment Index is applied to some measure to adjust for low-income subsidy/dual eligibility status.



Measure weights determined by type of measure.

- 1 for process measure or new measure
- 2 for patient experience measure
- 3 for outcome measure
- 5 for improvement measure



All measures are scored, scores are turned into a star rating based on thresholds, and the stars are aggregated into an overall star rating.



Like MCAS, CMS Star measures use performance thresholds (cut points) to assign ratings to each measure. The Star measure cut points (performance score ranges) are set after the measurement year, based on how plans nationally performed in the previous reporting cycle.

# Star Measure Sources

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**Healthcare Effectiveness Data and Information Set** is a widely used set of performance measures developed by the National Committee for Quality Assurance (NCQA). This includes things like preventive screenings (e.g., mammograms, colonoscopies), management of chronic conditions (e.g., diabetes, asthma), and appropriate medication use.



**Consumer Assessment of Healthcare Providers and Systems** is a program that develops and maintains standardized surveys to collect patient feedback on their experiences with healthcare.



This includes **administrative data** collected directly by CMS through various operational systems, such as the Complaints Tracking Module (CTM) within the Health Plan Management System (HPMS). This data is used to track things like call center performance, the volume of complaints, and beneficiary disenrollment.



**Health Outcomes Survey** is a Centers for Medicare & Medicaid Services (CMS) survey that randomly samples Medicare Advantage (MA) plan members to assess their overall health and well-being. It focuses on factors like physical and mental health, functional status, and patient-provider communication.



By 2027, HEDIS measures will account for around 26% of the overall Star Rating. That makes HEDIS/Star measures that providers can impact key to Star performance!

# Driving Star Ratings Through HEDIS Success : A Review of the HEDIS Performance Measure Set

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## Healthcare Effectiveness Data and Information Set (HEDIS)

- A set of performance measures developed by the National Committee for Quality Assurance (NCQA)
- Designed to standardize measurement specifications to evaluate and compare health plan performance and quality
- Include more than 90 measures across six domains of care divided into measures/sub-measures that include preventive care and condition specific care
- Used by providers to monitor patients' health, identify developing issues, and prevent further complications

### How is HEDIS data collected?

Depending on the measure, data may be collected through:

- Administrative/claims data
- Supplemental files sent in by the provider during the year
- Medical record reviews
- Surveys
- Electronic clinical data systems (ECDS)

**Many Managed Care Accountability Set (MCAS) measures used to evaluate Medi-Cal performance are HEDIS measures**

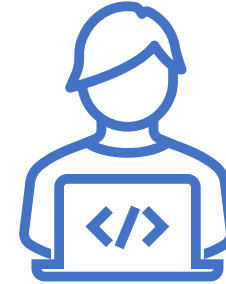
- The practices and workflows that drive MCAS measure performance drive HEDIS and Star Measure success!

# Supporting HEDIS Measure Performance

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## How Can I Improve HEDIS Scores?

- Submit claim/encounter data for each service rendered
- Make sure that chart documentation reflects all services billed
- Bill (or report by encounter submission) all delivered services, regardless of contract status
- Close gaps with patient-reported data by documenting the specific performing provider, the exact year of the screening, and the clinical outcome (e.g., “Colonoscopy at the office of Dr. Ramirez in 2025, results normal”)
- Ensure that all claim/encounter data is submitted in an accurate and timely manner
- Include CPT II codes to provide additional details for data capture



CPT II codes support quality reporting and HEDIS documentation by capturing preventive care activities directly on claims

For Example:

3017F — Colorectal cancer screening documented and reviewed

This CPT II code is often used to indicate that appropriate colorectal cancer screening was performed or documented in the medical record

# Why Star Ratings Matter

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## The CMS 5-Star Rating System is designed to:

- Help beneficiaries compare plans to make informed decisions
- Drive quality improvement initiatives
- Reward higher-performing plans



