Preferred Care Partners

A UnitedHealthcare Company

Quality Reference Guide

2026 Dates of Service

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PART C Measures (HEDIS, NCQA)

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Glossary of Terms

Measurement year

In most cases, the 12-month time frame between which a service was rendered – generally Jan.1 – Dec. 31. Data collected from this time frame is reported during the reporting year.

Reporting year

The time frame when data is collected and reported. The service dates are from the measurement year, which is usually the year prior. In some cases, the service dates may go back more than one year.

Example: The 2026 reporting year would include data from services rendered during the measurement year, which would be 2025 and/or any time prior. Results from the 2026 reporting year would likely be released in June 2026, depending on the quality program.

Denominator

The number of members who qualify for the measure criteria, based on NCQA technical specifications.

Numerator

The number of members who meet compliance criteria based on NCQA technical specifications for appropriate care, treatment or service.

Medical record data

The information taken directly from a member's medical record to validate services rendered that weren't captured through medical or pharmacy claims, encounters or supplemental data.

Collection and reporting method

- Administrative – Measures reported as administrative use the total eligible population for the denominator. Medical, pharmacy and encounter claims count toward the numerator. In some instances, health plans use approved supplemental data for the numerator.
- Hybrid – Measures reported as hybrid use a random sample of 411 members from a health plan's total eligible population for the denominator. The numerator includes medical and pharmacy claims, encounters and medical record data. In some cases, health plans use auditor-approved supplemental data for the numerator.
- Supplemental data – Standardized process in which clinical data is collected by health plans for purposes of HEDIS improvement. Supplemental clinical data is additional data beyond claims data.

Proportion of days covered (PDC)

- According to the Pharmacy Quality Alliance (PQA), the PDC is the percent of days in the measurement period covered by prescription claims for the same medication or another in its therapeutic category.

Required exclusion

Members are excluded from a measure denominator based on a diagnosis and/or procedure captured in their Claim/encounter/ Pharmacy data. If applicable, the required exclusion is applied after the claims data is processed
within certified HEDIS software while the measure denominator is being created.
For example: Members with end-stage renal disease (ESRD) during the measurement year or year prior will be excluded from the statin therapy for patients with cardiovascular disease (SPC) measure denominator.

- Members with a claim for hospice services during the measurement year will be excluded from all applicable measures.

Breast Cancer Screening (BCS-E)

New for 2026

CMS Weight: 1
P4P Weight: 1

• Removed required exclusion for the combination of unilateral mastectomy with a bilateral modifier.

Definition

Percentage of members ages 40-74 who were recommended for routine breast cancer screening and had a mammogram screening completed on or by Oct. 1st; 2 years prior to the measurement year through Dec. 31 of the measurement year.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 58%	≥ 58% to <71 %	≥ 71% to <76 %	≥ 76% to < 84%	≥ 84%
P4P Thresholds	< 63%	≥ 63% to <72 %	≥ 72% to <77 %	≥ 77% to < 85%	≥ 85%

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Mammography	
CPT®/CPT II	77061, 77062, 77063, 77065, 77066, 77067
LOINC	103885-0, 103886-8, 103892-6, 103893-4, 103894-2, 24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0, 72137-3, 72138-1, 72139-9, 72140-7, 72141-5, 72142-3, 86462-9, 86463-7, 91517-3, 91518-1, 91519-9, 91520-7, 91521-5, 91522-3
SNOMED	12389009, 24623002, 43204002, 71651007, 241055006, 241057003, 241058008, 258172002, 439324009, 450566007, 723778004, 723779007, 723780005, 726551006, 833310007, 866234000, 866235004, 866236003, 866237007, 384151000119104, 392521000119107, 392531000119105, 566571000119105, 572701000119102, 1333997002, 1333998007, 1333999004, 1334000002, 1334001003, 1334002005, 308001000000100, 308031000000106

Breast Cancer Screening (BCS-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members who died • Members receiving palliative care	Any time during the measurement year
Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: • Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). • Advanced Illness: Indicated by 1 of the following: – At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). – Dispensed dementia medication Donepezil, Donepezil-Memantine, Galantamine, Rivastigmine or Memantine	**Frailty** diagnoses must be in the measurement year and on different dates of service **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year

Breast Cancer Screening (BCS-E) (cont.)

Exclusion	Time frame
Bilateral mastectomy • History of bilateral mastectomy • Any combination of the following that indicate a mastectomy on both the left and right side: – Absence of the left and right breast – Unilateral mastectomy (claims or medical record) with a bilateral modifier or a bilateral qualifier value – Left unilateral mastectomy – Right unilateral mastectomy • Members who had gender-affirming chest surgery with a diagnosis of gender dysphoria	Any time in a member's history through Dec. 31 of the measurement year

Important Notes

Measure Notes	Test, Service or Procedure to close care opportunity	Medical record detail including, but not limited to
• This measure does not include biopsies, breast ultrasounds or MRIs • If documenting a mammogram in a member's history, please include the month and year. The result is not required.	Mammogram – all types and methods including screening, diagnostic, film, digital or digital breast tomosynthesis	• Consultation reports • Diagnostic reports • Health history and physical

Breast Cancer Screening (BCS-E) (cont.)

Additional measure resources

• **ACS NBCRT Risk Assessment Toolkit – NBCRT**	The American Cancer Society National Breast Cancer Roundtable (ACS NBCRT) assembled this digital toolkit to support practices and providers in conducting breast cancer risk assessments. Breast cancer risk assessment helps identify individuals at higher risk for breast cancer to enable personalized screening, prevention and early detection strategies. This toolkit presents evidence-based breast cancer risk assessment tools and provides guidance for providers on their effective use.
• **Recommendation: Breast Cancer: Screening | United States Preventive Services Taskforce**	U.S. Preventive Services Task Force recommendations for biennial screening for women aged 40-74 years.
• **Safety Considerations for COVID-19 Vaccines | COVID-19 | CDC**	Per the CDC, lymphadenopathy may occur 4-6 weeks after the COVID-19 vaccination. Please encourage your patients to wait the appropriate amount of time before scheduling their mammogram or complete the mammogram before receiving the COVID-19 vaccine, to account for lymphadenopathy. This will help prevent the vaccine impacting screening results.

Colorectal Cancer Screening (COL-E)

New for 2026

- No applicable changes to this measure

CMS Weight: 1
P4P Weight: 1

Definition

Percentage of members ages 45–75 who had an appropriate screening for colorectal Cancer.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 48%	≥ 48% to <60 %	≥ 60% to <70%	≥ 70% to < 78%	≥ 78%
P4P Thresholds	< 52%	≥ 52% to <64%	≥ 64% to <72 %	≥ 72% to < 81%	≥ 81%

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Colonoscopy	
CPT®/CPT II	44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398
HCPCS	G0105, G0121
SNOMED	8180007, 12350003, 25732003, 73761001, 174158000, 174185007, 235150006, 302052009, 367535003, 443998000, 444783004, 446521004, 446745002, 447021001, 709421007, 710293001, 711307001, 789778002, 1209098000, 48021000087103, 48031000087101, 174173004, 174179000, 609197007, 771568007, 1217313001, 1304042004, 1304043009, 1304044003, 1304045002, 1304049008, 1304050008, 174171002, 311774002, 426699005, 773128008,
History of colonoscopy	
SNOMED	851000119109

When using SNOMED codes to identify history of procedures, the date of the procedure must be available (do not use the date when the provider documented the procedure as the date of the procedure).

