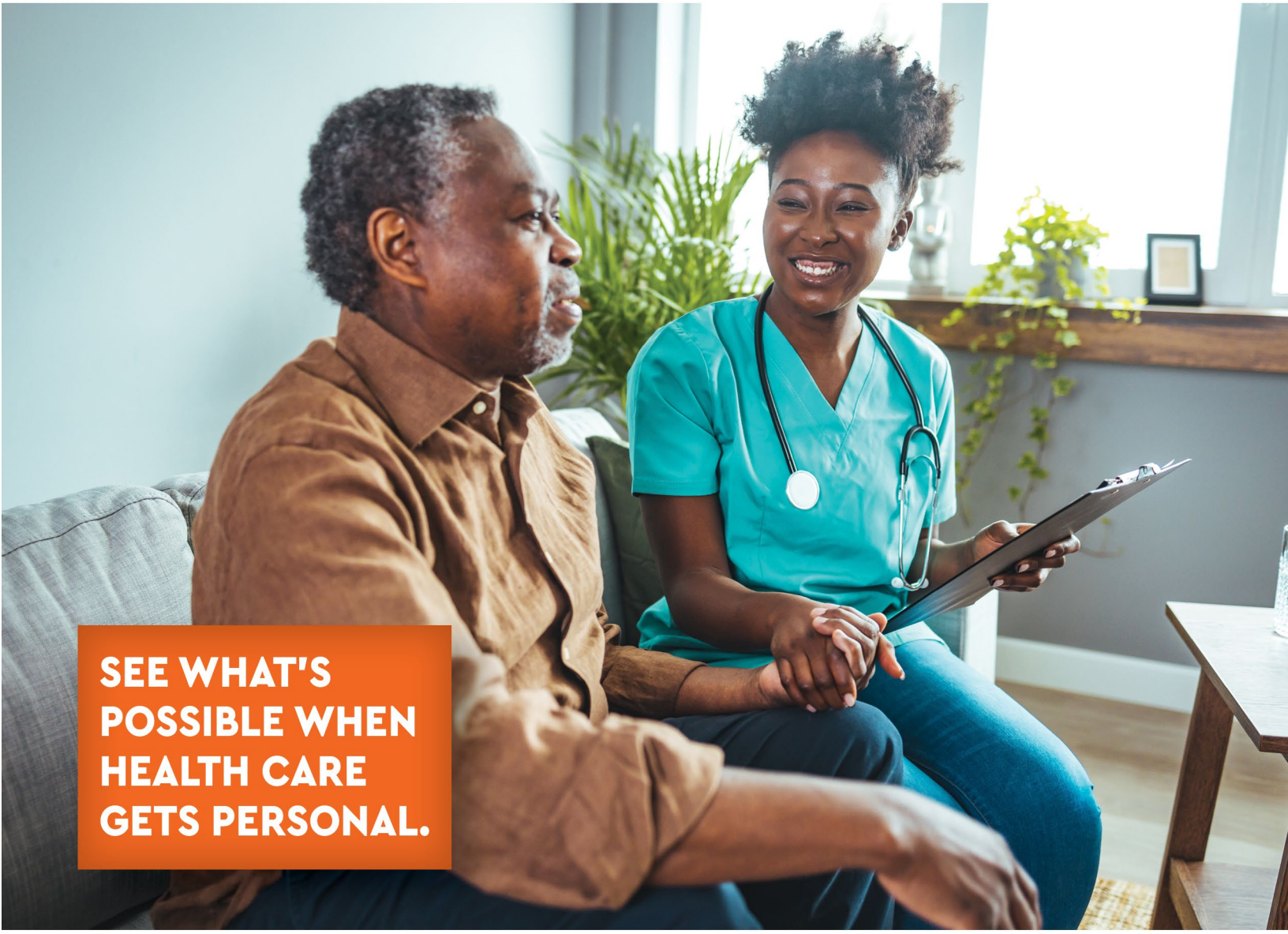
VILLAGECAREMAX



2026 HEDIS REFERENCE GUIDE

www.villagecaremax.org

Table of Contents

About HEDIS® MY 2026 Quick Reference Guide

- VillageCareMAX in association with you is committed to providing high-quality healthcare to our members.
- Preventive care and chronic care management are crucial to achieving this goal
- We use HEDIS quality metrics to measure and track our performance

To assist in improving your HEDIS scores, this reference guide will help you,

- Report data accurately and efficiently
- Identify and address gaps in patient care

We appreciate your partnership in delivering excellent care for our members.

VILLAGECAREMAX

What Is HEDIS®?

HEDIS® (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) objectively measure, report, and compare quality across health plans.

NCQA develops HEDIS® measures through a committee represented by purchasers, consumers, health plans, health care providers, and policy makers.

The Healthcare Effectiveness Data Information Set (HEDIS) is one of health care's most widely used performance improvement tools.

How are HEDIS® rates used?

State and federal governments are moving towards a more quality-driven healthcare industry. HEDIS rates evaluate a health insurance company's ability to improve preventive health outreach for members. Physician-specific scores are used to measure your practice's ability to provide a wide array of care to patients ranging from health screenings to medication management.

How to submit data to improve your HEDIS® scores?

- **Administrative Claims**
  - Submit claim/encounter data for each service rendered with appropriate billing codes to be paid correctly. This reduces the need for medical record review as well. Services that are not billed or billed inaccurately will not be included in the quality calculation.
  - Submit applicable exclusion/ frailty codes when members should be excluded from HEDIS measures.
  - Accurate and timely submission of claims data is the best way to ensure all services are captured.
- **EMR Access**

  Consider granting VillageCareMAX access to your EMR system. This can reduce the administrative burden on your practice. We would request read-only access to the medical records of our members, and the ability to download the records to be securely stored for the purpose of reviews and audits.

  Your Network Management Representative can give you more information about this important initiative.

This guide has been updated with information from the release of the HEDIS® MY 2025 Volume 2 Technical Specifications by NCQA and is subject to change.

*Codes are subject to change
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Clinical Documentation and HEDIS SCORES

Charting, Medical Coding and Billing:

- Ensure that your clinical documentation reflects all services billed.
- Document to the highest specificity to assist with coding to the highest level of specificity.
- Timely submission of claim or encounter data for each and every service rendered.
- Use CPT Category II codes to provide additional details and reduce record requests.

