



PERFORMANCE MEASURES GUIDE

A guide to quality and utilization metrics to improve performance in value-based care.

[Featuring 2025 Performance Dashboard Details]

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Purpose of this Guide

This guide is designed to improve clarity and competency in understanding key quality and utilization measures in the 2025 contracts. By detailing each measure including inclusions, exclusions, and documentation requirements, it equips member CHC teams with the knowledge needed to accurately report, track, and improve performance outcomes as part of the network.

Why This Matters

During recent Q4 initiatives, staff identified an educational opportunity for our network. Many healthcare professionals lacked a clear understanding of individual measures, proper documentation for compliance, and the broader impact of performance scores on healthcare quality and financial incentives. This guide bridges that gap, empowering member CHCs with:

- **Improved Quality Measure Literacy:** Clear definitions of measures, including thresholds, patient populations, and required documentation.
- **Enhanced Performance Competency:** A deeper understanding of how performance metrics drive shared savings, reimbursement, and patient care outcomes.
- **Actionable Insights:** Practical strategies for closing care gaps through improved documentation practices and proactive interventions.

How to Use This Guide

The following pages provide a structured overview of each 2025 Performance Dashboard measure for Medicare and commercial value-based care shared savings contracts, in addition to the Medicare Advantage Star Rating program performance measures. This guide serves as a standardized reference to help CHC teams align clinical workflows, optimize reporting accuracy, and drive strategic improvements in care delivery.

2025 Performance Dashboard & Measure Descriptions

View the official [2025 Performance Dashboard](#).

Medicare Shared Savings Contracts (MSSP, Aetna MA, Humana MA)			
Performance Area	Distribution %	Measure	Measure Description
Utilization – 50%	30% 15% 0%	<u>Contribution to Shared Savings</u> Tier 3: <95% expected spend Tier 2: 95-105% expected spend Tier 1: >105% expected spend	Compares actual medical costs for the performance year to the expected spend (Medical Cost Target), which is based on risk adjustment/HCC and/or historical expenditures. The goal is to keep actual spend under 95% of the expected spend to contribute to shared savings.
	10% 7.5% 5%	<u>ED Utilization/1000</u> Tier 3: <500/1000 Tier 2: 501-600/1000 Tier 1: 601-700/1000	The emergency department (ED) utilization measure calculates the number of ED visits in a state per 1,000 participant months for Medicare participants aged 18 years or older with at least 10 months of enrollment. Excludes ED visits that resulted in an inpatient or observation stay. For example: Score of 3200 = avg. of 3.2 visits per patient per month NCQA Description
	10% 7.5% 5%	<u>HCC Re-capture Rate</u> Tier 3: ≥85% Tier 2: 75-84% Tier 1: 70-74%	Hierarchical Condition Categories (HCC) recapture rates measure how effectively healthcare providers redocument chronic conditions in subsequent years for accurate risk adjustment and reimbursement under CMS guidelines. CMS requires annual documentation of certain chronic conditions, failing to recapture diagnoses can lead to lower risk scores and reduced funding for patient care. CHPA HCC and Risk Adjustment 101 Quick Guide
Quality – 50%	20% 15% 10%	<u>AWV Completion Rate</u> Tier 3: ≥35% Tier 2: 25-34% Tier 1: 20-24%	The percentage of attributed patients who have a completed and reimbursed Annual Wellness Visit (AWV) within the measurement year.
	15% 10% 7.5%	<u>Diabetes A1c>9</u> Tier 3: ≤20% Tier 2: 21-24% Tier 1: 25-28%	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c]) or glucose management indicator (GMI) was greater than or equal to nine during the measurement year. CMS Tech Specs
	10% 7.5% 5%	<u>Controlling High Blood Pressure</u> Tier 3: ≥85% Tier 2: 80-84% Tier 1: 75-79%	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year. CMS Tech Specs
	5%	Medication Adherence Support Plan	Completion of the ‘Medication Adherence Support Plan Attestation Form’ which includes a written plan to improve medication adherence among patients within your organization.

Green = Network Tier Target

Commercial Shared Savings Contracts (Anthem Commercial)			
Performance Area	Distribution %	Measure	Measure Description
Utilization – 50%	30% 15% 0%	<u>Contribution to Shared Savings</u> Tier 3: <95% expected spend Tier 2: 95-105% expected spend Tier 1: >105% expected spend	<i>Compares actual medical costs for the performance year to the expected spend (Medical Cost Target), which is based on risk adjustment/HCC and/or historical expenditures. The goal is to keep actual spend under 95% of the expected spend to contribute to shared savings.</i>
	15% 10% 7.5%	<u>ED utilization observed vs. expected</u> Tier 3: ≤107.89 Tier 2: 141-107 Tier 1: 176-140	<i>For patients 18 years of age and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year. Expressed as a rate per 1,000 members, adjusted for their risk. Sum of qualifying visits to an emergency department for patients in the denominator during the measurement period. These represent the observed ED visits.</i>
Quality – 50%	20% 15% 10%	<u>Child and Adolescent Wellness Visits</u> Tier 3: ≥85% Tier 2: 65-75% Tier 1: 45-65%	<i>This HEDIS measure looks at the percentage of patients 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.</i>
	20% 15% 10%	<u>Diabetes Glycemic Control HgbA1c<9</u> Tier 3: ≥60% Tier 2: 55-59% Tier 1: 50%-54%	<i>This measure looks at the percentage of patients 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c HbA1c or glucose management indicator GMI) was less than or equal to nine during the measurement year.</i>