Colorectal Cancer Screening (COL-E) (cont.)

Computed tomography (CT) colonography	
CPT®/CPT II	74261, 74262, 74263 This service isn't covered for UnitedHealthcare Medicare Advantage members.
LOINC	60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3

Stool DNA (sDNA) with FIT test	
CPT®/CPT II	81528 This code is specific to the Cologuard® FIT-DNA test., 0464U
LOINC	77353-1, 77354-9
SNOMED	708699002
Flexible sigmoidoscopy	
CPT®/CPT II	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350
Flexible sigmoidoscopy	
HCPCS	G0104
History of flexible sigmoidoscopy	
SNOMED	841000119107

When using SNOMED codes to identify "history of" procedures, the date of the procedure must be available (do not use the date when the provider documented the procedure as the date of the procedure).

FOBT	
CPT®/CPT II	82270, 82274
HCPCS	G0328
LOINC	12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6, 104738-0, 107189-3, 107190-1, 107191-9
SNOMED	59614000, 167667006, 389076003, 71711000112103

Colorectal Cancer Screening (COL-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members receiving palliative care • Members who died	Any time during the measurement year
Members who had colorectal cancer or a total colectomy	Any time during the member's history through Dec. 31 of the measurement year
Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: • Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). • Advanced Illness: Indicated by 1 of the following: – At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). – Dispensed dementia medication Donepezil, Donepezil-Memantine, Galantamine, Rivastigmine or Memantine	• **Frailty** diagnoses must be in the measurement year and on different dates of service • **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year

Colorectal Cancer Screening (COL-E) (cont.)

Important Measure Notes

Test, Service or Procedure to close care opportunity	Time Frame
Colonoscopy	Measurement year or 9 years prior
• Flexible sigmoidoscopy • CT colonography	Measurement year or 4 years prior
Stool DNA (sDNA) with FIT Test	Measurement year or 2 years prior
iFOBT, gFOBT, FIT	Measurement year

Colorectal Cancer Screening (COL-E) (cont.)

Tips and best practices to help close this care opportunity

- Patient-reported screenings are acceptable *only if:*
  - Taken as part of the patient's history by a **PCP or specialist who provides primary care**
  - Included in the patient's **medical or health history**. Clearly state:
- Type of test performed
- (e.g., colonoscopy, flexible sigmoidoscopy, stool DNA [sDNA] with FIT, CT colonography, FOBT)
- Example: "Colonoscopy completed in 2024"
  - **Date of service** (year when the screening was performed)
- It's important to submit any codes that reflect a member's history of malignancy for colorectal cancer
  - If a member is new to the care provider and the diagnosis is discovered during the history and physical, the code should be submitted with the initial visit claim
  - If a member isn't new to the care provider, but the member's chart has documented history of the diagnosis , the ICD-10 Diagnosis code should be submitted on any visit claim
- Member refusal will **not** make them ineligible for this measure
  - Please recommend a Flexible sigmoidoscopy, stool DNA (sDNA) with FIT test or FOBT if a member refuses or can't tolerate a colonoscopy
- There are 2 types of acceptable FOBT tests – guaiac (gFOBT) and immunochemical (iFOBT)
- Blood-based biomarker tests are not currently approved by NCQA and not the part of MY2026 Value set to close HEDIS gaps. Therefore blood-based biomarker test does not meet numerator compliance.
- Contact your laboratory services provider to procure iFOBT supplies for use in your office
  - Physicians, nurse practitioners and physician assistants can provide the kit to the members during their routine office visits. Members can then collect the sample at home and send the specimen and requisition form directly to the laboratory services vendor in a post-paid envelope.
- Digital Rectal Exams (DRE) performed in the office setting will not meet compliance. If the member collected the stool sample in accordance with the manufacturer's instructions provided with the kit, it will address any existing gaps.

Controlling High Blood Pressure (CBP)

New for 2026

- No applicable changes to this measure

CMS Weight: 3
P4P Weight: 3

Definition

Percentage of members ages 18–85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled at **<140/90 mmHg** during the measurement year.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 67%	≥ 67% to <75 %	≥ 75% to 80%	≥ 80% to < 86%	≥ 86%
P4P Thresholds	< 72%	≥ 72% to <78%	≥ 78% to <83 %	≥ 83% to < 88%	≥ 88%

Codes

The following codes can be used to submit outcome results for this measure; they are not intended to be a directive of your billing practice.

Systolic blood pressure levels 130-139 mm Hg	
CPT®/CPT II	3075F
Systolic blood pressure level <130 mmHg	
CPT®/CPT II	3074F
Systolic blood pressure level >/=140 mmHg	
CPT®/CPT II	3077F

Controlling High Blood Pressure (CBP) (cont.)

Diastolic blood pressure level 80-89 mmHg	
CPT®/CPT II	3079F
Diastolic blood pressure level <80 mmHg	
CPT®/CPT II	3078F
Diastolic blood pressure level >/=90 mmHg	
CPT®/CPT II	3080F

***Please continue to code using CPT II codes for a blood pressure reading including a diastolic >90 and systolic >140, as it is important for tracking and addressing quality of care and health outcomes.**

Controlling High Blood Pressure (CBP) (cont.)

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members receiving palliative care • Members who died • Members with a diagnosis of pregnancy	Any time during the measurement year
Members ages 81 and older as of Dec.31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service	**Frailty** diagnoses must be in the measurement year on different dates of service
Members 66-80 years of age as of Dec.31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: – Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). – Advanced Illness: Indicated by 1 of the following: o At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). o Dispensed dementia medication Donepezil, Donepezil- memantine, galantamine, rivastigmine or memantine	• **Frailty** diagnoses must be in the measurement year on different dates of service • **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year on or before Dec. 31 of the measurement year
- Dialysis - End-stage renal disease (ESRD) - Kidney transplant - Nephrectomy	On or before Dec 31 of the measurement

Controlling High Blood Pressure (CBP) (cont.)

Important Measure notes

Measure Notes		Test, Service or Procedure to close care opportunity
• BP reading must be on or after the second hypertension diagnosis and must be the latest performed within the measurement year. • BP readings taken on the same day the member receives a common low-intensity or preventive procedure can be used. Examples include, but aren't limited to: – Eye exam with dilating agents – Injections (e.g., allergy, Depo- Provera®, insulin, lidocaine, steroid, testosterone toradol or vitamin B-12) – Intrauterine device (IUD) insertion – Tuberculosis (TB) test – Vaccinations – Wart or mole removal	• BP readings taken in the following situations will not count toward compliance: - During an acute inpatient stay or an emergency department visit - On the same day as a diagnostic test or Therapeutic procedure that requires change in medication on or 1 day before test. *Except for Fasting Blood test.* Examples include but not limited: ○ Colonoscopy ○ Dialysis, Infusion, Chemotherapy ○ Nebulizer treatment with Albuterol • If the retrieval method is not mentioned (i.e., manual/digital), assume the method was digital and is acceptable	• BP reading taken during the measurement year via: - Outpatient visits - Telephone or telehealth visits - Virtual check-ins or e-visits - Non-acute inpatient visits • Member reported BP readings must be taken with a digital device, in any of these visit settings and documented in member's medical record. Does not require documentation that it was taken with a digital device. • Ranges and threshold will not meet the intent of the measure. A specific BP result needs to be documented. Documentation of average BP will meet the intent of the measure. • If multiple BPs were taken on the same day, the lowest systolic and the lowest diastolic should represent the BP result for the date of service

Controlling High Blood Pressure (CBP) (cont.)