*Codes are subject to change

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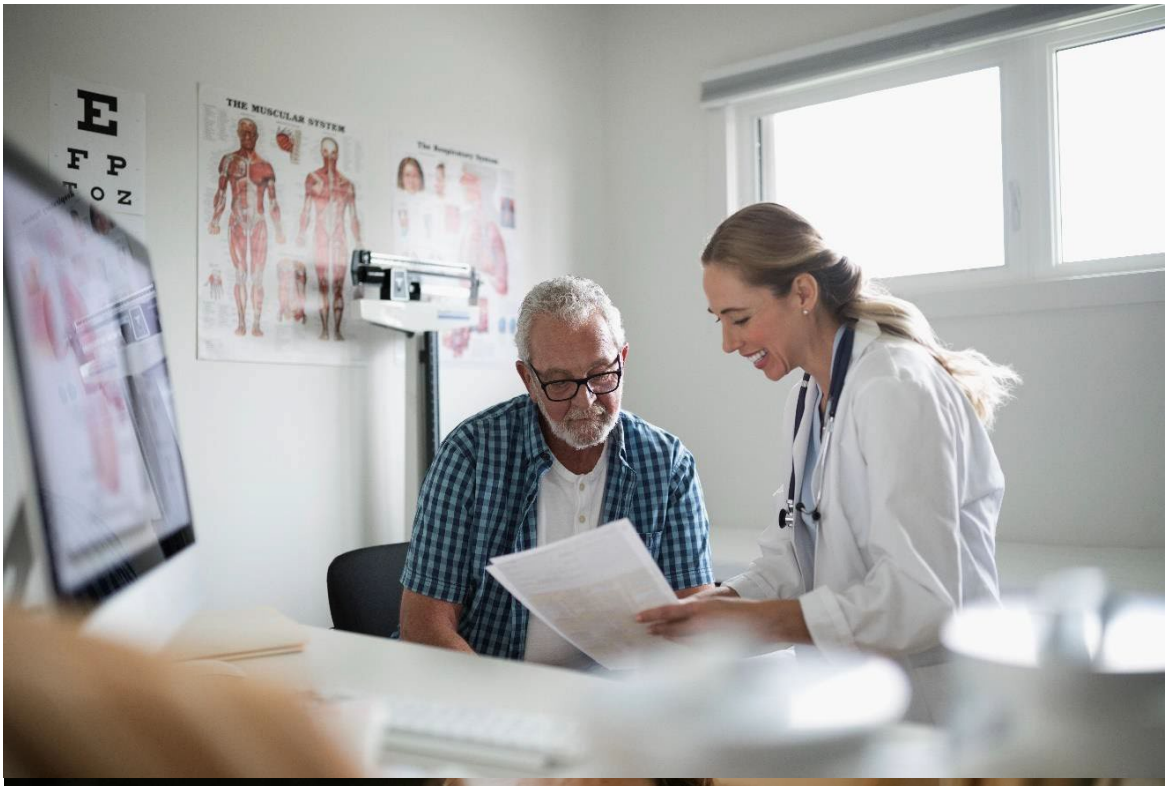
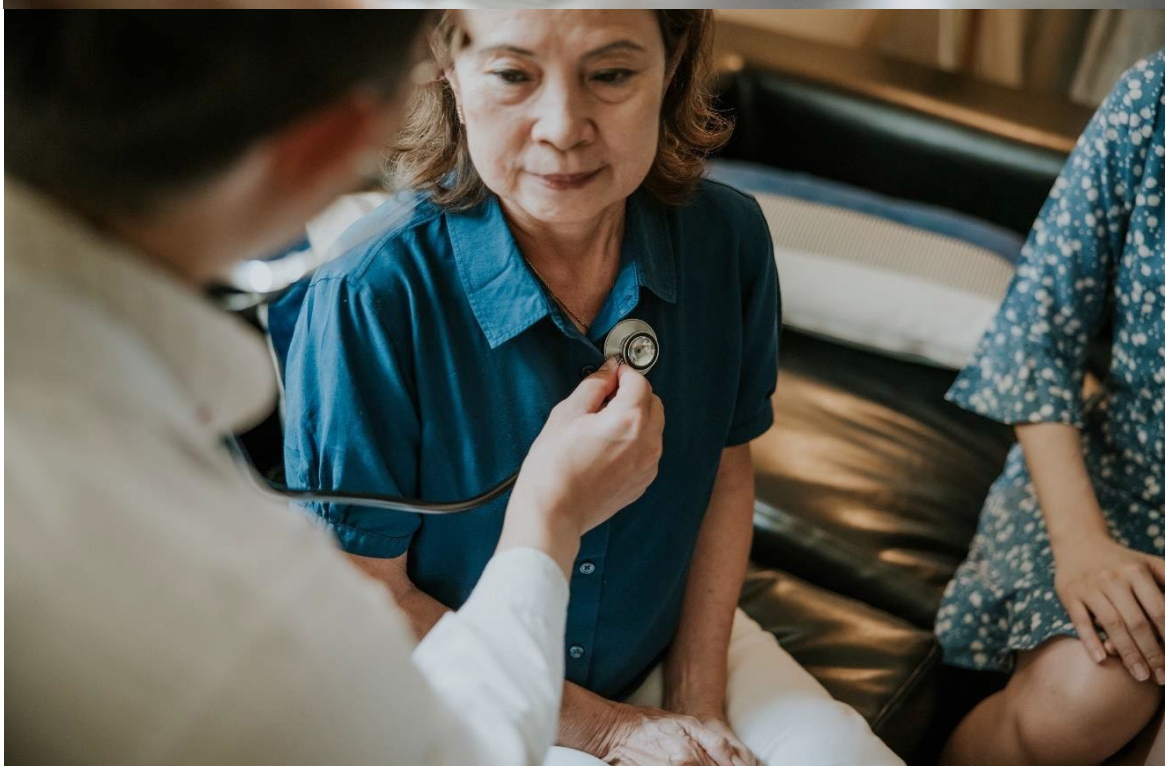
ACCESS AND AVAILABILITY OF CARE

Contents

(AAP) Adult Access to Preventative/Ambulatory Services





*Codes are subject to change

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ADULT ACCESS TO PREVENTATIVE/AMBULATORY SERVICES (AAP)

Definition: The percentage of members 20 years and older who had an ambulatory or preventative care visit with any provider type during the measurement year.