## Star Ratings are the plan's report card

- The bonus threshold (four stars): Plans that achieve four stars or higher receive a 5% Quality Bonus Payment from CMS.
  - This is often the difference between profit and loss
- Rebates: Higher stars mean the plan keeps a higher percentage of savings (rebates) to fund extra benefits (dental, vision, \$0 copays)
- Marketing advantages
- 5-Star plans are allowed to enroll members year-round (special election period)
- Low-performing plans (<three stars) for three years in a row can be terminated by CMS



## The Star Rating Timeline:

- ↪ Measurement Year 2026
- ↪ Reporting Year 2027
- ↪ Star Rating Year 2028
- ↪ Payment Year 2029

This determines the 2028 Star Rating, which impacts the plan's 2029 payment quality bonus payment. So, what providers do TODAY directly impacts 2028 Star success and 2029 payment.

# Part C 5 Star Measures and Weights

Measure Name	Weighting Category	Weight
Breast Cancer Screening	Process Measure	1
Colorectal Cancer Screening	Process Measure	1
Annual Flu Vaccine	Process Measure	1
Improving and Maintaining Physical Health	Outcome Measure	1*
Improving and Maintaining Mental Health	Outcome Measure	1*
Monitoring Physical Activity	Process Measure	1
Special Needs Plan (SNP) Care Management	Process Measure	1
Care for Older Adults – Medication Review	Process Measure	1
Care for Older Adults – Functional Assessment	Process Measure	1
Osteoporosis Management in Women who had a Fracture	Process Measure	1
Diabetes Care – Eye Exam	Process Measure	1
Diabetes Care – Blood Sugar Controlled	Immediate Outcome Measure	3
Kidney Health Evaluation for Patients with Diabetes	Process Measure	1
Controlling Blood Pressure	Immediate Outcome Measure	3
Reducing the Risk of Falling	Process Measure	1
Improving Bladder Control	Process Measure	1
Medication Reconciliation Post-Discharge	Process Measure	1
Plan All-Cause Readmissions	Outcome Measure	3
Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1

Part C Measure Name	Weighting Category	Weight
Transitions of Care	Process Measure	1
Follow Up after ED Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
Getting Needed Care	Patient Experience and Complaints Measure	2
Getting Appointments and Care Quickly	Patient Experience and Complaints Measure	2
Transitions of Care	Process Measure	1
Rating of Health Care Quality	Patient Experience and Complaints Measure	2
Rating of Health Plan	Patient Experience and Complaints Measure	2
Care Coordination	Patient Experience and Complaints Measure	2
Complaints about the Health Plan	Patient Experience and Complaints Measure	2
Members Choosing to Leave the Plan	Patient Experience and Complaints Measure	2
Health Plan Quality Improvement	Improvement Measure	5
Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2
Reviewing Appeals Decisions	Measures Capturing Access	2
Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2

Source: <https://www.cms.gov/files/document/2026-star-ratings-measures.pdf>



# Part D 5 Star Measures and Weights

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Part D Measure Name	Weighting Category	Weight
Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2
Complaints about the Drug Plan	Patient Experience and Complaints Measure	2
Members Choosing to Leave the Plan	Patient Experience and Complaints Measure	2
Drug Plan Quality Improvement	Improvement Measure	5
Rating of Drug Plan	Patient Experience and Complaints Measure	2
Getting Needed Prescription Drugs	Patient Experience and Complaints Measure	2
MFP Price Accuracy	Process Measure	1
Medication Adherence for Diabetes Medications	Immediate Outcome Measure	3
Medication Adherence for Hypertension (RAS antagonists)	Immediate Outcome Measure	3
Medication Adherence for Cholesterol (Statins)	Immediate Outcome Measure	3
MTM Program Completion Rate for CMR	Process Measure	1
Statin Use in Persons with Diabetes	Process Measure	1

Source: <https://www.cms.gov/files/document/2026-star-ratings-measures.pdf>

# 5-Star Performance: The Provider's Role



# The Provider Role in 5 Star



Everyone on the healthcare team plays a role in ensuring patients get the highest quality care. From making appointments, to conducting screenings, to providing care, to ensuring a positive experience, 5 Star is a team effort.