Tips and best practices to help close this care opportunity

- It is important to document patient reported vitals in the official medical record when conducting telehealth, telephone or online assessment visits. Please encourage patients to use a digital device to track and report their BP during every visit.
- **Always list the date of service and BP reading together**
  - If BP is listed on the vital flow sheet, it must have a date of service
- It's critical to follow up with a member for a BP check after their initial diagnosis . Schedule member's follow-up visit prior to discharging from clinic.
  - Members who have an elevated BP during an office visit in August, September or October should be brought back in for a follow-up visit before Dec. 31
- Talk with members about what a lower goal BP reading is
  - For example: 130/80 mmHg
- Remind members who are NPO for a fasting lab they should continue to take their anti-hypertensive medications with a sip of water on the morning of their appointment
- If your office uses manual blood pressure cuffs, don't round up the BP reading For example: 138/89 mmHg rounded to 140/90mmHg
- If a member's initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading. Retake the member's BP after they've had time to rest.
  - For example: If a member's first BP reading was 160/80 mmHg and the second reading was 120/90 mmHg, use the 120 systolic of the second reading and the 80 diastolic of the first reading to show a BP result of 120/80 mmHg
  - Place a BP recheck reminder at exam room to recheck blood pressure if initial blood pressure was 140/90 or higher
- If a member is seeing a cardiologist for their hypertension, please encourage them to also have their records transferred to their primary care provider's office
- If a member is new to your office, please get their medical record from their previous care provider to properly document the transfer of care

Eye Exam for Patients With Diabetes (EED)

New for 2026

- No applicable changes for this measure

CMS Weight: 1
P4P Weight: 1

Definition

Percentage of members ages 18–75 with diabetes (Types 1 and 2) who had a retinal eye exam.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 60%	≥ 60% to <72 %	≥ 72% to 80%	≥ 80% to < 86%	≥ 86%
P4P Thresholds	< 60%	≥ 60% to <72%	≥ 72% to <80%	≥ 80% to < 86%	≥ 86%

Eye Exam for Patients With Diabetes (EED) (cont.)

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice

Scenario 1: Eye exam with or without evidence of retinopathy billed by any provider type during the measurement year OR eye exam without evidence of retinopathy during prior year billed by any provider type

Diabetic eye exam without evidence of retinopathy	
CPT®/CPT II	2023F, 2025F, 2033F

Diabetic eye exam with evidence of retinopathy	
CPT®/CPT II	2022F, 2024F, 2026F

Scenario 2: Autonomous eye exam billed by any provider type during the measurement year

Autonomous eye exam (imaging of retina)	
CPTR/CPT II	92229
LOINC	105914-6 (with a result), LA34398-0, LA34399-8

Scenario 3: Retinal imaging by a qualified reading center, billed by any provider type during the measurement year

Retinal imaging	
CPT®/CPT II	92227, 92228
SNOMED	3047001, 20067007, 314971001

Scenario 4: Diabetic retinal screening negative in year prior, billed by any provider type

Diabetic retinal screening negative in prior	
CPT®/CPT II	3072F (do not include code with a modifier)

Eye Exam for Patients With Diabetes (EED) (cont.)

Scenario 5: Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both the left and right eye by any provider, or a combination that indicates one eye is enucleated and the other was examined

Left eye	Right eye
Retinal exam finding: Any level of retinopathy (LOINC code 71490-7) **with** diabetic retinopathy severity level (LOINC codes LA18644-7, LA18645- 4, LA18643-9, LA18648-8, LA18646-2) **during the measurement year**	Retinal exam finding: Any level of retinopathy (LOINC code 71491-5) **with** diabetic retinopathy severity level (LOINC codes LA18644-7, LA18645- 4, LA18643-9, LA18648-8, LA18646-2) **during the measurement year**
Retinal exam finding: No retinopathy (LOINC code 71490-7 **with** LOINC code LA18643-9) in the **year prior to the measurement year**	Retinal exam finding: No retinopathy (LOINC code 71491-5 **with** LOINC code LA18643-9) in the **year prior to the measurement year**
Enucleation: ICD-10-PCS code 08T1XZZ any time during the member's history through Dec. 31 of the measurement year	Enucleation: ICD-10-PCS code 08T0XZZ any time during the member's history through Dec. 31 of the measurement year

Scenario 6: Retinal eye exam billed by an eye care professional during the measurement year OR retinal eye exam billed by an eye care professional during the prior year with a diagnosis of diabetes without complications

Retinal eye exam	
CPT®/CPT II	92002, 92004, 92012, 92014, 92018, 92019, 92134, 92137, 92201, 92202, 92230, 92235, 92250, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
HCPCS	S0620, S0621, S3000
SNOMED	252780007, 252781006, 252782004, 252783009, 252784003, 252788000, 252789008, 252790004, 252846004, 274795007, 274798009, 308110009, 30842004, 314972008, 36844005, 391999003, 392005004, 410441007, 410450009, 410451008, 410452001, 410453006, 410455004, 416369006, 417587001, 420213007, 425816006, 427478009, 53524009, 56072006, 56204000, 6615001, 700070005, 722161008
Diabetes mellitus without complications	
ICD-10 Diagnosis	E10.9, E11.9, E13.9
SNOMED	721111000124107, 721121000124104, 721201000124104, 31321000119102, 1481000119100, 111552007, 1217068008, 1217044000, 190412005, 1290118005, 313435000, 313436004. 290002008, 443694000, 444073006, 444074000, 444110003, 445353002, 870528001, 164971000119101

Eye Exam for Patients With Diabetes (EED) (cont.)

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members receiving palliative care • Members who died • Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: – Enrolled in an Institutional Special Needs Plan (I-SNP) – Living long term in an institution*	Any time during the measurement year
Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: •Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). •Advanced Illness: Indicated by 1 of the following: – At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). – Dispensed dementia medication Donepezil, Donepezil-Memantine, Galantamine, Rivastigmine or Memantine	• **Frailty** diagnoses must be in the measurement year and on different dates of service • **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
• Bi-lateral eye enucleation • Bilateral absence of eyes (SNOMED CT code 15665641000119103)	• Any time during the member's history through Dec. 31 of the measurement year

Eye Exam for Patients With Diabetes (EED) (cont.)

Important Notes

Measure Notes	Test, Service or procedure to close care opportunity	Medical record Detail including but not limited too
• Members without retinopathy should have an eye exam every 2 years • Members with retinopathy should have an eye exam every year	• Dilated or retinal eye exam • Fundus photography	• Consultation reports • Diabetic flow sheets • Eye exam report • Progress notes

Eye Exam for Patients With Diabetes (EED) (cont.)