Green = Network Tier Target

Additional information: [Anthem Commercial Tech Specs](#)

Measure Specifications & Documentation Guidelines

Preventive Screenings & Chronic Disease Management (Medicare Stars, Quality)

Controlling Blood Pressure (CBP)

Description	Documentation								
CMS Measure ID: CMS165v13 Numerator Patients 18-85 years of age by the end of the measurement period whose most recent blood pressure (BP) is adequately controlled (systolic BP <140 mmHg and diastolic BP <90 mmHg) during the measurement period. Denominator Patients 18-85 years of age by the end of the measurement period who had a visit during the measurement period and a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period. Exclusions · Hospice or palliative care · 81+ frailty only · 66–80 frailty and advanced illness · 66+ I-SNP or institutionalized · Dispensed Dementia Rx Optional: · Dialysis · End-stage renal disease (ESRD) (N18.5, N18.6, Z99.2) · Kidney transplant · History of kidney transplant (Z94.0, V42.0) · Nephrectomy · Non-acute inpatient admission · Pregnancy during measurement year	Visit documentation must state the hypertension diagnosis, the date the BP was completed, and the BP reading. · Documentation must be from the billing provider. · The BP reading must occur on or after the date of the second visit for hypertension. · Diagnosis and BP reading can come from different care providers, providing BP criteria is met in the managing provider's note. BP Readings that Count in the Measure · Outpatient visit · Telephone visit (N/A for UDS) · E-visit or virtual check-in · Remote monitoring event CPTII Codes <table border="0"> <tr> <td><i>One systolic:</i></td><td><i>And one diastolic:</i></td></tr> <tr> <td>3074F: Systolic <130 mm Hg</td><td>3078F: Diastolic <80 mm Hg</td></tr> <tr> <td>3075F: Systolic 130-139 mm Hg</td><td>3079F: Diastolic 80-89 mm Hg</td></tr> <tr> <td>3077F: Systolic >140 mm Hg</td><td>3080F: Diastolic >90 mm Hg</td></tr> </table> LOINC Codes Systolic: 8480-6 Diastolic: 8462-4 Mean: 8478-0 BP Panel: 35094-2 For Continuous Non-Invasive Monitoring: Systolic (Continuous): 75997-7 Diastolic (Continuous): 75995-1 Mean (Continuous): 75996-9	<i>One systolic:</i>	<i>And one diastolic:</i>	3074F: Systolic <130 mm Hg	3078F: Diastolic <80 mm Hg	3075F: Systolic 130-139 mm Hg	3079F: Diastolic 80-89 mm Hg	3077F: Systolic >140 mm Hg	3080F: Diastolic >90 mm Hg
<i>One systolic:</i>	<i>And one diastolic:</i>								
3074F: Systolic <130 mm Hg	3078F: Diastolic <80 mm Hg								
3075F: Systolic 130-139 mm Hg	3079F: Diastolic 80-89 mm Hg								
3077F: Systolic >140 mm Hg	3080F: Diastolic >90 mm Hg								
Close the Gap Tips & Recommendations									
· Utilize the lowest systolic and diastolic on date of service. The lowest values may come from two separate BP readings. For example, if two BP readings are 136/90 and 144/82, use 136/82 as the final reading. · Patient may self-report BP from an appropriate digital device during a telehealth visit. · Write extended-day prescriptions (90 or 100-day depending on benefit). · Recommend automatic refills to support adherence. · If a patient's BP is taken and is $\geq$ to 140/90, repeat measurement at the end of the visit.									

Depression Screening and Follow Up (DEP)

Description	Documentation
CMS Measure ID: CMS2v14 Numerator Patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter. Denominator All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period. Denominator Exceptions: · Patient refuses to participate in or complete the depression screening. · Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results, patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status). Exclusions · Patients who been diagnosed with bipolar disorder at any time prior to the qualifying encounter.	Screening Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms. Standardized Depression Screening Tool A normalized and validated depression screening tool developed for the patient population in which it is being utilized (<i>see CMS Tech Specs for full list of accepted SDSTs</i>). Follow-Up Plan Documented follow-up for a positive depression screening must include one or more of the following: · Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen. · Pharmacological interventions. · Other interventions or follow-up for the diagnosis or treatment of depression. Gap closure is based on claims data only, CPT codes are not available for this measure until 2026.
Close the Gap Tips & Recommendations	
· Clinicians should routinely screen all adults for depression using a standardized tool. · Clinicians should establish and maintain follow-up with patients. · Clinicians should screen and monitor depression in pregnant and post-partum women. · The United States Preventive Services Task Force (USPSTF) recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.	