DESCRIPTION	CODES
Ambulatory Visits	CPT: 99381-99384, 99391-99394 ICD-10: Z00.00, Z00.01 CPT Category II: G0402, G0438, G0439, G0463, T1015
Online Assessments	CPT: 99444
Telephone Visits	CPT: 98966-98968, 99441-99443
Telephone Modifier	95, GT

Helpful Tips: Complete an appointment with all assigned patients annually during the measurement year. Use the appropriate codes to close gaps.

*Codes are subject to change
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Prevention and Screening

Contents

- (COA) Care for Older Adults
- (COL) Colorectal Cancer Screening
- (BCS) Breast Cancer Screening

*Codes are subject to change
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CARE FOR THE OLDER ADULT (COA)

Definition: The percentage of adults 66 years and older who had each of the following during the measurement year 2026:

1. Medication Review
2. Functional Status Assessment – At least one functional assessment during the measurement year

★ CARE FOR OLDER ADULTS (COA) – MEDICATION REVIEW

Definition: A medication review by a clinical pharmacist or prescribing practitioner ***and*** the presence of a medication list in the medical record during the measurement year 2026.

Clinical Documentation – The medication list must be documented in the medical record and the medication review must be completed on the same date of service.

DESCRIPTION	CODES
Medication List	CPT Category II: 1159F
Medication Review	CPT Category II: 1160F

Helpful Tip: Code 1159F (medication list) ***must*** be submitted with 1160F (medication review by a prescribing practitioner or clinical pharmacist) on the same date of service.

*Codes are subject to change
★ = CMS Stars Measure

★ CARE FOR OLDER ADULTS (COA) – FUNCTIONAL STATUS ASSESSMENT

Definition: At least one functional status assessment during the measurement year 2026.

Assessment of at least ***five*** **Activities of Daily Living** (ADLs), including but not limited to:

- Bathing
- Dressing
- Eating
- Transferring
- Toileting
- Walking

OR

Assessment of at least ***four*** **Instrumental Activities of Daily Living** (IADLs), including but not limited to: Chores, such as:

- Laundry
- Cleaning
- Cooking
- Driving or using Public Transportation
- Grocery Shopping
- Home Repair
- Paying Bills or other Financial Tasks
- Taking Prescribed Medications
- Using the Phone
-

DESCRIPTION	CODES
Functional Status Assessment	CPT Category II: 1170F

*Codes are subject to change

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★ COLORECTAL CANCER SCREENING (COL-E)

Definition: The percentage of members **45-75** years of age who had appropriate screening for colorectal cancer.

Clinical documentation must include a date of service when documenting a Colonoscopy, Flexible Sigmoidoscopy, CT Colonography, Fecal Immuno-Chemical Testing (FIT) DNA, or Fecal Occult Blood Test (FOBT).

Member reported screenings are acceptable if documented in the chart as part of the patient's history.

DESCRIPTION	CODES
Colonoscopy *Between 2017 and 2026*	CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398
CT Colonography *Between 2022 and 2026*	CPT: 74261-74263
Flexible Sigmoidoscopy *Between 2022-2026*	CPT: 45330-45335, 45337-45342, 45345-45347, 45349-45350
FIT-DNA (Cologuard®) Test *Between 2024-2026*	CPT: 81528
Fecal Occult Blood Test (FOBT) *During 2026*	CPT: 82270, 82274

★ BREAST CANCER SCREENING (BCS-E)

Definition: The percentage of members **ages 40-74** who had a mammogram to screen for breast cancer between October 1, 2024 through December 31 of measurement year 2026.

Clinical Documentation must include a date of service when documenting a mammogram reported by the patient.

DESCRIPTION	CODES
Mammography *Between October 1, 2024, and December 31, 2026*	CPT: 77061-77063, 77065-77067
History of Bilateral Mastectomy	ICD-10: Z90.13

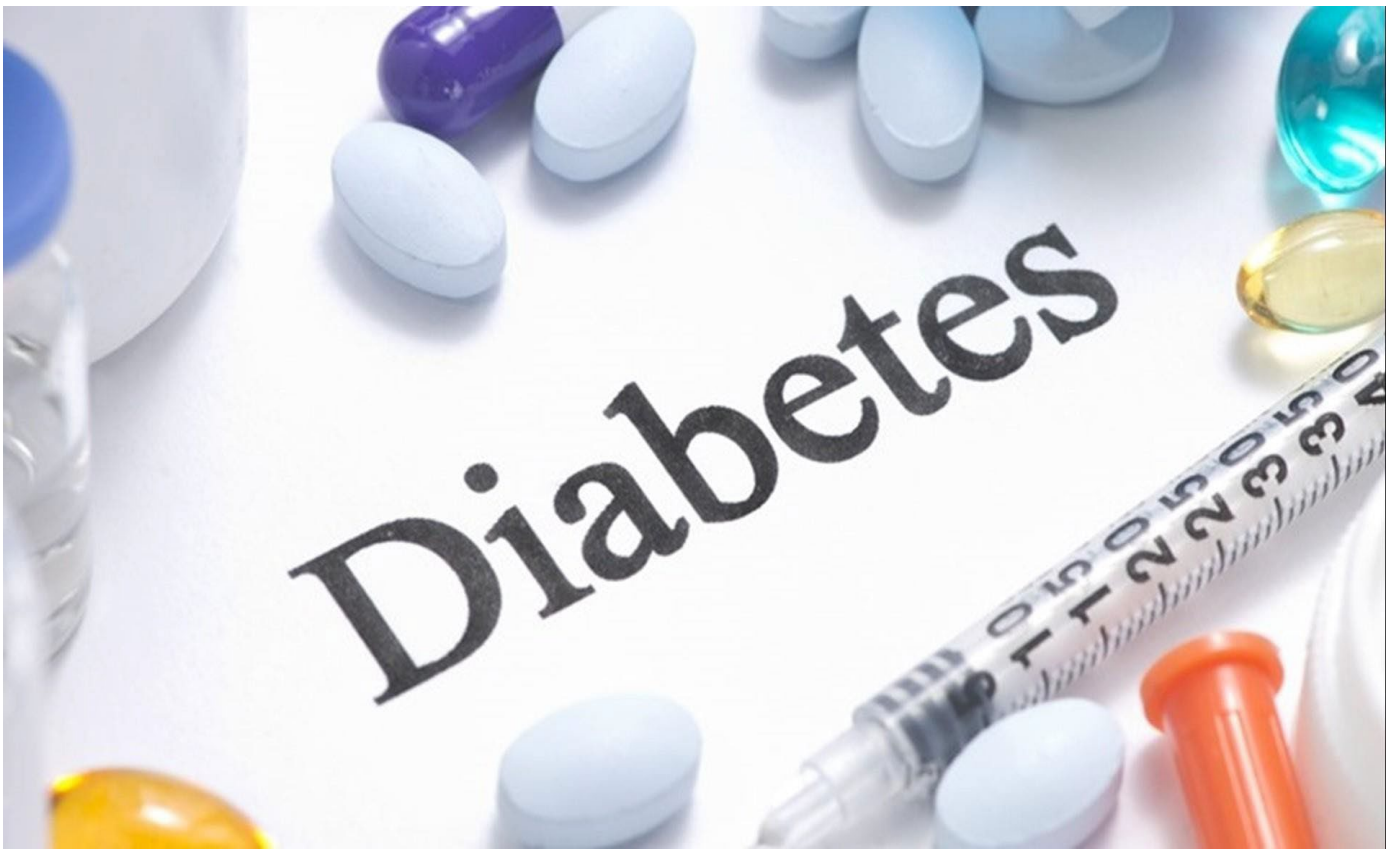
Helpful Tip: Member reported screenings are acceptable if documented in chart with date (can be month/year, in physician progress note).