Tips and best practices to help close this care opportunity

- **If documenting the history of a dilated eye exam in a member's chart and do not have the eye exam report from the eye care professional, always list the date of service, test, result and that retinopathy was assessed by an eye care professional**
  - For example: "Last diabetic eye exam with John Smith, OD, was June 2024 with no retinopathy"
- Documentation of a diabetic eye exam by an optometrist or ophthalmologist isn't specific enough to meet the criteria. The medical record must indicate that a **dilated or retinal exam** was performed. If the words "dilated" or "retinal" are missing in the medical record, a notation of "dilated drops used" and findings for macula and vessels will meet the criteria for a dilated exam.
- If history of a dilated retinal eye exam and result is in your progress notes, please ensure that a date of service, the test or result, and the care provider's credentials are documented. The care provider must be an optometrist or ophthalmologist, and including only the date of the progress note will not count.
- A slit-lamp examination will not meet the criteria for the dilated eye exam measure. There must be additional documentation of dilation or evidence that the retina was examined for a slit-lamp exam to be considered compliant
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results will be compliant.
  - Alternatively, results may be read by:
    - A qualified reading center that operates under the direction of a medical director who is a retinal specialist
    - A system that provides artificial intelligence (AI) interpretation
- If a copy of the fundus photography is included in your medical record it must include results, date and signature of the reading eye care professional for compliance
- Documentation of hypertensive retinopathy should be considered the same as diabetic retinopathy
- Dilated retinal eye exams with results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Glycemic Status Assessment for Patients With Diabetes (GSD)

New for 2026

CMS Weight: 3
P4P Weight: 3

- No applicable changes for this measure

Definition

The percentage of members ages 18–75 of age with diabetes (Types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) showed their blood sugar is under control during the measurement year adequate control is < 8.0%, poor control is > 9.0%).

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 54%	≥ 54% to <77 %	≥ 77% to 87%	≥ 87% to < 91%	≥ 91%
P4P Thresholds	< 59%	≥ 59% to <82%	≥ 82% to <89%	≥ 89% to < 93%	≥ 93%

Codes

The following codes can be used to submit outcome results for this measure; they are not intended to be a directive of your billing practice.

HbA1c < 7.0%	
CPT®/CPT II	3044F
SNOMED	165679005
HbA1c ≥ 7.0% and <8.0%	
CPT®/CPT II	3051F
HbA1c ≥ 8.0% and ≤ 9.0%	
CPT®/CPT II	3052F

Glycemic Status Assessment for Patients With Diabetes (GSD) (cont.)

HbA1c > 9.0%	
CPT®/CPT II	3046F
SNOMED	451061000124104
Glucose management indicator (GMI)	
LOINC	**97506-0**

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members receiving palliative care • Members who died	Any time during the measurement year
Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: • Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). • Advanced Illness: Indicated by 1 of the following: – At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). – Dispensed dementia medication Donepezil, Donepezil-Memantine, Galantamine, Rivastigmine or Memantine	• **Frailty** diagnoses must be in the measurement year and on different dates of service • **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
• Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: – Enrolled in an Institutional Special Needs Plan (I-SNP) – Living long term in an institution*	Any time during the measurement year

* Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions.

Glycemic Status Assessment for Patients With Diabetes (cont.)

Important Notes

Measure Notes	Test, Service or procedure to close care opportunity	Medical Record Detail including but not limited to
• HbA1c or glucose management indicator (GMI) test must be performed during the measurement year. • If multiple tests were performed in the measurement year, the result from the last test is used. • Always list the date of service, result and test together • CPT II Codes that are on a lab claim (POS 81) or include a modifier do not count toward numerator compliance	• A1c, HbA1c, HgbA1c • Glycohemoglobin • Glycohemoglobin A1c • Glycated hemoglobin • Glycosylated hemoglobin • HB1c • Hemoglobin A1c • Continuous glucose	• Diabetic flow sheets • Consultation reports • Lab reports • Progress notes • Vitals sheet • Continuous glucose monitoring data

Kidney Health Evaluation for Patients With Diabetes (KED)

New for 2026

CMS Weight: 1
P4P Weight: 1

- No applicable changes for this measure

Definition

Percentage of members ages 18–85 with diabetes (Types 1 and 2) who had a kidney health evaluation in the measurement year. **Both** an eGFR and a uACR test are required on same or different dates of service.

- At least 1 estimated glomerular filtration rate (eGFR); AND
- At least 1 urine albumin-creatinine ratio (uACR) test identified by one of the following:
  - A quantitative urine albumin test AND a urine creatinine test (billed for service dates 4 days or less apart);OR
  - A uACR

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 34%	≥ 34% to <51 %	≥ 51% to 62%	≥ 62% to < 74%	≥ 74%
P4P Thresholds	< 45%	≥ 45% to <58%	≥ 58% to <69%	≥ 69% to < 80%	≥ 80%

Kidney Health Evaluation for Patients With Diabetes (KED) (cont.)

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Estimated glomerular filtration rate lab test	
CPT®/CPT II	80047, 80048, 80050, 80053, 80069, 82565
LOINC	102097-3, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6
Quantitative urine albumin lab test	
CPT®/CPT II	82043
LOINC	14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7, 100158-5
Urine creatinine lab test	
CPT®/CPT II	82570
LOINC	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
Urine albumin creatinine ratio test	
LOINC	13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1,

Kidney Health Evaluation for Patients With Diabetes (KED) (cont.)

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members receiving palliative care • Members age 81 years or older who had at least 2 frailty diagnoses on different dates of service • Members who died	Any time during the measurement year
Members with evidence of ESRD or dialysis	Any time during the member's history on or prior to Dec. 31 of the measurement year
• Members 66-80 years of age as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: – Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). – Advanced Illness: Indicated by 1 of the following: o At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). o Dispensed dementia medication Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	• **Frailty** diagnoses must be in the measurement year and on different dates of service • **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year

*Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions.

Kidney Health Evaluation for Patients With Diabetes (KED) (cont.)

Tips and best practices to help close this care opportunity

- The American Diabetes Association (ADA) and National Kidney Foundation (NKF) guidelines recommend annual kidney health evaluation for patients with diabetes
- Advise members that some complications from diabetes may be asymptomatic. For example, kidney disease is asymptomatic in its earliest stages and routine testing, and diagnoses may help prevent/delay some life-threatening complications.
- Create automatic flags in EHR to alert staff to know when members are due for screenings. Use EHR to send text reminders that labs are due. Educate and remind members of the importance and rationale behind having these labs completed annually.
- Provide education to members about the disease process to help increase health literacy and improve management of the health condition
- Foster a PCP-specialist collaboration to ensure labs are completed annually and to prevent duplicate labs or non-compliance
- Order and request labs to have members complete prior to appointment to allow results to be available for discussion on the day of the office visit
- Track and reach out to members who have missed appointments

Transitions of Care - TRC- NIA

Notification of Inpatient Admission

New for 2026

- No applicable changes for this measure

Definition

For members ages 18 and older, percentage of acute or non-acute inpatient discharges on or between Jan. 1—Dec. 1 of the measurement year with a notification of inpatient admission documented the day of or 2 days after the admission (3 days total).

Required Exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members who died	Any time during the measurement year

Transitions of Care - TRCNIA -Notification of Inpatient Admission (cont.)