Diabetes: Glycemic Status Assessment >9% (GSD)

Description	Documentation
CMS Measure ID: CMS122v13 Numerator Patients whose most recent HbA1c is >9.0%, is missing, or was not performed during the measurement period. Denominator Patients 18-75 years of age with diagnosis of diabetes (Type I or II). Exclusions · Hospice or palliative care · 66–80 frailty and advanced illness · 66+ I-SNP or institutionalized · Dispensed Dementia Rx · Long term Nursing home · No diagnosis of diabetes in any setting and steroid-induced diabetes	Qualifying Events · Point of Care Testing HbA1c · Quest/LabCorp venus blood draw · CGM Reading CPTII Codes Achieved by any of the following screening results: · 3044F: HbA1c level < 7.0% · 3046F: HbA1c level > 9.0% · 3051F: Most recent HG A1c > 7.0% and <8.0% · 3052F: Most recent HG A1c > 8.0% and < 9.0% Note: Report with date of test, not with date of office visit.
Close the Gap Tips & Recommendations	
· Follow a standardized therapeutic inertia protocol. · Implement Continuous Glucose Monitoring (CGM). · Order appropriate labs including metabolic profile, lipid profile, eGFR and Urine Microalbumin. · Write extended-day prescriptions (90- or 100-day depending on benefit). · Recommend automatic refills to support adherence. · Encourage the use of mail-order pharmacy or in-office pharmacy. · Report the appropriate CPT II code for the A1c result value with the date of test, not the date of the date of the office visit when the test was reviewed. · Use POC testing and report CPT II code for A1c result. · Schedule office visits in regular intervals based on patients' chronic disease management needs to obtain timely lab work and optimize medication adherence.	

Eye Exam for Patients with Diabetes (EED)

Description	Documentation
CMS Measure ID: CMS131v13 Numerator Patients in the denominator who had a retinal eye exam during the measurement year. This includes diabetics who had one of the following: · <u>diagnosis of retinopathy</u> and a retinal or dilated eye exam by an eye care professional in the measurement period. · <u>no diagnosis of retinopathy</u> and a retinal or dilated eye exam by an eye care professional in the measurement period OR the year prior to the measurement period. Denominator Patients 18-75 years of age with a diagnosis of diabetes (Type I or Type II). Exclusions · Patients who do not have a diagnosis of diabetes during the measurement year or the year prior. · Had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or the year prior. · Hospice or palliative care. · 66+ frailty and advanced illness. · Bilateral eye enucleation any time during the member's history. · Dispensed Dementia Rx. · 66+ I-SNP or institutionalized.	Qualifying Events · Patients fall into this measure either by claim/encounter data and/or by pharmacy data. · The retinal or dilated eye exam must be performed by an optometrist or ophthalmologist. * · Any provider, including PCP, can report the appropriate CPT II code for the eye exam results, it does not have to be reported by only the ophthalmologist or optometrist. *Retinal eye exam may be completed by a trained medical professional, but results <u>must be</u> interpreted by an optometrist or ophthalmologist. CPTII Codes · 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy. · 2023F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy. · 2024F: Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy. · 2025F: Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy. · 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy. · 2033F: Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed, without evidence of retinopathy. · 3072F: Low risk retinopathy (no evidence of retinopathy in the prior year).
Close the Gap Tips & Recommendations	
· Adults with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within five years after the onset of diabetes (Level of evidence: B). · Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist at the time of the diabetes diagnosis (Level of evidence: B). · If there is no evidence of retinopathy for one or more annual eye exams and glycemia is well controlled, then screening every 1–2 years may be considered. · If any level of diabetic retinopathy is present, subsequent dilated retinal examinations should be repeated at least annually by an ophthalmologist or optometrist. · If retinopathy is progressing or sight threatening, then examinations will be required more frequently (Level of evidence: B).	

Kidney Health Evaluation (KED) for Patients with Diabetes

Description	Documentation
CMS Measure ID: CMS951v3 Numerator Patients in the denominator who received a kidney health evaluation defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ration (uACR), during the measurement year. Denominator Patients 18-85 years of age with diabetes (Type I or Type II). Exclusions · Patients with a diagnosis of CKD Stage 5 active during the measurement period. · Patients who do not have a diagnosis of diabetes during the measurement year or the year prior. · Had a diagnosis end stage renal disease (ESRD) any time during the patients' medical history or prior to December 31st of the measurement. · Hospice or palliative care.	At least one uACR identified by: · Both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) and a urine creatinine (Urine Creatinine Lab Test Value Set) with service dates four days or less apart. · OR a uACR (Urine Albumin Creatinine Ratio Lab Test Value Set). CPT/LOINC Codes · 80047, 80048, 80050, 80053, 80069, 82565: EGFR · 82043: Quantitative urine albumin lab test · 82570: Urine creatinine lab test · 13705-9, 14958-3, 14959-1, 3000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 8998-9, 9318-7: uACR
Close the Gap Tips & Recommendations	
· Implement standing orders for KED/Diabetic Profile. · At least annually, urinary albumin (e.g., spot urinary albumin-to-creatinine ratio) and eGFR should be assessed in people with type 1 diabetes with duration of ≥5 years and in all people with type 2 diabetes regardless of treatment. · Utilize appropriate coding to reflect care provided. · Educate patients on how diabetes can affect the kidneys and recommend strategies to prevent kidney damage, like controlling blood pressure, blood sugar, cholesterol, and lipid levels. · Remind patients to take medication as prescribed (ACE inhibitors and ARBs). · Avoid nonsteroidal anti-inflammatory drugs (NSAIDs). · Coordinate diabetic care with specialists, including endocrinologists, nephrologists, cardiologists, and ophthalmologists as needed. · Provide diabetes education and support resources - limit protein intake and salt in diet. · Follow-up with patients to discuss and educate on lab results.	