*Codes are subject to change
★ = CMS Stars Measure

DIABETES CARE

Contents

- **(GSD) Glycemic Status Assessment for Patients with Diabetes**
- **(BPD) Blood Pressure Control for Patients with Diabetes**
- **(EED) Eye Exam for Patients with Diabetes**
- **(KED) Kidney Disease Evaluation**
- **(SPD) Statin Therapy for Patients with Diabetes**



*Codes are subject to change

★ = CMS Stars Measure

★GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES (GSD)

Definition: The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status was at the following levels during the measurement year:

- HbA1c or glucose management indicator (<8.0%)
- HbA1c or glucose management indicator poor control (>9.0%)

Clinical documentation – The member is compliant if the **most recent*** HbA1c test during measurement year 2026 is <8%.

*__PLEASE NOTE__: The NCQA definition of "most recent" is the HbA1c test closest to December 31, 2026.

DESCRIPTION	CODES
HbA1c Test	CPT: 83036-83037 CPT Category II: 3044F, 3046F
HbA1c Level <7.0%	CPT Category II: 3044F
HbA1c Level >7.0% and <8.0%	CPT Category II: 3051F
HbA1c Level >8.0% and <9.0%	CPT Category II: 3052F
HbA1c Level >9.0%	CPT Category II: 3046F

Helpful Tip: HbA1c test with results can be used as supplemental data, which may reduce the need for medical record review.

BLOOD PRESSURE CONTROL FOR PATIENTS WITH DIABETES (BPD-E)

Definition: The percentage of members ages 18-75 with diabetes (Types 1 and 2) whose blood pressure was adequately controlled (BP <140/90 mm Hg) during the measurement year (2026).

Clinical Documentation – The **most recent*** BP reading taken in an outpatient setting during 2026. Adequate control is both systolic BP <140 mm Hg and diastolic <90 mm Hg.

*__PLEASE NOTE__: The NCQA definition of "most recent" is the blood pressure reading closest to December 31, 2026.

DESCRIPTION	CODES
Most recent systolic blood pressure less than 130 mm Hg	CPT Category II: 3074F
Most recent Systolic blood pressure 130-139 mm Hg	CPT Category II: 3075F
Most recent systolic blood pressure greater than or equal to 140 mm Hg	CPT Category II: 3077F
Most recent diastolic blood pressure less than 80 mm Hg	CPT Category II: 3078F
Most recent diastolic blood pressure 80-89 mm Hg	CPT Category II: 3079F
Most recent diastolic blood pressure greater than or equal to 90 mm Hg	CPT Category II: 3080F
Remote BP Monitoring	CPT: 99784, 93788, 93790, 99091

Helpful Tip: If the member's BP is elevated, you can take multiple readings during the same visit. Allow the member to rest and retake the BP.

*Codes are subject to change
★ = CMS Stars Measure

★ EYE EXAM FOR PATIENTS WITH DIABETES (EED)

Definition: The percentage of members ages 18-75 with diabetes (Types 1 and 2) who had any one of the following:

- A retinal or dilated eye exam by an optometrist or ophthalmologist during the measurement year 2026.
- Negative retinal or dilated eye exam by an optometrist or ophthalmologist during the year prior to measurement year 2026 (negative exam in 2025).
- Bilateral eye enucleations any time during the member's history through December 31 of the current year (2026) for exclusion.

DESCRIPTION	CODES
Diabetic Retinal Screening *with* Evidence of Retinopathy	CPT Category II: 2022F, 2024F, 2026F
Diabetic Retinal Screening *without* Evidence of Retinopathy	CPT Category II: 2023F, 2025F, 2033F
Diabetic Eye Exam without Evidence of Retinopathy in Prior Year	CPT Category II: 3072F
Unilateral Eye Enucleation – Left	ICD-10: 08T1XZZ
Unilateral Eye Enucleation – Right	ICD-10: 08T0XZZ

Helpful Tip: Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

★KIDNEY DISEASE EVALUATION (KED)

Definition: The percentage members 18-85 years of age with Diabetes (Types 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR) during measurement year 2026.

Members are required to complete **both** of the following during measurement year 2026 on the same or different dates of service:

1. At least one estimated Glomerular Filtration Rate (eGFR) lab test.
2. At least one uACR identified by both a quantitative urine albumin test and a urine creatinine test with service dates four (4) or less days apart.

DESCRIPTION	CODES
Estimated Glomerular Filtration Rate Test	CPT: 80047, 80048, 80050, 80053, 80069, 82565
Quantitative Urine Albumin Test	CPT: 82043
Urine Creatinine Test	CPT: 82570

Helpful Tip: Members who have evidence of ESRD or dialysis at any time during the member's history are excluded from this measure.

*Codes are subject to change
★ = CMS Stars Measure

STATIN THERAPY FOR PATIENTS WITH DIABETES (SPD-E)

Definition: The percentage of members 40-75 years of age with diabetes, who do not have clinical atherosclerotic cardiovascular Disease (ASCVD) who met the following criteria:

1. Received statin therapy-percentage of members who were dispensed at least one statin medication of any intensity during measurement year 2026.
2. Statin Adherence-percentage of members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Note: the treatment period begins with the prescription start date through the last day of measurement year 2026.