Important Notes

Measure Notes	Test, Service or procedure to close care opportunity	Medical Record Detail including but not limited to
• Admission is defined as the date of the inpatient admission or the date of admission when an observation stay turns into an inpatient admission • Administrative data doesn't count toward the numerator for inpatient admission notification • Documentation that a care provider sent a member to the ED visit(s) that resulted in an inpatient admission does not meet compliance for the numerator • Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3total days)	Medical record documentation must be about the admission and can include record of a discussion or information transfer between the following: • Inpatient staff/care provider and the member's PCP or ongoing care provider • Emergency department (ED) facility and the member's PCP or ongoing care provider • A shared electronic medical record system and the member's PCP or ongoing care provider • The member's health plan and their PCP or ongoing care provider • Evidence that the information was integrated in the appropriate medical record and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after discharge (3 total days) meets criteria **OR** Medical Record documentation that: • The member's PCP or ongoing care provider admitted the member to the hospital • A specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider • The member's PCP or ongoing care provider ordered tests or treatments during the member's inpatient stay. • The PCP or ongoing care provider performed a readmission exam or received communication about a planned inpatient admission	• Health history and physical • Home health records • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes

Transitions of Care - TRC -MRP – Medication Reconciliation Post-Discharge

New for 2026

CMS Weight: .25
P4P Weight: .25

- No applicable changes for this measure

Definition

For members ages 18 and older, percentage with an acute or non-acute inpatient discharge on or between Jan. 1–Dec. 1 of the measurement year with medication reconciliation documented on the date of the discharge through 30 days after the discharge (31 days total).

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 40%	≥ 40% to <60%	≥ 60% to 74%	≥ 74% to < 87%	≥ 87%
P4P Thresholds	< 44%	≥ 44% to <56%	≥ 56% to <69%	≥ 69% to < 79%	≥ 79%

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Medication Reconciliation	
CPT®/CPT II	1111F, 99483, 99495, 99496, 99605, 99606
SNOMED	430193006, 428701000124107

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

Important Notes

Measure Notes	Test, Service or procedure to close care opportunity	Medical Record Detail including but not
• The Medication Reconciliation Post-Discharge numerator assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the Medication list documented in the medical record or the process used to document the most recent Medication list in the medical record. • Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse • A medication reconciliation performed without the member present meets compliance • Medication reconciliation must be completed on the date of discharge or 30 days afterward (continued on next page)	• Discharge medications and outpatient medications reconciled and documented in the outpatient medical record • Current medications and Medication list reviewed and documentation of any of the following: ○ Documentation in the discharge summary that states current and discharge medications were reconciled and filed in the outpatient medical record ○ Notation of current medications that also references discharge medications ○ Notation of current medications and that discharge medications were reconciled ○ Review of discharge Medication list and current Medication list on the same date of service ○ Notation if no medications were prescribed at discharge ○ Evidence the member was seen for a hospital post-discharge follow-up visit with evidence of medication reconciliation or review ○ Documentation and evidence the member was seen for post-discharge hospital follow-up indicating the provider was aware of the hospitalization or discharge	• Health history and physical • Home health records • Medication list • Progress notes • Skilled nursing facility minimum data set • (MDS) form • SOAP notes

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

Important Notes (cont.)

Measure Notes		Test, Service or procedure to close care opportunity
• Medication reconciliation can be documented if there is evidence that: ○ A member was seen for a post-discharge follow-up ○ Medication review or reconciliation was completed at the appointment • A Medication list must be present in the outpatient record to fully comply with the measure • Documentation of post-op/ surgery follow-up without a reference to hospitalization, admission or inpatient stay does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization • Medication reconciliation does not require the member to be present	• If the member is unable to communicate with provider, interaction between the member's caregiver and the provider meets numerator criteria • The numerator assesses if medication reconciliation post discharge occurred. It does not attempt to assess of the quality of the Medication list in the medical record or process used to document the most recent Medication list in the medical record. • The presence of a discharge summary alone in the outpatient medical record is not compliant for this measure component • Medication review of the home health agency outcome and assessment information set (OASIS) form without evidence of inpatient discharge and current medications reconciled is unacceptable • A provider signature is not required to meet the criteria. The printed provider name and credentials (i.e., prescribing practitioner, clinical pharmacist, or registered nurse) AND a documented reconciled/reviewed statement may be used as evidence that the appropriate provider performed the reconciliation, in place of an • actual signature.	• Licensed practical/ vocational nurse (LPN/ LVN) services alone do not meet the criteria. However, if these services were co-signed by one of the appropriate provider types within the correct time frame, this meets the criteria.

Transitions of Care - TRC- PE – Patient Engagement After Inpatient Discharge

New for 2026

- No applicable changes for this measure

CMS Weight: .25
P4P Weight: .25

Definition

For members ages 18 and older, percentage of acute or non-acute inpatient discharges on or between Jan. 1—Dec. 1 of the measurement year with engagement documented within 30 days of the discharge. Do not include patient engagement that happens on the day of discharge.

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

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 44%	≥ 44% to <56%	≥ 56% to 69%	≥ 69% to < 79%	≥ 79%
P4P Thresholds	< 44%	≥ 44% to <56%	≥ 56% to <69%	≥ 69% to < 79%	≥ 79%

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Outpatient visits	
CPT®/CPT II	99483, 99345, 99342, 99344, 99341, 99350, 99348, 99349, 99347, 99385, 99386, 99387, 99384, 99382, 99381, 99383, 99245, 99243, 99244, 99242, 99205, 99203, 99204, 99202, 99211, 99215, 99213, 99214, 99212, 99422, 99423, 99421, 99395, 99396, 99397, 99394, 99392, 99391, 99393, 99401, 99402, 99403, 99404, 99411, 99412, 98971, 98972, 98970, 99458, 99457, 98981, 98980, 98967, 98968, 98966, 99442, 99443, 99441, 99429, 99456, 99455
HCPCS	G0439, G0438, G2252, G2012, G2251, T1015, G0463, G0402, G0071, G2250, G2010

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

Outpatient visits	
SNOMED	866149003, 444971000124105, 84251009, 77406008, 50357006, 281036007, 209099002, 90526000, 456201000124103, 3391000175108, 185464004, 86013001, 439740005, 386472008, 314849005, 185317003, 386473003, 401267002, 185463005, 185465003
UBREV	0511, 0983, 0521, 0517, 0523, 0510, 0520, 0522, 0514, 0519, 0529, 0982, 0515, 0513, 0516, 0526, 0528, 0527
Transitional care management	
CPT®/CPT II	99495, 99496

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members who died	Any time during the measurement year

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

Important Notes

Measure Notes	Test, Service or procedure to close care opportunity	Medical Record Detail including but not limited to
• Member engagement must be completed within 30 days of the discharge • Member engagement on the day of the discharge will not be compliant • If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria	Member engagement can include a: • Outpatient visit (e.g., in-home visit, office visit) • Telehealth visit: Must include real-time interaction with the care provider • E-visit or virtual check-in • Transitional care management	• Health history and physical • Home health records • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes

Transitions of Care - TRC - RDI – Receipt of Discharge Information

New for 2026

- No applicable changes for this measure

Definition

For members ages 18 and older, percentage of acute or non-acute inpatient discharges on or between Jan. 1—Dec. 1 of the measurement year with a receipt of discharge information documented the day of or 2 days after the discharge (3 days total).