Breast Cancer Screening (BCS)

Description	Documentation
CMS Measure ID: CMS125v13 Numerator Patients in the denominator who had one or more mammograms within the measurement year or 15 months prior to the measurement year. Measure Timeline Oct. 1 two years prior to the measurement year through Dec. 31 of the measurement year. Denominator Patients 52-74 years of age. Exclusions · Bilateral mastectomy, or documentation of unilateral mastectomies of left and right side on the same or different dates of service. · Hospice or palliative care. · 66+ frailty and advanced illness. · Dispensed Dementia Rx. · 66+ I-SNP or institutionalized.	Closing these gaps can only be done through a paid claim for an authorized test (Medicare), or through supplemental data uploads to the payer (UHC, Humana, and most MA plans).
Close the Gap Tips & Recommendations	
· This measure evaluates primary screening only - do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening.	

Colorectal Cancer Screening (COL/CCS)

Description	Documentation
CMS Measure ID: CMS130v13 Numerator Patients in the denominator who had an appropriate screening for colorectal cancer during the measurement year or years prior to the measurement year depending on the test type: · Colonoscopy - 10 years (January 1, 2015, to present) · Flexible Sigmoidoscopy - five years (October 1, 2021, to present) · Fecal Occult Blood Test [FOBT] - current measurement year (Jan 1, 2025- Dec 31, 2025) · FIT-DNA (Cologuard brand) - three years (October 1, 2023, to December 31st, 2025) · FIT (non-Cologuard) - current measurement year (Jan 1, 2025- Dec 31, 2025) · CT Colonography during the measurement period or the four years prior to the measurement period Denominator Patients 45-75 years of age. Exclusions · Total Colectomy documented within the medical record (partial colectomy does not count) · Colorectal Cancer · Hospice or palliative care · 66+ frailty and advanced illness · Dispensed Dementia Rx · 66+ I-SNP or institutionalized	Closing these gaps can only be done through a paid claim for an authorized test (Medicare), or through supplemental data uploads to the payer (UHC, Humana, and most MA plans).
Close the Gap Tips & Recommendations	
· For supplemental data uploads, the consultation is not required for gap closure. · Can document the MM/DD/YYYY of the screening, what type of screening was performed, and the findings in a signed encounter note to report compliance in this measure.	

Osteoporosis Management in Women who had a Fracture (OMW)

Description	Documentation
CMS Measure ID: CMS 418 Anthem Osteoporosis Management in Women who had a Fracture OMW The percentage of women in the denominator who either had a bone mineral density (BMD) test or received a prescription for a drug to treat osteoporosis in the six months after the fracture. Denominator Women aged 50-85 years who suffered a fracture, except fractures of the finger, toe, face, or skull in the six months prior to the measurement period through June 30 of the measurement period. Exclusions · Hospice or palliative care · Ages 81 and older with frailty* only · Ages 67–80 with frailty* and advanced illness · Ages 67 and older with I-SNP or who are institutionalized · Patients who had a BMD test 24 months prior to fracture · Patient had a bone mineral density test in the past two years OR received osteoporosis medication or therapy in the past 12 months · Patients aged 65 and older in Institutional Special Needs Plans (SNP) or residing in long term care with POS code 32, 33, 34, 54 or 56 anytime during the measurement period	This measure can only be closed through a claim for a BMD scan or a claim for dispensed medications. · 76977: Ultrasound bone density measurement · 77078: CT, bone mineral density study, one or more sites; axial skeleton · 77080: Dual-energy X-ray absorptiometry (DXA, bone density study, one or more sites, axial skeleton · 77081: DXA, bone density study, one or more sites; appendicular skeleton · 77085: DXA, bone density study, one or more sites: axial skeleton, including vertebral fracture assessment CPT Codes · CPT II 3095F: Central dual energy X-ray absorptiometry, spinal densitometry X-ray, ultrasonography for densitometry, CT bone density axial and Peripheral Dual-energy X-ray Absorptiometry (DXA). · G8633: bisphosphonates (alendronate, alendronate-cholecalciferol, ibandronate, risedronate, zoledronic acid, calcitonin, teriparatide, denosumab, and raloxifene).
Close the Gap Tips & Recommendations	
· Standing BMD scan orders. · Initiate appropriate referrals and orders for bone mineral density testing. · Screen patient for risk of falls and help ensure they have resources or equipment.	

Care of Older Adults (Medicare Stars-Specific)

Care of Older Adults - Functional Status Assessment (COA FSA)

Description	Documentation
Numerator Patients in the denominator who have evidence of at least one functional status assessment completed in the measurement year. Denominator Patients 66 years of age and older on a Medicare Advantage Special Needs Plan (SNP). Exclusions · Deceased in measurement year · Hospice or palliative care	Documentation must include at least one of the following: · Progress notes, IHSS forms, HRA forms, AWE form. · Notation that Activities of Daily Living (ADL) were assessed or that at least five were assessed. · Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the activities were assessed. · Result of assessment using a standardized functional status assessment tool. · Notation of cognitive status, ambulation status, sensory ability (hearing, vision, and speech) and, other functional independence (e.g., exercise). · FSA that is done via telehealth, or virtual check-in meets numerator compliance. Can use a standardized FSA tool and results. Can be closed through claims or through supplemental data upload (MA plans): · 1170F Functional status assessed. · 99483 Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient setting, home or domiciliary or rest home, with a list of specific required elements.
Close the Gap Tips & Recommendations	
· Conduct FSA during annual wellness visits, chronic care management visits, or telehealth check-ins. · Use validated tools like the Katz Index of Independence in Activities of Daily Living (ADLs) or the Lawton-Brody Instrumental Activities of Daily Living (IADLs). · Encourage patients to self-report functional abilities via patient portals before visits.	