**Providers play a significant role in promoting the health of Total Care Advantage members.**

Today We Will Focus on the Provider Role Specifically.

- Looking at ways daily practice—from closing clinical gaps to enhancing communication—powers Star measure scores
  - Ensuring the delivery of deliver high-quality, evidence-based care that improves patients' lives
  - Ensuring the star measure ratings represent that care

The following slides outline the provider practices that can contribute to improved Medicare Star Ratings performance.

# The Provider Role in 5 Star: Prioritize Preventive Care

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- Maximize Annual Wellness Visits (AWVs)
- Close Preventive Screening Care Gaps during AWV and all visits including:
  - Colorectal Cancer Screening (COL): Members 45 to 75. Updating history or providing at-home test kits.
  - Breast Cancer Screening (BCS): Members 50 to 74. Ordering or verifying recent mammograms
  - Osteoporosis Management (OMW): Women 67 - 85 who suffered a fracture
  - Care for Older Adults (COA) Members 66 years and older. Complete and document pain screen and medication review.
- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with care gaps



# The Provider Role in 5 Star: Manage and Code Chronic Conditions

- Closely track and manage patients with chronic diseases like diabetes and cardiovascular disease
- Convert members from 30-day fills to a 100-day medication supply to support chronic condition management and Star performance for diabetes, cholesterol, and blood pressure medication adherence measures
- Ensure members receive all required labs and screenings and that their conditions are documented
  - Capture chronic conditions at every visit
    - ✓ Make sure diagnoses like diabetes and hypertension are documented annually
  - Check and record key values
  - Order and follow up on needed tests
- Document and code ALL chronic conditions - diagnosis, severity, and status.
  - If it's not documented and coded, it won't be reflected in quality data

## Labs/Tests Aligned to Star Measures

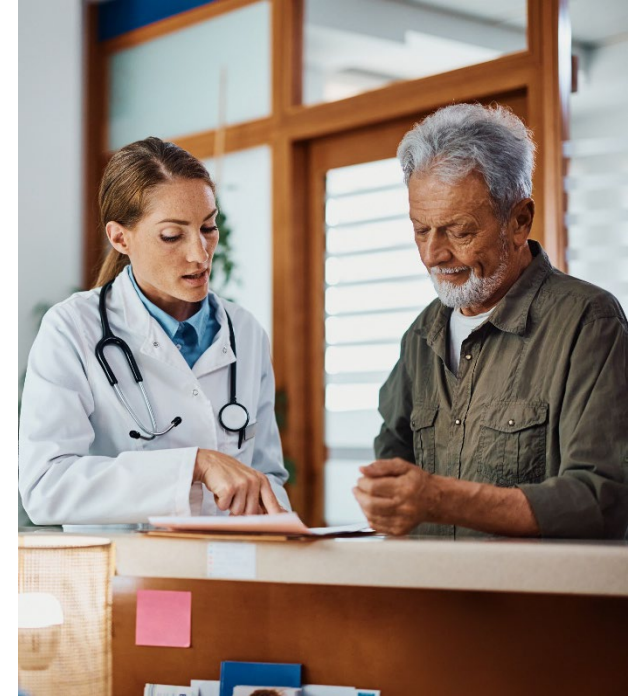
Star Measure	Lab/Test	Considerations	Provider Actions
Diabetes Blood Sugar Control (GSD)	HbA1c	A1c value captured ( $\leq 9\%$ improves score; missing or $>9\%$ hurts)	Order A1c, review result, adjust treatment if elevated
Kidney Health Evaluation for Diabetes (KED)	eGFR, uACR	At least one eGFR in measurement year	Order CMP or eGFR, uACR annually
Controlling Blood Pressure (CBP)	BP reading	Last BP reading $<140/90$	Recheck and document BP during visit
Diabetes Eye Exam (EED)	Exam	Eye exam completed and documented	Refer and ensure report is received