Important Notes

Measure Notes	Test, Service or procedure to close care opportunity	Medical Record Detail including but not limited to
• Administrative data doesn't count toward the numerator for discharge notification • In a shared electronic medical record system, a received date is not necessary to meet • Compliance for this numerator. As long as the PCP or ongoing provider has access to the discharge information on the day of discharge or 2 days after discharge meets the intent of the measure • Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR	• Discharge information must include all of the following in the outpatient medical record: • The name of the care provider responsible for the member's care during the inpatient stay • Services or treatments provided during the inpatient stay • Diagnoses at discharge • Test results or documentation that either test results are pending or no test results • are pending • Instructions for patient care post discharge to the PCP or ongoing care provider • Current Medication list	• Discharge care plan • Discharge summary • Health history and physical • Home health records • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes

Osteoporosis Management in Women Who Had a Fracture (OMW)

New for 2026

• No applicable changes for this measure

CMS Weight: 1
P4P Weight: 1

Definition

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 6 months of the fracture (does not include fractures to the finger, toe, face or skull).

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 32%	≥ 32% to <41 %	≥ 41% to 53%	≥ 53% to < 68%	≥ 68%
P4P Thresholds	< 34%	≥ 34% to <42%	≥ 42% to <54%	≥ 54% to < 71%	≥ 71%

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Bone mineral density tests	
CPT®/CPT II	76977, 77078, 77080, 77081, 77085, 77086
ICD-10 Procedure	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
LOINC	100225-2, 101804-3, 101805-0, 104938-6, 24701-5, 24890-6, 24966-4, 38261-4,38262-2, 38263-0, 38264-8, 38265-5, 38266-3, 38267-1, 46278-8, 46279-6,46383-6, 80932-7, 80933-5, 80934-3, 80935-0, 80936-8, 80937-6, 80938-4,80939-2, 80940-0, 80941-8, 80942-6, 80943-4, 80944-2, 80945-9, 80946-7,80955-8, 80956-6, 83311-1, 85385-3, 85386-1, 85387-9, 85388-7, 85389-5, 85390-3, 85391-1, 85392-9, 85393-7, 85394-5
SNOMED	385342005, 391059003, 391060008, 391061007, 391064004, 391065003, 391066002, 391069009, 391070005, 391071009, 391075000, 391076004, 391078003, 391079006, 391080009, 391081008, 391082001, 440083004, 440099005, 440100002, 449781000, 707218004, 1345131002 385342005, 391059003, 391060008, 391061007, 391064004, 391065003, 391066002, 391069009, 391070005, 391071009, 391075000, 391076004,

Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)

Osteoporosis medication therapy	
HCPCS	J0897, J1740, J3110, J3111, J3489, Q5136
Long-acting osteoporosis medications (during inpatient stay only)	
HCPCS	J0897, J1740, J3489, Q5136

Dispensed at least 1 of the following osteoporosis medications within 180 days of their discharge for a fracture:

Drug category	Medications	
Bisphosphonates	• Alendronate • Alendronate-cholecalciferol • Ibandronate	• Risedronate • Zoledronic acid
Other agents	• Abaloparatide • Denosumab	• Raloxifene • Romosozumab • Teriparatide

Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members who died	Any time during the measurement year
Members receiving palliative care	During the intake period through the end of the measurement year
Members ages 81 and older as of Dec. 31 of the measurement year who had at least 2 diagnoses of frailty*	**Frailty** diagnoses must be on different dates of service during the intake period through the end of the measurement year
Members ages 67–80 as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: • Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). • Advanced Illness: Indicated by 1 of the following: – At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). – Dispensed dementia medication Donepezil, Donepezil-Memantine, Galantamine, Rivastigmine or Memantine	• Frailty diagnoses must be on 2 different dates of service during the intake period through the end of the measurement year • Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 67 and older as of Dec. 31 of the measurement year who are either: • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution*	Any time during the measurement year

Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)

Important Notes

Denominator Notes	Test, Service or procedure to close care opportunity	Medical Record Detail including but not limited to
• BMD test must take place within 6 months of the fracture • If the fracture resulted in an inpatient stay, a BMD test administered during the stay will close the care opportunity	BMD test	• Medication list • Progress notes
• Osteoporosis medication must be dispensed within 6 months of the fracture • Documentation that the medications aren't tolerated is not an exclusion for this measure	Osteoporosis medications identified through pharmacy data	

Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)

Tips and best practices to help close this care opportunity

- The post-fracture treatment period to close this care opportunity is only 6 months. Please see members for an office visit as soon as possible after an event occurs.
- Osteoporosis medication must be filled using a member's Part D prescription drug benefit
- Osteoporosis therapies are captured through medical claims
- To help prevent women from being included in this measure incorrectly, please check that fracture codes are used appropriately — and not before a fracture has been verified through diagnostic imaging. If a fracture code was submitted in error, please submit a corrected claim to fix the misdiagnosis and remove the member from this measure.
- A referral for a BMD will **not** close this care opportunity
- Women at risk for osteoporosis should be prescribed a bone density screening every 2 years. At-risk women include those who are:
  - At increased risk for falls or have a history of falls
  - Being monitored to assess their response to, or efficacy of, a Federal Drug Administration (FDA) -approved osteoporosis drug therapy regime
  - Diagnosed with primary hyperparathyroidism
  - Estrogen deficient
  - On long-term steroid therapy
- Bone density screening is a covered benefit for most benefit plans
- Best practice is to schedule a BMD at a time it is recommended and ordered, prior to the member leaving the clinic

Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)

Example:
Fracture date: March 2, 2026
Important note: The index episode start date (IESD) is the date you begin counting for the appropriate testing or treatment — IESD plus 180 days.

Scenario 1: Inpatient Hospital stay with no direct transfer Admission date: March 2, 2026
Discharge date with no direct transfer: March 4, 2026, IESD

Scenario 2: Inpatient Hospital stay with direct transfer
Admission date to second facility: March 3, 2026
Discharge date from second facility**:** March 8, 2026, IESD

Scenario 3: Outpatient or observation/emergency department (ED) visit date: March 6, 2026, IESD
Important note: This scenario assumes the member didn't go to a hospital on the day of their fall and/or wasn't admitted for inpatient stay.

Fracture date: March 2, 2026				
Fracture diagnosis setting	**IESD**	**Bone mineral density test**	**Osteoporosis therapy**	**Dispensed Rx to treat osteoporosis**
Scenario 1: Inpatient Hospital stay with no direct transfer	**Discharge date:** March 4, 2026	**During inpatient stay:** March 2–4, 2026 **On IESD or within 180 days after IESD:** March 4–Aug. 31, 2026	**During inpatient stay:** March 2–4, 2026 (long-acting osteoporosis medications only)	**On IESD or within 180 days after IESD:** March 4–Aug. 31, 2026

Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)

Fracture date: March 2, 2026				
Fracture diagnosis setting	**IESD**	**Bone mineral density test**	**Osteoporosis therapy**	**Dispensed Rx to treat osteoporosis**
Scenario 2: Inpatient Hospital stay with direct transfer	**Discharge date from second facility:** March 8, 2026	**During inpatient stay:** March 2–8, 2026 **On IESD or within 180 days after IESD:** March 8–Sept. 4, 2026	**During inpatient stay:** March 2–8, 2026 (long-acting osteoporosis medications only)	**On IESD or within 180 days after IESD:** March 8–Sept. 4, 2026
Scenario 3: Outpatient or observation/ ED visit	**Visit date:** March 6, 2026	**On IESD or within 180 days after IESD:** March 6–Sept. 2, 2026	**On IESD or within 180 days after IESD:** March 6–Sept. 2, 2026	**On IESD or within 180 days after IESD:** March 6–Sept. 2, 2026

Plan All-Cause Readmissions (PCR)

New for 2026

- Updated the measure definition

CMS Weight: 3
P4P Weight: 3

Definition

The risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays) for members ages 18 and older.