Care of Older Adults - Medication Review (COA MDR)

Description	Documentation
HEDIS Measure C06 Anthem Care for Older Adults For dual eligible (Medicare and Medicaid) patients ages 66 and older with evidence that a medication review was performed by a clinical pharmacist or prescribing practitioner, the presence of a medication list in the medical record in the measurement year, and/or notation that the member is not taking any medication and the date when it was noted. Numerator Patients in the denominator with evidence that a medication review was performed by a clinical pharmacist or prescribing practitioner, the presence of a medication list in the medical record in the measurement year, and/or notation that the member is not taking any medications. Denominator Patients 66 years of age and older on a Medicare Advantage Special Needs Plan (SNP). Exclusions Patient is deceased in measurement year.	- Can be closed through claims or through supplemental data upload (MA plans). - Document both medication list and medication review and report both CPT II codes. - Medication review must be completed by a prescribing care provider or clinical pharmacist. Bill either primary code WITH one of the following secondary codes (see below): Primary Codes 1159F: Medication list documented in medical record. G8427: Eligible clinician attests to document in the medical record they obtained, updated, or reviewed the patient's current medications. Secondary Codes 1160F: Review of all medications (such as prescriptions, OTCs, herbal therapies, and supplements) by a prescribing practitioner or clinical pharmacist documented in the medical record. 90863: Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services. 99483: Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient setting, home or domiciliary or rest home, with a list of specific required elements. 99605, 99606: Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient.
Close the Gap Tips & Recommendations	
Progress notes containing all of the following: - Current medication list in the calendar year. - Notation of medication review in the calendar year. - Date and notation that the member is not taking any medication in the calendar year. - This task can be delegated to another care team member, as long as the provider reviews and signs off on the medication list or encounter note. Complaint verbiage in medical record: - Verbiage saying "Medication was reviewed and reconciled..." or "medications reviewed and reconciled" with the date of the review performed and the clinicians' signature is compliant.	

Care of Older Adults - Pain Assessment (COA PNS)

Description	Documentation
HEDIS Measure C07 Numerator Patients in the denominator who have evidence of at least one pain assessment in the measurement year. Denominator Patients 66 years of age and older on a Medicare Advantage Special Needs Plan (SNP). Exclusions Patient is deceased in measurement year.	· Date of pain screening must be documented if result is not inside a chart note from an encounter. · Date and notation of “no pain” in the medical record after the member’s pain was assessed is complaint. Can be closed through claims or through supplemental data upload (MA plans). Bill either code for gap closure: · 1125F Pain severity quantified; pain present · 1126F Pain severity quantified; no pain present
Close the Gap Tips & Recommendations	
Progress notes: · Notation of a pain assessment (which may include positive or negative findings for pain) OR result of assessment using a standardized pain assessment tool. · Numeric rating scales (verbal or written); Pain Thermometer, Pictorial Pain Scales, Visual analogue scale. · Brief Pain Inventory, Chronic Pain Grade, PROMIS Pain Intensity Scale OR Pain Assessment in Advanced Dementia (PAINAD) Scale	

Care Coordination & Transitions of Care (Medicare Stars, Quality)

Advanced Care Planning

Description	Documentation
Numerator Patients in the denominator who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. Denominator Patients aged 65 years and older. Exclusions Received Hospice services anytime during the measurement period.	Can be closed through claims or through supplemental data upload (MA plans) 99497: Advance care planning including the explanation and discussion of advanced directives, including the use (and completion) of standard forms, by the physician or other qualified health care professional; first 30 minutes, face-to-face with patient, family, and/or surrogate. Code 99498 can be used for each additional 30 minutes. 1157F: Advance care plan or similar legal document present in the medical record. 1158F: Advance care planning discussion documented in the medical record. - S0257: Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate. 1123F: Advance care planning discussed and documented. Advance care plan or surrogate decision maker documented in the medical record. 1124F: Advance care planning discussed and documented in the medical record. Patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. 99483: Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient setting, home or domiciliary or rest home, with a list of specific required elements. - Z66: Do not resuscitate.
Close the Gap Tips & Recommendations	
Any one of the following meets compliance: - Advance Directives - Actionable medical orders - Copy of Living Wills - Copy of documentation of surrogate decision maker - Evidence of oral statements noted in the medical record in the calendar year	

Follow-up After ED visit for Multiple High-Risk Chronic Conditions (HEDIS)