**Great care + clear documentation = better outcomes and higher Star Ratings!**

# The Provider Role in 5 Star: Influence CAHPS Star Measure Performance with Every Interaction

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- Provider Communication
  - Survey Question: “In the last six months, how often did your provider explain things in a way that was easy to understand?”
  - Provider Impact: Clear, respectful communication = higher experience scores
- Getting Care Quickly
  - Survey Question: “When you needed care right away, how often did you get care as soon as you needed?”
  - Provider Impact: Access and scheduling drive satisfaction. Support timely follow-up.
- Care Coordination
  - Survey Question: “How often did your provider seem informed about care you got from specialists?”
  - Provider Impact: Closed-loop communication and follow-up matter
- Health and Medication Support
  - Survey Question: “In the last six months, did someone talk with you about all the medicines you were taking?”
  - Provider Impact: Medication review and chronic care discussions improve experience



# The Provider Role in 5 Star: Influence Health Outcome Survey (HOS) and Administrative Star Measures

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## ➤ Influence Health Outcome Survey (HOS) Star measures

- Survey of members' perception of their physical health, mental health, daily functioning, and overall quality of life over time
- Support member physical and mental health through proactive chronic condition management
- Assess functional status, mobility, fall risk, and activities of daily living during routine care and AWWs
- Screen for urinary incontinence and address quality-of-life concerns impacting daily functioning
- Reinforce medication adherence and symptom management to support independence and health
- Coordinate care across providers, caregivers, and support services for complex D-SNP members
- Promote clear communication and member engagement, which influence HOS survey outcomes

## ➤ Influence Administrative Star measure performance at the point of care with accurate documentation, timely responses, and clear clinical communication

- Submit complete, accurate prior authorization/coverage requests with strong medical necessity documentation to prevent delays and downstream denials
- Ensure timely response and clear clinical rationale for coverage determinations and appeal support
- Maintain accurate documentation/coding to reduce errors, claim issues, confusion, disenrollment
- Support efficient care transitions and scheduling workflows to minimize access barriers that drive grievances, disenrollment dissatisfaction
- Communicate clearly with members about care decisions, next steps, and alternative care options to reduce appeals and complaints

# The Provider Role in 5 Star: Coordinate Care Effectively

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- Ensure members discharged from the hospital or ER are seen timely
- Contribute to the Individualized Care Plan (ICP) Contribution: Providers must actively engage in developing and updating the ICP
- Interdisciplinary Care Team (ICT) Leadership: Collaborate with specialists, care managers, and social workers to coordinate care and ensure all team members work toward the patient's unified health goals
  - Review the plan with members during visits, providing feedback to case managers
- Document follow-up plans, visits, medication reconciliation, and member/caregiver education
- Consider referral for care management
  - TCA Care Navigators can be reached via email at: [dsnpcarecoordinationteam@goldchp.org](mailto:dsnpcarecoordinationteam@goldchp.org) or call Member Services: 1-888-301-1228 (TTY: 711)
  - The assigned TCA Care Navigator can also be found on the GCHP provider portal and on the Individualized Care Plan (ICP) sent to the assigned primary care physician/clinic