A lower rate indicates a better score for this measure.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	> 12%	≤ 12% to >10 %	≤ 10% to >9 %	≤ 9% to > 7%	≤7 %
P4P Thresholds	> 11%	≤ 11% to >9 %	≤ 9% to >8 %	≤ 8% to > 6%	≤6%

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services	Any time during the measurement year
• Member died during the inpatient stay • Members with a principal diagnosis of pregnancy on the discharge claim • Principal diagnosis of a condition originating in the perinatal period on the discharge claim • Acute hospitalizations where the discharge claims has a diagnosis for: – Chemotherapy maintenance – Principle diagnosis of rehabilitation – Organ transplant – Potentially planned procedure without a principal acute diagnosis	Jan. 1—Dec. 1 of the measurement year

Plan All-Cause Readmissions (PCR) (cont.)

Outlier exclusions — Removed from eligible population

Exclusion	Time frame
• Medicaid and Medicare members in the eligible population with 4 or more acute inpatient or observation stays	Jan. 1—Dec. 1 of the measurement year
• Commercial members in the eligible population with 3 or more acute inpatient or observation stays	Jan. 1—Dec. 1 of the measurement yea

Plan All-Cause Readmissions (PCR) (cont.)

Tips and best practices to help close this care opportunity

- The denominator for this measure is based on discharges and not members specifically
- An acute discharge can be from any type of facility, including behavioral health facilities
- Discharges are excluded if a direct transfer takes place after Dec. 1 of the measurement year
- Encourage members to engage in palliative care or hospice programs as appropriate to drive lower readmissions for high risk patients to reduce hospitalizations
- Please help members avoid readmission by:
  - Following up with them within 1 week of their discharge
  - Making sure they filled their new prescriptions post-discharge
  - Implementing a robust, safe discharge plan that includes a post-discharge phone call to discuss these questions:
    - Do you completely understand all the instructions you were given at discharge
    - Do you completely understand the medications and your medication instructions? Have you filled all your prescriptions?
    - Have you made your follow-up appointments? Do you need help scheduling them?
    - Do you have transportation to the appointment and/or do you need help arranging transportation?
    - Do you have any questions?
- A lower readmission rate and comprehensive diagnosis documentation will drive better scores for this measure
- Patients with multiple comorbidities are expected to return post inpatient or observation discharge at a higher rate. Ensure all suspect conditions are appropriately identified in the patient's medical record and claims.

Care for Older Adults (COA) – Functional status assessment

CMS Weight: 1
P4P Weight: 1

New for 2026

- No applicable changes for this measure

Definition

Percentage of adults 66 and older who had evidence of a Functional status assessment in the measurement year.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 87%	≥ 87% to <92 %	≥ 92% to <96 %	≥ 96% to < 99%	≥ 99%
P4P Thresholds	< 87%	≥ 87% to <92 %	≥ 92% to <96 %	≥ 96% to < 99%	≥ 99%

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Functional status assessment	
CPT®/CPT II	1170F, 99483
HCPCS	G0438, G0439
SNOMED	304492001, 3585880002

Required exclusions(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members who died	Any time during the measurement year

Care for Older Adults (COA) – Functional status assessment (cont.)

Important Notes

Measure Notes	Test, Service or Procedure to close opportunity	Medical Record Detail including
• Functional status assessment must occur within the measurement year • Functional status assessment conducted in an acute inpatient setting will not meet compliance • Telehealth visits are acceptable to meet this numerator	Standardized functional status assessment tool and results Assessment of Instrumental Activities of Daily Living (IADL) or at least 4 of the following assessed: • Chores, such as laundry • Cleaning/housework • Cooking/meal prep • Driving or using public transportation • Grocery shopping • Home repair • Paying bills or other financial tasks • Taking prescribed medications • Using a phone Activities of Daily Living (ADLs) or at least 5 of the following assessed: • Bathing • Dressing • Eating meals/snacks • Getting up and down from sitting or lying position • Using the restroom • Walking	• Functional status assessment forms • Health history and physical • Home health records • Occupational therapy notes • Physical therapy notes • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes

Care for Older Adults (COA) – Functional status assessment (cont.)

Tips and best practices to help close this care opportunity

- **Always clearly document the date of service of the Functional status assessment**
- A Functional status assessment done in an acute inpatient setting will **not** meet compliance
- A Functional status assessment limited to an acute or single condition, event or body system, such as lower back or leg, will **not** meet compliance
- The following notations will **not** meet compliance:
  - "Functional status reviewed" doesn't indicate that a complete Functional status assessment was performed
- Documentation of "normal motor/sensory" during an exam or a checked box next to "normal motor/sensory" on a neurological exam isn't enough evidence for a Functional status assessment
- A Functional status assessment may be conducted with the member in various manners (phone, in person, virtually, etc.) and is not limited to being completed by clinician
- Functional status assessments can be accepted as supplemental data, reducing the need for some chart review

Care for Older Adults (COA) – Medication Review

New for 2026

- No applicable changes for this measure

CMS Weight: 1
P4P Weight: 1

Definition

Percentage of adults ages 66 and older who had a Medication review by a clinical pharmacist or prescribing practitioner and the presence of a medication list in the medical record or transitional management services in the measurement year.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 58%	≥ 58% to <85 %	≥ 85% to <93 %	≥ 93% to < 98%	≥ 98%
P4P Thresholds	< 58%	≥ 58% to <85%	≥ 85% to <93%	≥ 93% to < 98%	≥ 98%

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Medication list	
CPT®/CPT II	1159F This code (Medication list documented) must be submitted with 1160F (review of all medications by a prescribing practitioner or clinical pharmacist documented) on the same date of service.
HCPCS	G8427
SNOMED	428191000124101, 432311000124109 Submission of either code **must** also be submitted with one of the SNOMED codes listed for medication review on the same date of service

Medication review	
CPT®/CPT II	99605, 99606, 90863, 99483, 1160F(This code (1160F - review of all medications by a prescribing practitioner or clinical pharmacist documented) must also be submitted with 1159F (Medication list documented) on the same date of service)
SNOMED	719327002, 719328007, 719329004, 461651000124104 Submission of either code **must** also be submitted with one of the SNOMED codes listed for medication review on the same date of service

Care for Older Adults (COA) – Medication Review (cont.)

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Transitional care management	
CPT®/CPT II	99495, 99496

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members who died	Any time during the measurement year

Care for Older Adults (COA) – Medication Review (cont.)