Description	Documentation
HEDIS Measure C18 Anthem 2025 Tip Sheet Numerator A follow-up service must occur within seven days after the ED visit (including the visit day). Acceptable forms of follow-up include: · Outpatient visits · Telephone or telehealth visits · E-visits or virtual check-ins · Transitional care management services · Case management visits · Complex care management services · Outpatient or telehealth behavioral health visits · Intensive outpatient encounters or partial hospitalization · Community mental health center visits · Substance use disorder services · Electroconvulsive therapy Denominator Patients 18 years of age and older with two or more different high-risk chronic conditions that had an ED visit between January 1 and December 24 of the measurement year. <i>Note:</i> If a patient has more than one ED visit, they could be in the measure more than once. Exclusions · Admitted to an acute or nonacute inpatient facility on or within seven days after the ED visit, regardless of the principal diagnosis for admission. · Received hospice services anytime during the measurement year. · Deceased during the measurement year.	· Document that the visit specifically addressed the ED visit or chronic conditions (e.g., medication adjustments, referrals, health education). · Outline next steps, including medication management, referrals, lab work, or additional visits. · If billing for transitional care management (TCM) (e.g., CPT 99495), ensure documentation includes: · Date of the ED visit · Date of initial contact (phone, email, or video within two business days) · Date of face-to-face visit (must occur within 7–14 days) CPT Codes · E/M Services (New & Established Patients): 99202–99205, 99211–99215 · Preventive Visits: 99381–99387 (new), 99391–99397 (established) · Telehealth & Virtual Check-Ins: 99441–99443 (phone), 99421–99423 (e-visits) · Medicare Initial Preventive Exam: G0402 · Annual Wellness Visits: G0438–G0439 · Remote & Virtual Services: G2010 (video/images review), G2012 (virtual check-in) · FQHC Visit Code: T1015 · Moderate Complexity: 99495 (face-to-face visit within 14 days) <i>Note:</i> These codes should be used when documenting follow-up services within seven days of an ED visit to ensure compliance with the Follow-Up After ED Visit for Multiple High-Risk Chronic Conditions (FMC) HEDIS measure.
Close the Gap Tips & Recommendations	
· Contact patients as soon as ED discharge notification is received and schedule follow-up visit. · Discuss the discharge summary; verify understanding of instructions and that all new prescriptions were filled. · Complete a thorough medication reconciliation with the patient and/or caregiver. · The diagnosis for the follow-up visit does not need to match that of the ED visit and does not need to be associated with the chronic conditions that resulted in the member being put into the denominator. · Virtual care visits are acceptable for follow-up (audio and/or video, e-visits, virtual check-ins). · Keep open appointments so patients with an ED visit can be seen within seven days of their discharge. · Instruct patients to call their practitioner with any concerns or worsening of symptoms.	

Plan All Cause Readmissions (PCR)

Description	Documentation
HEDIS Measure C15 PCR Numerator Patients readmitted within 30 days for any reason. Denominator Patients 18+ years discharged from an inpatient stay. Exclusions Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date. Exclude hospital stays for the following reasons: · The member expired during the stay · Members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim · A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim A planned hospital stay using any of the following: · A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set) · A principal diagnosis of rehabilitation (Rehabilitation Value Set) · An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set) · A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set)	Can only be closed through claims data. · Clearly document the initial discharge date and any readmission within 30 days. · Specify if the readmission was planned (excluded) or unplanned (included in PCR measure). · Note any post-discharge visits (in-person, telehealth, phone check-ins) within 7-14 days. · Note any post-discharge visits (in-person, telehealth, phone check-ins) within 7-14 days. · Document SDOH screenings (transport, food, housing) and referrals made.
Close the Gap Tips & Recommendations	
· Schedule follow-ups before discharge (in-person or telehealth). · Medication reconciliation within seven days. · Use care coordinators for post-discharge outreach. · Screen for social needs (transportation, food, housing). · Educate patients on warning signs & when to seek help. · Establish a transitions of care (TOC) process/workflow.	

Transitions of Care - Medication Reconciliation Post- Discharge (TRC MRP)

Description	Documentation
NCQA Measure Specs Numerator The number of discharges where medication reconciliation was completed and documented by a prescribing practitioner, clinical pharmacist, or registered nurse within 30 days post-discharge. - Must be documented in the outpatient medical record. - May occur during a follow-up visit, via telehealth, or through care coordination efforts. Denominator - Discharges for members 18 years and older from an inpatient setting (including acute hospitals, SNF, and behavioral health hospitals). - The discharge must be followed by at least one outpatient visit, telephone visit, or e-visit/virtual check-in within 30 days to be included in the denominator. Exclusions - Received hospice or palliative care. - Discharges resulting in readmission within 30 days to the same or different inpatient setting. - Deceased during the measurement period.	- Clearly document that medication reconciliation was performed within 30 days of discharge. - Include documentation discharge from Inpatient stay, date of discharge and date of visit reconciliation to confirm compliance. - Record must include evidence of reviewed and reconciled medications, including updates or discontinuations. - Acceptable locations for documentation: - Outpatient progress notes - Discharge summary (if completed within 30 days) - Medication list updates within the electronic health record (EHR) CPT Codes 99495: Transitional Care Management (TCM) with moderate complexity (face-to-face visit within 14 days) 99496: TCM with high complexity (face-to-face visit within seven days) 1111F: Medication reconciliation performed and documented within 30 days of discharge
Close the Gap Tips & Recommendations	
- Offer telehealth medication reconciliation for patients who face transportation or mobility challenges. - Use multichannel outreach (phone, text, patient portals) to schedule follow-up visits and address barriers to care. - Implement real-time hospital discharge alerts in EHRs to trigger medication reconciliation workflows. - Utilize clinical pharmacists or pharmacy techs for medication reviews, adherence counseling, and reconciliation documentation. - Offer prescription delivery, financial assistance referrals, or community-based support programs to improve follow-through. - Assign CHWs or case managers to follow up with recently discharged patients, ensuring medication reconciliation within 30 days.	