DESCRIPTION	PRESCRIPTIONS	
High-Intensity Statin Therapy	• Atorvastatin 40-80 mg • Amlodipine-Atorvastatin 40-80 mg • Ezetimibe-Simvastatin 80 mg	• Rosuvastatin 20-40 mg • Simvastatin 80 mg
Moderate-Intensity Statin Therapy	• Atorvastatin 10-20 mg • Amlodipine-Atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Ezetimibe-Simvastatin 20-40 mg	• Pravastatin 40-80 • Lovastatin 40 mg • Fluvastatin 40-80 mg • Pitavastatin 2-4 mg
Low-Intensity Statin Therapy	• Simvastatin 5-10 mg • Ezetimibe-Simvastatin 10mg • Pravastatin 10-20 mg	• Lovastatin 10-20 mg • Fluvastatin 20-40 mg

*Diagnosis of myalgia, myositis, myopathy or rhabdomyolosis during the measurement year is a required exclusion. These exclusionary diagnoses must be documented each year. A diagnosis from a prior year will not carry over to the current year. These exclusionary diagnoses can come from claims or medical record data. Medical record documentation must contain two patient identifiers.

EXCLUSION DESCRIPTION	ICD-10-CM CODES
Myalgia	M79.10–M79.12, M79.18
Myositis	M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M60.9
Myopathy	G72.0, G72.2, G72.9
Rhabdomyolysis	M62.82

*Codes are subject to change
★ = CMS Stars Measure

CARDIOVASCULAR CONDITIONS

Contents

*Codes are subject to change

★ = CMS Stars Measure

BLOOD PRESSURE CONTROL FOR PATIENTS WITH HYPERTENSION (BPC-E)

Definition: The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose most recent BP <140/90 mm Hg during the measurement year.

Clinical Documentation – The **most recent*** BP reading taken in an outpatient setting during 2024. Adequate control is both systolic BP <140 mm Hg and diastolic <90 mm Hg.

This is a second year Electronic Clinical Data Systems (ECDS) measure, and does not replace Controlling High Blood Pressure (CBP). Clinical documentation is the same as CBP.

★ CONTROLLING HIGH BLOOD PRESSURE (CBP)

Definition: The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Clinical Documentation – The **most recent*** BP reading taken in an outpatient setting during 2026. Adequate control is both systolic BP <140 mm Hg and diastolic <90 mm Hg.

***PLEASE NOTE**: The NCQA definition of "most recent" is the blood pressure reading closest to December 31, 2026.

DESCRIPTION	CODES
Most recent systolic blood pressure less than 130 mm Hg	CPT Category II: 3074F
Most recent Systolic blood pressure 130-139 mm Hg	CPT Category II: 3075F
Most recent systolic blood pressure greater than or equal to 140 mm Hg	CPT Category II: 3077F
Most recent diastolic blood pressure less than 80 mm Hg	CPT Category II: 3078F
Most recent diastolic blood pressure 80-89 mm Hg	CPT Category II: 3079F
Most recent diastolic blood pressure greater than or equal to 90 mm Hg	CPT Category II: 3080F
Remote BP Monitoring	CPT: 99784, 93788, 93790, 99091

Helpful Tip: If BP result is >140/90, recheck the BP at the end of the visit and document. Member reported BP readings and BP readings collected via telehealth are acceptable if documented in the medical record with date and value.

*Codes are subject to change
★ = CMS Stars Measure

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC-E)★

Definition: The percentage of members (both male and female) 21-75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD).

The following criteria must be met for this measure:

1. Members dispensed at least one high-intensity or moderate intensity statin medication during measurement year 2026.
2. Members on statin medication of any intensity for at least 80% of the treatment period. ***Note***: the treatment period begins with the prescription start date through the last day of measurement year 2026.

DESCRIPTION	PRESCRIPTIONS	
High-Intensity Statin Therapy	• Atorvastatin 40-80 mg • Amlodipine-Atorvastatin 40-80 mg • Rosuvastatin 20-40 mg	• Simvastatin 80 mg • Ezetimibe-Simvastatin 80 mg
Moderate-Intensity Statin Therapy	• Atorvastatin 10-20 mg • Amlodipine-Atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Ezetimibe-Simvastatin 20-40 mg	• Fluvastatin 40-80 mg • Pitavastatin 2-4 mg • Lovastatin 40 mg • Pravastatin 40-80 mg

*Diagnosis of myalgia, myositis, myopathy or rhabdomyolosis during the measurement year is a required exclusion. These exclusionary diagnoses must be documented each year. A diagnosis from a prior year will not carry over to the current year. These exclusionary diagnoses can come from claims or medical record data. Medical record documentation must contain two patient identifiers.

EXCLUSION DESCRIPTION	ICD-10-CM CODES
Myalgia	M79.10–M79.12, M79.18
Myositis	M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M60.9
Myopathy	G72.0, G72.2, G72.9
Rhabdomyolysis	M62.82

*Codes are subject to change
★ = CMS Stars Measure

CARE COORDINATION

Contents

- **(ACP) Advance Care Planning**
- **(TRC) Transitions of Care**

*Codes are subject to change
★ = CMS Stars Measure

ADVANCE CARE PLANNING (ACP)

Definition: The percentage of adults 66-80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during the measurement year (2026).

Advance Care Planning is a discussion or documentation about the preferences for resuscitation, life-sustaining treatment, and end of life care.

Description	Codes
Advanced Care Planning	CPT: 99483, 99497 CPT Category II: 1123F, 1124F, 1157F, 1158F ICD-10: Z66

Helpful Tip: Documentation of a provider asking a member if an advance care plan is in place and the member replying "no" is not acceptable.

★ TRANSITIONS OF CARE (TRC)

Definition: The percentage of discharges for members 18 and older who had each of the following. Four rates are reported:

- Notification of Inpatient Admission
- Receipt of Discharge Information
- Patient Engagement after Inpatient Discharge
- Medication Reconciliation Post-Discharge

★ TRANSITIONS OF CARE – NOTIFICATION OF INPATIENT ADMISSION (TRC)

Documentation of receipt of notification of Inpatient Admission on the date of admission through 2 days after admission (3 days total).