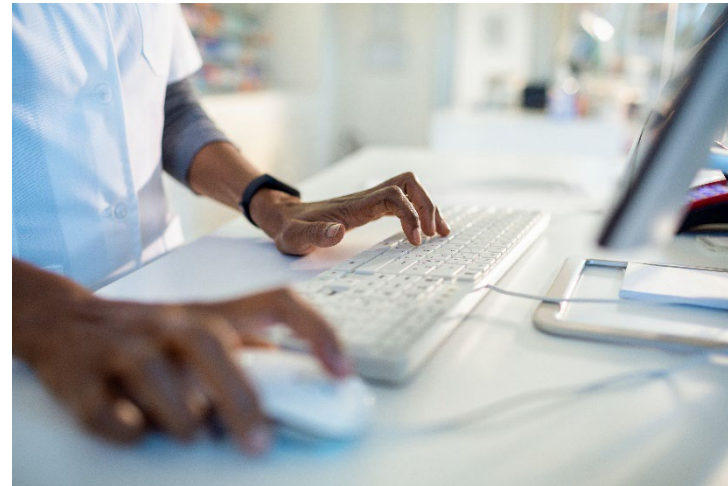


# Steps to Impact Star Measure Ratings

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The next slides focus on simple actions you can take during each visit to impact Star Ratings

- You'll note the sample of Star measures detailed in these slides are Clinical and Preventive HEDIS Star Measures
  - Reminder: Providers directly impact every measure performance through care delivery and documentation!



# Glycemic Status Assessment for Patients With Diabetes (GSD)

**Metric:** The percentage of diabetic MA enrollees ages 18 to 75 whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year. \*This measure for public reporting is reverse scored so higher scores are better. \*Weight = 3

## Exclusions:

- Persons in hospice or using hospice services
- Persons who die any time during the measurement year
- Persons receiving palliative care
- Persons 66 years of age and older as of Dec. 31 with frailty and advanced illness

## Closing the Gap:

- GSD is a hybrid measure Hybrid Measure closed through claims and chart review
- GSD is closed based on result of the HbA1c or GMI > documenting and coding the test result is critical to gap closure
- GSD, at a minimum, is also closed by a note indicating the date the HbA1 was completed and the result
- Repeat abnormal lab tests later in the year, as the most recent result in the measurement period closes the gap

## Sample Codes

### Identifying Patients with Diabetes

- Method 1: Claim/Encounter Data. Members with at least two face-to-face visits (any setting) on different dates of service with a diabetes diagnosis
  - For list of diabetes diagnostic codes, click [HERE](#)
- Method 2: Members who were dispensed at least one diabetes medication and had at least one diagnosis of diabetes during the measurement year or the year prior.
  - For list of diabetes medications, click [HERE](#)

## HbA1c Codes

Category	Code	Description
CPT	83036, 83037	HbA1c Lab Test
CPT	3051F, 3052F, 3044F, 3046F	HbA1c Lab Test Result/Finding
CPT	3051F, 3044F	HbA1c Level < 8.0
CPT	3052F, 3046F	HbA1c Level >= 8.0

# Eye Exam for Patients with Diabetes (EED)

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

**Exclusions:**

- Members who do not have diabetes diagnosis during the measurement or prior year
- Members who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid induced diabetes
- Members with bilateral absence of eye enucleation
- Persons in hospice or using hospice services
- Are age 66 and older with advanced illness and frailty
- Members who passed away during the measurement year
- Members who received palliative care during the year
- Members 66 and older as of Dec. 31 of measurement year enrolled in an I-SNP or living long term in an institution (LTI)

**Closing the Gap:**

- EED is closed through claims data. Be sure to document results and date of exam by eye care professional and claims codes
- To document a history of a dilated eye exam without the official report, include the date of service, name or specialty of the assessing eye care professional (optometrist or ophthalmologist), and the exam findings or results
- Patient-reported exams > document the DOS, results, eye care professionals' name/credentials

**Sample Codes**

**Compliant Measure Summary:** A diabetic member meets the measure if ONE of the below is documented:

- ▶ Retinal/dilated eye exam done by an eye care professional (optometrist or ophthalmologist) or fundus photography during the measurement year.
- ▶ Negative retinal/dilated eye exam (result – no evidence of retinopathy) documented by an eye care professional in the year prior.

Eye Exam:

Category	Code	Description
CPT II	2022F, 2024F, 2026F	With retinopathy
CPT II	2023F, 2025F, 2033F	Without retinopathy
CPT	92002, 92004, 92012, 92137, 92201, 92230, 99204, 99242- 99245	Retinal Eye Exam
CPT	9227, 9228	Retinal imaging interpretation billed by any practitioner

For more codes click [HERE](#).