Transitions of Care - Patient Engagement After Inpatient Discharge (TRC PE)

Description	Documentation
HEDIS Measure C17 Numerator Patients 18 years and older who had patient engagement (follow-up interaction) within 30 days after discharge from an inpatient stay. Denominator Patients 18+ years discharged from an inpatient setting (hospital, rehab, SNF, or behavioral health facility). Exclusions: · Received hospice or palliative care · Patients who were readmitted to an inpatient setting within 30 days of discharge · Deceased during the measurement year	Can only be closed with claims or supplemental data. Patient engagement can include any of the following: · Outpatient visit (office or home) · Telephone visit · E-visit or virtual check-in between member and provider · Telehealth visit · Transitional care management · Standing BMD scan orders · Initiate appropriate referrals and orders for bone mineral density testing · Screen patient for risk of falls and help ensure they have resources or equipment The discharge must be followed by a qualifying engagement within 30 days. Do not include patient engagement that happens on the day of discharge.
Close the Gap Tips & Recommendations	
· Patient engagement must be completed within 30 days of the discharge. · Outreach on the day of discharge will not be compliant.	

Pharmacy & Medication Adherence (Medicare Stars-Specific)

Medication Adherence: Hypertension (ACE/ARBS)

Description
PQA: Proportion of Days Covered: Renin Angiotensin System Antagonists (PDC-RASA) Numerator Individuals who met the PDC threshold of 80% during the measurement year. Denominator Individuals 18 years and older who prescription claimed ≥ 2 prescriptions for any RASA or RASA combination product on different dates of service in the treatment period.

Medication Adherence: Cholesterol (Statins)

Description
PQA: Proportion of Days Covered: Statins (PDC-STA) Numerator Individuals who met the PDC threshold of 80% during the measurement year Denominator Individuals 18 years and older who prescription claimed ≥ 2 prescriptions for any statin or statin combination product on different dates of service in the treatment period.

Medication Adherence: Diabetes (non-insulin)

Description	Documentation
PQA: Proportion of Days Covered: Diabetes All Class (PDC-DR) Numerator Individuals who met the PDC threshold of 80% during the measurement year. Denominator Individuals 18 years and older whose prescription claimed ≥ 2 prescription claims for any of the diabetes medication on different dates of service in the treatment period.	These classes of diabetes medications are included in this measure: biguanides, dipeptidyl peptidase-4 (DPP-4) inhibitors, incretin mimetics, meglitinides, sodium-glucose cotransporter-2 (SGLT2) inhibitors, sulfonylureas and thiazolidinediones. <i>Patients on insulin are excluded from this measure.</i>
Close the Gap <i>Tips & Recommendations</i>	

- Follow evidence-based practices.
- Use/implement standardized medication adherence protocol.
- Utilize monthly medication adherence reports for targeted outreach.
- Improve medication access and affordability.
- 90- to 100-day refills when appropriate/work into med refill protocol.
- Encourage use of 340B and in-house pharmacy.
- Engage patients with education and support.
- Adherence tools, programs, reminders.

Statin Use for Patients with Diabetes (SUPD)

Description	Documentation
PQA: Statin Use in Persons with Diabetes (SUPD) Numerator Individuals from the denominator with ≥ 1 prescription claims for a statin medication during the measurement year. Denominator Individuals ages 40 to 75 years with ≥ 2 prescription claims on different dates of service for any diabetes medication during the measurement year. Exclusions · Patients with a diagnosis of end-stage renal disease (ESRD) · Patients with rhabdomyolysis or myopathy – G72.0, G72.89, G72.9, M60.80, M60.9, M62.82 · Patients who are pregnant, lactating or undergoing therapy for fertility · Patients with liver disease/cirrhosis · Patients with prediabetes · Patients with polycystic ovary syndrome (PCOS) · Hospice or palliative care	Patient must have been <u>dispensed at least two diabetes medications</u> during the measurement year. · This includes medications such as metformin, sulfonylureas, DPP-4 inhibitors, SGLT2 inhibitors, GLP-1 receptor agonists, or other non-insulin antidiabetic drugs (note: Diagnosis is inferred from pharmacy claims, not clinical coding). · The patient must be dispensed a statin medication (any intensity) during the measurement year. · This is validated through pharmacy claims data, not provider documentation or EHR notes.
Close the Gap Tips & Recommendations	
· Implement standardized workflows to ensure that all patients with diabetes (ages 40-75) are assessed for statin therapy during routine visits. · Train care team members, including nurses and community health workers, educate patients on the cardiovascular benefits of statins and address misconceptions about side effects. · Assist patients in navigating prescription assistance programs, Medicaid, or 340B pharmacy discounts to improve medication affordability and access. · Use data analytics (Monthly Med Adherence Reports) to generate lists of patients who are on diabetes medications but have not been prescribed a statin.	