Clinical documentation in the outpatient medical record must include evidence of notification of inpatient admission that includes evidence of the date when the documentation was received. Acceptable documentation includes:

- Communication between the member's PCP or ongoing care provider and inpatient providers/staff or emergency department (e.g., phone call, email, fax).
- Communication about admission to the member's PCP or ongoing care provider through a health information exchange or an automated admission or discharge and transfer (ADT) alert system.
- Communication about the admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system.
- Communication about admission to the member's PCP or ongoing care provider from the member's health plan.
- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission.

*Codes are subject to change
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★ TRANSITIONS OF CARE – RECEIPT OF DISCHARGE INFORMATION (TRC)

Documentation of receipt of Discharge Information on the day of discharge through 2 days after the discharge (3 days total).

Clinical documentation in the outpatient medical record must include evidence of receipt of discharge information. Acceptable documentation includes:

- The practitioner responsible for the member's care during the inpatient stay
- Procedures or treatment provided.
- Diagnoses at discharge
- Current medication list
- Testing results, or documentation of pending tests or no tests pending.
- Instructions for patient care post-discharge

Helpful Tip: Implement a process to receive auto alerts when a member is admitted or discharged from an inpatient facility.

★ TRANSITIONS OF CARE – PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE (TRC)

Documentation of patient engagement (e.g., office visit, visit to home, telehealth) provided within 30 days after discharge.

Clinical documentation in the outpatient record must include evidence of member engagement. Acceptable documentation includes:

- An outpatient visit, including office visits and home visits.
- A telephone visit.
- A telehealth visit (synchronous visit where real-time interaction occurred between the member and provider using audio and video communication).
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider).

DESCRIPTION	CODES
Patient Engagement	CPT: 99201-05, 99211-15, 99241-45, 99341-45, 99347-50, 99381-87, 99391-97, 99401-04, 99411-12, 99429, 99455-56, 99483

*Codes are subject to change

★ = CMS Stars Measure

★ TRANSITIONS OF CARE – MEDICATION RECONCILIATION POST-DISCHARGE (TRC)

Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Clinical documentation in the outpatient record must include evidence of medication reconciliation and the date when it was performed. Acceptable documentation includes:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
- Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up.

DESCRIPTION	CODES
Medication Reconciliation	CPT Category II: 1111F

Helpful Tip: Medication reconciliation post-discharge can be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse.

*Codes are subject to change
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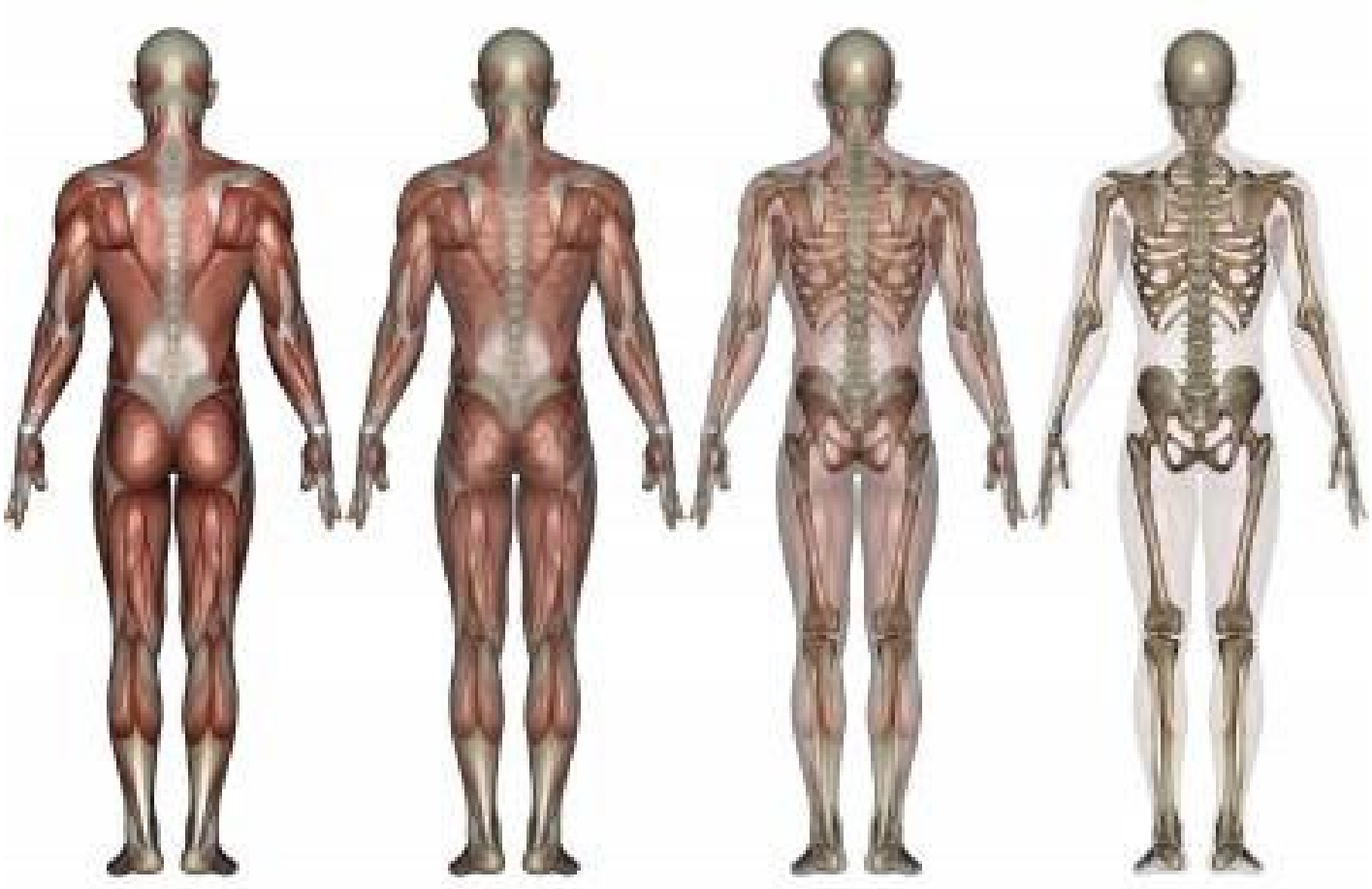
MUSCULOSKELETAL CONDITIONS

Contents

- **(OMW) Osteoporosis Management in Women who had a Fracture**
- **(OSW) Osteoporosis Screening in Older Women**



*Codes are subject to change
★ = CMS Stars Measure

★ OSTEOPOROSIS MANAGEMENT IN WOMAN WHO HAD A FRACTURE (OMW)

Definition: The percentage of women ages 67-85 who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis within six months of the fracture.