# Kidney Health Evaluation for Patients with Diabetes (KED)

**Metric:** Members 18 to 85 years of age with diabetes (type 1 and type 2) as of Dec. 31 of the measurement year 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.

## Exclusions:

- Members who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid induced diabetes
- Members with a diagnosis of End Stage Renal Disease (ESRD) or who had dialysis at any time in their history
- Persons in hospice or using hospice services
- Are 66 and older with advanced illness and frailty
- Members who passed away during the measurement year
- Members who received palliative care during the year
- Members 66 and older as of Dec. 31 of the measurement year enrolled in an I-SNP or living long term in an institution (LTI)

## Closing the Gap:

- KED is closed if the diabetic member has had BOTH of the following during the measurement year: at least one eGFR test result and at least one uACR test result

Lab test reports should indicate both an eGFR and uACR were performed during the measurement year on the same or different dates of service.

## Sample Codes

Category	Code	Description
CPT	80047, 80048, 80050, 80053, 80069, 82565	Estimated Glomerular Filtration Rate (eGFR)
CPT	82043	Quantitative Urine Albumin Test
CPT	82570	Urine Creatinine Lab Test
LOINC	13705-9, 14958-3, 4959-1 30000-4, 44292-1 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7	Urine Albumin-Creatinine Ratio Lab Test (uACR)

For more codes and to identify members with diabetes, click [HERE](#).

# Controlling Blood Pressure (CBP)

**Metric:** Members 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg). \*Weight = 3

**Exclusions:**

- Enrolled in an Institutional SNP (I-SNP) during the measurement year
- Living long-term in an institution during the measurement year
- Members 66 to 80 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness
- Members must meet BOTH frailty and advanced illness criteria to be excluded:
  - Frailty - At least two indications of frailty with different dates of service during the measurement period
  - Advanced Illness on at least two different dates of service
- Dispensed dementia medication

**Closing the Gap:**

- Identify the most recent BP reading noted during the measurement period
- The BP reading must occur on or after the date of the second diagnosis of hypertension

**Sample Codes:**

**Identifying Patients with Hypertension**

Category	Code	Description
ICD 10	110	Essential primary hypertension

**Identifying Representative Blood Pressure**

Category	Code	Description
CPT II	3077F	Systolic >= 140
CPT II	3074F-3075F	Systolic < 140
CPT II	3079F	Most recent diastolic 80-89
CPT II	3078F	Most recent diastolic <80
CPT II	3080F	Most recent diastolic >= 90

For more codes, including codes used to identify clinic setting of BR reading, click [HERE](#).

- Both the systolic and diastolic must be below the above readings to be considered “controlled” (highest compliant BP: 139-89 mmHg)
- Use CPT-II codes to report BP on claims/in EHRs

# Colorectal Cancer Screening (COL)

**Metric:** The percentage of MA enrollees ages 50 to 75 as of Dec. 31 of the measurement year who had appropriate screenings for colorectal cancer.

**Exclusions:**

- History of colorectal cancer and/or total colectomy any time during the person's history
- Persons in hospice or using hospice services
- Persons who die any time during the measurement year
- Persons receiving palliative care
- Persons 66 years of age and older as of Dec. 31 with frailty and advanced illness

**Closing the Gap:**

- Test/screening or exclusion code(s) with service date(s) - detailed documentation > test, procedure, date and results
- Screening Includes: Stool DNA with FIT test in the measurement year or 2 years prior
  - Flexible sigmoidoscopy in the measurement year or 4 years prior
  - CT colonography in the measurement year or 4 years prior
  - Colonoscopy in the measurement year or nine years prior
- Fecal occult blood test during the measurement period

**TIP:** Update patient charts yearly to indicate colorectal cancer screening. Include which test was performed, date of screening, and test result.