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Description	Documentation
<u>HEDIS MY2026 Statin Therapy for Patients with Cardiovascular Disease (SPC)</u> Numerator · Statin Therapy: Member was dispensed at least one moderate- or high-intensity statin during the measurement year. Denominator Males (21–75) & Females (40–75) diagnosed with clinical atherosclerotic cardiovascular disease (ASCVD) during the measurement year. Exclusions · Hospice or palliative care · Ages 81 and older with frailty* only · Ages 67–80 with frailty* and advanced illness · Ages 67 and older with I-SNP or who are institutionalized · Patients with the following diagnoses or services in the current or prior measurement year for: Pregnancy, In vitro fertilization (IVF), End-stage renal disease (ESRD) or dialysis, and/or Cirrhosis · Patients with myalgia, myositis, myopathy or rhabdomyolysis during the current measurement year: G72.0, G72.2, G72.9, 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, M62.82, M79.1, M79.10, M79.11, M79.12, M79.18	Pharmacy Claims – Must confirm statin therapy through prescription fills. Exclusion Codes Required – Medical exclusions must be documented using ICD-10 codes. Treatment Period Tracking – Starts from first statin fill date through last day of the year.
Close the Gap Tips & Recommendations	
· 90- or 100-day prescription fill for trials. · Implement standardized workflows to ensure that all patients with ASCVD are assessed for statin therapy during routine visits. · Train care team members, including nurses and community health workers, educate patients on the cardiovascular benefits of statins and address misconceptions about side effects. · Assist patients in navigating prescription assistance programs, Medicaid, or 340B pharmacy discounts to improve medication affordability and access. · Use data analytics (Monthly Med Adherence Reports) to generate lists of patients who are on diabetes medications but have not been prescribed a statin.	

Medication Therapy Management - Comprehensive Medication Review (CMR)

Description	Documentation
PQA: Completion Rate for Comprehensive Medication Review (CMR) Numerator - Members who received a Comprehensive Medication Review (CMR) during the measurement year. - The CMR must be completed by a pharmacist or qualified provider and documented in the medical record. Denominator Medicare Part D members who meet all three criteria: - Have multiple chronic conditions - Take multiple Part D medications - Are likely to incur annual costs above the CMS-designated threshold for covered Part D drugs Exclusions - Hospice or palliative care - Declined participation in a CMR	The CMR must include: - A review of all medications (prescription, OTC, herbal, and supplements) - Identification of medication-related problems - A personalized medication list (PML) for the patient - A medication action plan (MAP) outlining any recommendations Documentation must be recorded in the members' file and shared with them <u>within seven days of the CMR.</u> Common CPT Codes for CMR 99605 – First 15 minutes of a medication therapy review, new patient 99606 – Follow-up medication therapy review, established patient 99607 – Additional 15-minute increments
Close the Gap Tips & Recommendations	
- Schedule CMRs as part of annual wellness visits or chronic care management (CCM). - Train care teams and pharmacists to engage patients in discussions about adherence, side effects, and interactions. - Provide patients with an easy-to-read medication list and clear instructions on next steps. - Use telehealth and phone consultations to increase CMR completion rates.	

Pharmacy Risk & Safety (Quality, Medicare Stars)

Polypharmacy - Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

Description	Documentation
<u>PCA: Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH)</u> Patients 65 and older with concurrent use (overlapping day's supply for at least 30 cumulative days) of two or more unique anticholinergic (ACH) medications. Numerator Patients prescribed two or more anticholinergic meds for at least 30 total days within the measurement year - Includes patients with at least two fills of each medication on different dates of service in the targeted drug class during the measurement period. Denominator Patients 65+ with concurrent use (overlapping day's supply for at least 30 cumulative days) of two or more unique anticholinergic (ACH) medications. Exclusions · Hospice or palliative care · Short-term anticholinergic therapy (<30 days total)	Can only be closed with pharmacy claims or exclusion codes. Common Anticholinergic Medications (Poly-ACH Risk Drugs): · First-Generation Antihistamines: Diphenhydramine, Hydroxyzine · Bladder Antispasmodics: Oxybutynin, Tolterodine, Solifenacin · Tricyclic Antidepressants: Amitriptyline, Doxepin · Antipsychotics: Chlorpromazine, Clozapine · Muscle Relaxants: Cyclobenzaprine, Baclofen · Antiemetics: Promethazine, Meclizine
Close the Gap Tips & Recommendations	
· To be compliant for this measure, concurrent use of two or more anticholinergics must be limited to LESS than 30 cumulative overlapping days during the measurement period. · Lower rates are better for this measure (inverse measure).	

Concurrent Use of Opioids and Benzodiazepines (COB)

Description	Documentation
<u>PQA: Concurrent Use of Opioids and Benzodiazepines (COB)</u> Numerator Members with concurrent use of opioids and benzodiazepines for 15 or more days within the measurement year. Denominator Members 18 years and older with at least two or more prescription claims for opioids and two or more prescription claims for benzodiazepines, with at least 15 days of overlapping use during the measurement year. Exclusions · Hospice or Palliative Care · Cancer Diagnosis · Members with a single opioid or benzodiazepine fill (must have at least two fills of each medication to be included)	· Prescription claims must reflect opioid and benzodiazepine fills with at least 15 days of overlap. · Ensure proper documentation of exclusions (hospice, palliative care, cancer diagnosis) in medical records using ICD-10 codes. · Review prescription drug monitoring program (PDMP) reports to track concurrent use.
Close the Gap Tips & Recommendations	
· Use EHR alerts to flag patients prescribed both opioids and benzodiazepines. · Implement medication review protocols to assess necessity and deprescribe when possible. · Educate providers on risks of concurrent use, including overdose and respiratory depression. · Engage pharmacists and care teams in reviewing prescription history and recommending safer alternatives. · Encourage non-pharmacologic treatments for anxiety, insomnia, and chronic pain management when appropriate.	