DESCRIPTION	CODES
Bone Mineral Density Test	CPT: 76977, 77078, 77080-77082, 77085, 77086
Osteoporosis Medication Therapy	HCPCS: J0897, J1740, J3110, J3111, J3489

Osteoporosis Medications:

DESCRIPTION	PRESCRIPTIONS	
Bisphosphonates:	• Alendronate • Ibandronate • Zoledronic Acid	• Alendronate-Cholecalciferol • Risedronate
Other Agents	• Abaloparatide • Raloxifene • Teriparatide	• Denosumab • Romosozumab

OSTEOPOROSIS SCREENING IN OLDER WOMEN (OSW)

Definition: The percentage of women 65-75 years of age who received osteoporosis screening.

Clinical documentation includes evidence of one or more osteoporosis screening tests on or between the member's 65th birthday and December 31 of measurement year 2026.

DESCRIPTION	CODES
Osteoporosis Screening Tests	CPT: 76977, 77078, 77080, 77081, 77085

*Codes are subject to change
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Medication Management

Contents

- **Medication Adherence Diabetes**
- **Medication Adherence Hypertension**
- **Medication Adherence Statins**
- **Deprescribing of Benzodiazepines (DBO)**

*Codes are subject to change
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MEDICATION ADHERENCE DIABETES (PDC-DIA) ★

Definition: Percentage of members ages 18 and older with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication during the measurement year (2026)

Clinical Documentation – N/A
Pharmacy claims are used to collect the percentages of days covered.

Diabetes Medication Classes included in this measure are:

- Biguanides
- DPP-4 inhibitors
- Incretin mimetics
- Meglitinides
- SGLT2 inhibitors
- Sulfonylureas
- Thiazolidinediones

Helpful Tip: Encourage medication adherence by providing 100-day prescriptions, and encourage home delivery.

MEDICATION ADHERENCE FOR HYPERTENSION (PDC-RAS) ★

Definition: Percentage of members ages 18 and older with a prescription for a blood pressure medication who adhere to their hypertension (RAS antagonists) medication at least 80 percent of the time in the measurement period (2026)

Clinical Documentation – N/A
Pharmacy claims are used to collect the percentages of days covered.

RAS Antagonist included in this measure are:

- Angiotensin II receptor blockers (ARBs)
- Angiotensin-converting enzyme (ACE) inhibitors
- Direct renin inhibitors

Helpful Tip: Encourage medication adherence by providing 100-day prescriptions, and encourage home delivery.

*Codes are subject to change
★ = CMS Stars Measure

MEDICATION ADHERENCE STATINS (PDC-STA) ★

Definition: Percentage of members ages 18 and older who adhere to their statin medication at least 80 percent of the time in the measurement period (2026)

Clinical Documentation – N/A
Pharmacy claims are used to collect the percentages of days covered.

Helpful Tip: Address any barriers the member may have with refilling their medication as well as side effects that may discourage the patient from continuing treatment.

DEPRESCRIBING BENZODIAZEPINES (DBO)

Definition: The percentage of members 67 years of age and older who were dispensed benzodiazepines and achieved a 20% decrease or greater in benzodiazepine dose (diazepam milligram equivalent [DME] dose) during the measurement year (2025).

Members with a diagnosis of seizure disorder, REM Sleep Behavior disorder, benzodiazepine withdrawal, or ethanol withdrawal on or before January 1 of the year prior to the measurement year and the ITE start date are excluded.

Clinical Documentation – N/A
Pharmacy claims are used to collect the percentage of members/covered days

Benzodiazepines included in this measure are:

- alprazolam (Xanax)
- chlordiazepoxide (Librax)
- clobazam (Onfi)
- clonazepam (Klonopin)
- clorazepate (Tranxene T-Tab)
- diazepam (Valium)
- estalozam (ProSom)
- flurazepam (Dalmane)
- lorazepam (Ativan)
- midazolam (Versed)
- oxazepam (Serax)
- temazepam (Restoril)
- triazolam (Halcion)

*Codes are subject to change
★ = CMS Stars Measure

Behavioral Health

Contents

*Codes are subject to change

★ = CMS Stars Measure

ADHERENCE TO ANTI-PSYCHOTIC MEDICATIONS FOR INDIVIDUALS WITH SCHIZOPHRENIA (SAA)

Definition: Percentage of members ages 18 and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period during measurement year 2026.

Members with a diagnosis of dementia or who did not have at least two antipsychotic medication dispensing events are excluded.

Clinical Documentation – N/A
Pharmacy claims are used to collect the percentages of days covered.

Antipsychotic medication classes included in this measure are:

- Phenothiazine antipsychotics (oral)
- Psychotherapeutic combinations (oral)
- Thioxanthenes (oral)
- Long-Acting Injections
- Miscellaneous antipsychotic agents (oral)

Helpful Tip: ICD-10 Codes to identify schizophrenia: F20.0-20.3, F20.5, F20.89, F.20.9, F25.0, F25.1, F25.8, F25.9

*Codes are subject to change
★ = CMS Stars Measure

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE (FUA)

Definition: The percentage of ED visits for members ages 13 and older with a principal diagnosis of substance use disorder (SUD) or any drug overdose diagnosis and who had a follow-upvisit.

Two rates are reported:

1. The percentage of ED visits for which the member received follow-up for SUD within the 7 days after the visit (8 days total)
2. The percentage of visits or discharges for which the member received follow-up for SUD within the 30 days after the visit (31 days total)

For both indicators, any of the following meet the criteria for a follow-up visit:

- An outpatient visit with a mental health provider or with diagnosis of substance use disorder or drug overdose.
- A behavioral health visit with a mental health provider or with a diagnosis of substance use disorder or drug overdose.
- An intensive outpatient visit or partial hospitalization with a mental health provider or with a diagnosis of substance use disorder or drug overdose.
- Opioid treatment service with a diagnosis of substance use disorder or drug overdose.
- A telehealth visit with a diagnosis of substance use disorder or drug overdose.
- A community mental health center visit with a diagnosis of substance use disorder or drug overdose.
- Non-residential substance abuse treatment center visit with a diagnosis of substance use disorder or drug overdose.
- An observation visit with a mental health provider or with a diagnosis of substance use disorder or drug overdose.
- Substance use disorder service.
- Behavioral health screening or assessment for substance use disorder or mental health disorders.
- A telephone visit with a mental health provider or with a substance use disorder or drug overdose.
- E-visit/virtual check-in) with a mental health provider or with a diagnosis of substance use disorder or drug overdose.
- A pharmacotherapy dispensing event or medication treatment event for substance use disorder.
- A medication dispensing event for alcohol or opioid use or dependence.