## Sample Codes

Category	Code	Description
CPT	45378, 44388, 44390, 45380, 45381, 45384, 45385, 44388, 45390, 44401, 44408, G0105, G0121	Colonoscopy
CPT	G0104, 45330-45335, 45337, 45340-45342, 45337, 45340-45342, 45350	Flexible Sigmoidoscopy
CPT	82270, 82274, G0328	FOBT
CPT	81528, 0464U	FIT-DNA
LOINC	77353-1, 77354-9	Noninvasive colorectal cancer DNA and occult blood screening in Stool Narrative
CPT	74261-74263	CT colonography

# Breast Cancer Screening (BCS)

**Metric:** The percentage of persons 40 to 74 years of age who had one or more mammograms to screen for breast cancer between Oct. 1 two years prior to the end of the current measurement year (MY 2026 reporting 50 to 74).

## Exclusions:

- History of bilateral mastectomy or both right and left unilateral mastectomies on the same or different dates of service (if exact date is unknown, the year is acceptable)
- Gender-affirming chest surgery (CPT code 19318) AND a diagnosis of gender dysphoria any time during the patient's history
- Persons in hospice or using hospice services
- Persons who die any time during the measurement year
- Persons receiving palliative care
- Persons 66 years of age and older as of Dec. 31 with frailty and advanced illness

## Closing the Gap:

- Close gap with documentation indicating a mammogram was completed and the date it was performed
- Patient reported mammogram is acceptable. Document date in the medical record
- Document and code screening mammograms and mastectomies on claims/encounter data
- Document the date of the last screening mammogram at the annual visit

## Sample Codes

### Exclusion Codes

Category	Code	Description
ICD-10-CM	Z90.11	Absence of right breast
ICD-10-CM	Z90.12	Absence of left breast
ICD-10-CM	Z90.13	Absence of bilateral breasts

### Mammogram Codes

Category	Code	Description
CPT	77061	Diagnostic digital breast tomosynthesis unilateral
CPT	77062	Diagnostic digital breast tomosynthesis; bilateral
CPT	77063	Screening digital breast tomosynthesis, bilateral
CPT	77065	Diagnostic mammography

For more mammogram codes click [HERE](#).

# Care for Older Adults (COA)

**Metric:** Members 66 years of age and older who had each of the following during the measurement period:

- Medication Review (Star measure): Documentation of a complete medication review of all a member's medications, including prescription medications, OTC medications herbs or supplements
- Functional Assessment (Star measure): Documentation of at least one functional status assessment
  - Valid functional assessment uses a standardized assessment tool to evaluate ADLs (bathing, dressing, etc.)/IADLs (shopping, use of transportation, finances, etc.)
- Pain Assessment (HEDIS measure, 2026 TCA priority measure): Documentation of at least one pain assessment plan during the measurement year.
  - Valid pain assessment uses a standardized tool or instrument to evaluate the presence or absence of pain and its severity

## Exclusions:

- Members in hospice or using hospice services
- Services provided in an acute inpatient setting
- Members who died any time during the measurement year

## Closing the Gap:

- Medication Review: Document date & coding of medication list (1159F) and review (1160F) by prescribing practitioner or clinical pharmacist
- Functional Assessment: Document evidence of a complete functional assessment (11170F), date, result

- Pain Assessment: Documentation and coding of a valid pain assessment that includes: tool, score, date

## Sample Codes

### Medication Review Codes

Category	Code	Description
CPT	90863, 99483, 9605, 99606	Medication Review
CPT II	1160F	Medication Review
CPT II	1159F	Medication List
CPT	99495, 99496	Transitional Care Management

For more medication review codes, click [HERE](#)

### Functional Assessment Codes

Category	Code	Description
CPT II	1170F	Functional status assessment (ADL/IADL)
HCPCS	G0438, G0439	Annual Wellness Visit

### Pain Assessment Codes

Category	Code	Description
CPT II	1125F	Pain severity quantified; pain present
CPT	1126F	Pain severity quantified; no pain present

# Plan All-Cause Readmission (PCR)

**Metric:** 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 during the measurement period. \*Weight = 3

## Exclusions:

- Hospital stays for the following reasons:
  - A principal diagnosis of pregnancy on the discharge claim
  - A principal diagnosis of a condition originating in the perinatal period on the discharge claim
- Member died during the stay
- Members in hospice or using hospice services anytime during the measurement year

## Closing the Gap/Prevent Readmissions:

- Accurate coding and documentation of chronic conditions, severity, and frailty-related diagnoses can support appropriate PCR measure exclusions
  - Differentiate planned versus urgent admissions in supporting documentation
  - Ensure all chronic conditions are accurately captured and updated in the medical record
- Schedule the post-discharge follow-up visit within seven days of release > the highest risk window for a patient to relapse

## Sample Codes

### Coding for Risk and Exclusions

- Unlike other Star measures, there is no single billing code that 'closes' the PCR gap
- PCR success is driven by two distinct efforts:
  - Clinical interventions to keep the patient from returning to the hospital
  - Precise administrative coding to accurately capture the patient's baseline risk and identify valid exclusions
    - Removes high-risk, non-preventable readmissions from PCR performance data

- Perform medication reconciliation post hospitalization
  - Order a 100-day medication supply for all new medications
- Ensure specialist follow-up appointments are completed
- Follow up on pending labs, imaging, or referrals after discharge
- Refer high risk members to Transitional Care Management/Outreach to TCA Care Navigators

# Key Takeaways: Provider's Role in Quality Measure Performance

## Providers > The CLINICAL ANCHOR

Deliver Preventive and Chronic Care  
 ➤ AWWs, Preventive Screenings

Improve CAHPS and HOS Outcomes  
 ➤ Communication, Access, Member Experience

Support Administrative Star Measures  
 ➤ Timely Documentation, Prior Authorization, Appeals Response and Accurate Claims

## Coding and Documenting Knowledge Gained in Previous Training Apply to Closing Gaps

- ✓ Maximize use of codes: Only codes will close gaps for Administrative and Electronic Measures
- ✓ Submit claim/encounter data for every service in an accurate and timely manner
- ✓ Document medical and detailed surgical history with dates and use of appropriate coding
  - Example: "Patient underwent a total abdominal colectomy (CPT 44150 / ICD-10 Z90.49) on Oct. 14, 2018, due to severe ulcerative colitis."
- ✓ Information from the medical record must validate all required measures or exclusion

**HCC Coding Quick Reference**

ICD-10-CM Codes that Report the 2022 HCC (HCC) Measure

ICD-10-CM Code	ICD-10-PCS Code	ICD-10-PCS Code	ICD-10-PCS Code
040A01	040A01	040A01	040A01
040A02	040A02	040A02	040A02
040A03	040A03	040A03	040A03
040A04	040A04	040A04	040A04
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040A97	040A97	040A97	040A97
040A98	040A98	040A98	040A98
040A99	040A99	040A99	040A99

**HCC Coding Quick Reference**

ICD-10-PCS Codes that Report the 2022 HCC (HCC) Measure

ICD-10-PCS Code	ICD-10-PCS Code	ICD-10-PCS Code	ICD-10-PCS Code
040A01	040A01	040A01	040A01
040A02	040A02	040A02	040A02
040A03	040A03	040A03	040A03
040A04	040A04	040A04	040A04
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040A06	040A06	040A06	040A06
040A07	040A07	040A07	040A07
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040A97	040A97	040A97	040A97
040A98	040A98	040A98	040A98
040A99	040A99	040A99	040A99

Tip: Keep your HCC Quick Reference Guide Handy!

- ### Final Thoughts:
- A care gap is only truly closed when clinical excellence meets precise documentation at the point of care.
  - Care provided today impacts the Star Rating assigned in 2028.