Helpful Tip: This measure focuses on follow-up treatment with a primary care provider or substance abuse specialist.

*Codes are subject to change

★ = CMS Stars Measure

FOLLOW-UP AFTER EMERGENCY ROOM VISIT FOR MENTAL ILLNESS (FUM)

Description: The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness with any provider.

Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

Clinical Documentation:

1. A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31total days). Include visits that occur on the date of the ED visit.
2. A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit.

- Acute or non-acute inpatient admission or residential behavioral health stay with a principal diagnosis of substance use disorder.
- An outpatient visit with a principal diagnosis of a mental health disorder.
- An intensive outpatient encounter or partial hospitalization with a principal diagnosis of a mental health disorder.
- A community mental health center visit with a principal diagnosis of a mental health disorder.
- Electroconvulsive therapy with a principal diagnosis of a mental health disorder.
- A telehealth visit with a principal diagnosis of a mental health disorder.
- An observation visit with a principal diagnosis of a mental health disorder.
- A telephone visit with a principal diagnosis of a mental health disorder.
- An e-visit or virtual check-in.

*Codes are subject to change

★ = CMS Stars Measure

FOLLOW-UP AFTER HIGH INTENSITY CARE FOR SUBSTANCE USE DISORDER (FUI)

Definition: The percentage of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of substance use disorder among members ages 13 and older that result in a follow-up visit or service for substance use disorder.

Two rates are reported:

1. The percentage visits or discharges for which the member received follow-up for substances use disorder within the 7 days after the visit or discharge.
2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.

Clinical Documentation:

1. A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.
2. A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet the criteria for a follow-up visit:

- Acute or non-acute inpatient admission or residential behavioral health stay with a principal diagnosis of substance use disorder.
- An outpatient visit with a principal diagnosis of substance use disorder.
- A behavioral health visit with a principal diagnosis of substance use disorder.
- An intensive outpatient visit or partial hospitalization.
- Opioid treatment service.
- Transitional care management services.
- A telehealth visit.
- A community mental health center visit.
- Non-residential substance abuse treatment center visit.
- An observation visit with a principal diagnosis of substance use disorder.
- Substance use disorder service with a principal diagnosis of substance use disorder.
- Residential behavioral health treatment with a principal diagnosis of substance use disorder.
- A telephone visit with a principal diagnosis of substance use disorder.
- Online assessment (e-visit/virtual check-in) with a principal diagnosis of substance use disorder.
- A pharmacotherapy dispensing event or medication treatment event for alcohol or other drug abuse or dependence.

Helpful Tip: This measure focuses on follow-up treatment with any provider type.

*Codes are subject to change

★ = CMS Stars Measure

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

Definition: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.

Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Clinical Documentation:

1. A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.
2. A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

*services rendered on the date of discharge do not count towards FUh

For both indicators, any of the following meet the criteria for a follow-up visit:

- An outpatient visit with a mental health provider.
- An intensive outpatient encounter or partial hospitalization.
- A community mental health center visit.
- Electroconvulsive therapy.
- A telehealth visit with a mental health provider
- An observation visit with a mental health provider
- Transitional care management services with a mental health provider.
- A visit in a behavioral healthcare setting.
- A telephone visit with a mental health provider.
- Psychiatric collaborative care management.

PHARMACOTHERAPY FOR OPIOID USE DISORDER (POD)

Definition: The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members 16 years of age and older with a diagnosis of OUD

Clinical Documentation – N/A
Pharmacy claims are used to collect the percentages of days covered.

*Codes are subject to change
★ = CMS Stars Measure

UTILIZATION

Contents

- **Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes (EDH)**
- **Follow-Up After Emergency Department Visit for People With Multiple High-Risk Conditions (FMC)**
- **Plan All –Cause Readmissions (PCR)**

*Codes are subject to change
★ = CMS Stars Measure

EMERGENCY DEPARTMENT VISITS FOR HYPOGLYCEMIA IN OLDER ADULTS WITH DIABETES (EDH)

Definition: Members ages 67 years of age and older with diabetes (types 1 and 2) who had an ED visit for hypoglycemia during the measurement year (2026).

Two rates are reported:

1. Members with diabetes (types 1 and 2) who had an ED visit for hypoglycemia during the measurement year.
2. Members with diabetes (types 1 and 2) who had at least one dispensing event of insulin within each 6-month treatment period from July 1 of the year prior to the measurement year through December 31 of the measurement year.

Clinical Documentation – N/A
Hospital ED claims are used to collect the percentage of members.

★ FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR PEOPLE WITH MULTIPLE HIGH-RISK CHRONIC CONDITIONS (FMC)

Definition: Percentage of emergency department (ED) visits for members ages 18 and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

Any of the following meet the criteria for a follow-up visit:

- Outpatient visits
- A telephone encounter
- Telehealth visit with any provider type
- Transitional Care Management
- Care Management visits
- Complex Care Management
- Outpatient or T\telehealth Behavioral Health visit
- Intensive outpatient encounter or partial hospitalization (psychiatric facility)
- Community mental health center visit
- Electroconvulsive therapy with any provider type
- Substance use disorder services
- E-visit or virtual check-in
- Domiciliary or rest home visit

Helpful Tip: Provide members with alternatives to ED locations including urgent care centers, telehealth or in-person office visits.

*Codes are subject to change
★ = CMS Stars Measure

★ PLAN ALL-CAUSE READMISSIONS (PCR)

Definition: For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Acute hospitalizations where the discharge claim has a diagnosis for chemotherapy maintenance, principle diagnosis of rehabilitation, organ transplant or potentially planned procedure without a principle acute diagnosis are excluded.

A lower rate indicates a better score for this measure.

Clinical Documentation – N/A
Hospital claims are used to collect the percentage of members.

Helpful Tip: Help members avoid readmissions by following up with them within 7 days of discharge. Initialize an outreach process to ensure timely follow-up with recently discharged members.

*Codes are subject to change
★ = CMS Stars Measure