Important Notes

Measure Notes	Test, Service or procedure to close care opportunity	Medical Record Detail Including, but not Limited to
• Medication list must be included in the medical record and Medication review must be completed by a prescribing provider or clinical pharmacist • A medication list, signed and dated during the measurement year by the appropriate practitioner type — prescribing practitioner or clinical pharmacist – meets compliance • A notation within the record that the medications were reviewed. If a notation is included, the signature is not needed. • Documentation that the medications aren't tolerated isn't an exclusion for this measure • A review of side effects for a single medication at the time of prescription alone does not meet compliance. • Medication review conducted in an acute inpatient setting will not meet compliance • Practitioner is not required to be the member's primary or ongoing care provider; any provider meeting the requirement of prescribing practitioner or clinical pharmacist can complete the medication review	• Medication list **and** medication review **or** dated clinician's note that says the member is **not** taking medications	• Health history and physical • Medication list • Progress notes • SOAP notes

Care for Older Adults (COA) – Medication Review (cont.)

Tips and best practices to help close this care opportunity

- **Always clearly document the date of service of the medication review or notation of no medications**
- A medication review conducted in an acute inpatient setting will **not** meet compliance
- A medication review may be conducted with a member over the phone if the clinician is a prescriber or clinical pharmacist. A registered nurse can collect the list of current medications from the member during the call, but there must be evidence that the appropriate practitioner reviewed the list.
  - For example: An electronic signature with credentials on the medication list
- The medication review must include all of the member's medications, including prescription and over-the-counter medications and herbal or supplemental therapies
- A medication list signed and dated within the measurement year by the prescribing practitioner or clinical pharmacist meets the criteria
  - The practitioner's signature along with a medication list in the member's chart is considered evidence that the medications were reviewed
  - A review of side effects for a single medication at the time of prescription alone will not meet compliance

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

New for 2026

- No applicable changes for this measure

CMS Weight: 1
P4P Weight: Info.

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.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 50%	≥ 50% to <59 %	≥ 59% to <67 %	≥ 67% to < 78%	≥ 78%
P4P Thresholds	< 55%	≥ 55% to <62 %	≥ 62% to <69 %	≥ 69% to < 80%	≥ 80%

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 1: Outpatient and telehealth visits	
CPT®/CPT II	98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99455, 99456, 99457, 99458
HCPCS	G0439, G0438, G2252, G2012, G2251, T1015, G0463, G0402, G0071, G2250, G2010
SNOMED	866149003, 444971000124105, 84251009, 77406008, 50357006, 281036007, 209099002, 90526000, 456201000124103, 3391000175108, 185464004, 86013001, 439740005, 386472008, 314849005, 185317003, 386473003, 401267002, 185463005, 185465003

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) (cont.)

Scenario 1: Outpatient and telehealth visits	
UBREV	0511, 0983, 0521, 0517, 0523, 0510, 0520, 0522, 0514, 0519, 0529, 0982, 0515, 0513, 0516, 0526, 0528, 0527
Scenario 2: Transitional care management	
CPT®/CPT II	99495, 99496
Scenario 3: Case management visits	
CPT®/CPT II	99366
HCPCS	T1016, T2022, T1017, T2023
SNOMED	386230005, 425604002, 416341003
Scenario 4: Complex care management	
CPT®/CPT II	99439, 99487, 99489, 99490, 99491
HCPCS	G0506
Scenario 5: Outpatient or telehealth behavioral health visit	
CPT®/CPT II	90847, 90853, 99238, 99239, 90875, 90876, 99223, 99222, 99221, 99255, 99253, 99254, 99252, 90849, 90791, 90792, 90845, 90840, 90839, 90832, 90833, 90834, 90836, 90837, 90838, 99233, 99232, 99231

AND

Place of service code

Code	Location		
03	School	**17**	Walk-in retail health clinic
05	Indian Health Service free-standing facility	**18**	Place of employment – worksite
07	Tribal 638 free-standing facility	**19**	Off-campus outpatient hospital

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) (cont.)

Code	Location		
09	Prison/correctional facility	**20**	Urgent care facility
11	Office	**22**	On-campus outpatient hospital
12	Home	**33**	Custodial care facility
13	Assisted living facility	**49**	Independent clinic
14	Group home	**50**	Federally qualified health center
15	Mobile unit	**71**	Public health clinic
16	temporary lodging	**72**	Rural health clinic

Scenario 6: Outpatient or telehealth behavioral health visit	
CPT®/CPT II	98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 99483, 98961, 98962, 98960, 99345, 99342, 99344, 99341, 99350, 99348, 99349, 99347, 99510, 99385, 99386, 99387, 99384, 99382, 99381, 99383, 99494, 99492, 99245, 99243, 99244, 99242, 99205, 99203, 99204, 99202, 99211, 99215, 99213, 99214, 99212, 99395, 99396, 99397, 99394, 99392, 99391, 99393, 99078, 99401, 99402, 99403, 99404, 99411, 99412, 99493
HCPCS	G0176, H0040, H0039, H0004, H0002, T1015, H0037, H0036, H2015, H2016, H2010, H2000, H2011, G0463, H0034, H0031, H2013, H2017, H2018, G0512, G0155, H2014, G0409, H2019, H2020, G0177, G0560
SNOMED	866149003, 444971000124105, 84251009, 77406008, 50357006, 281036007, 209099002, 90526000, 456201000124103, 391261003, 391257009, 391260002, 391225008, 391223001, 391224007, 3391000175108, 185464004, 86013001, 439740005, 391242002, 391237005, 391239008, 391233009, 185463005, 185465003
UBREV	0904, 0917, 0983, 0521, 0517, 0523, 0916, 0510, 0520, 0900, 0915, 0522, 0914, 0902, 0919, 0519, 0529, 0982, 0515, 0903, 0513, 0911, 0516, 0526, 0528, 0527

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) (cont.)

Scenario 7: Intensive outpatient encounter or partial hospitalization	
CPT®/CPT II	90847, 90853, 99238, 99239, 90875, 90876, 99223, 99222, 99221, 99255, 99253, 99254, 99252, 90849, 90791, 90792, 90845, 90840, 90839, 90832, 90833, 90834, 90836, 90837, 90838, 99233, 99232, 99231

AND

Place of service code

Code	Location
52	Psychiatric facility – partial hospitalization

Scenario 8: Intensive outpatient encounter or partial hospitalization	
HCPCS	H2012, S9485, S9484, G0410, S9480, G0411, H0035, S0201, H2001
SNOMED	305347001, 305345009, 305346005, 391048007, 391046006, 391047002, 391188004, 391187009, 391186000, 391185001, 391054008, 391038005, 391170007, 391153004, 391152009, 391150001, 391151002, 391195008, 391194007, 391191004, 391192006, 391211007, 391210008, 391209003, 391207001, 391208006, 391056005, 391133003, 391055009, 391256000, 391255001, 391252003, 391254002, 391042008, 391043003, 7133001, 391232004, 391228005, 391229002
UBREV	0905, 0907, 0912, 0913

Scenario 9: Community mental health center visit	
CPT®/CPT II	90847, 90853, 99238, 99239, 90875, 90876, 99223, 99222, 99221, 99255, 99253, 99254, 99252, 90849, 90791, 90792, 90845, 90840, 90839, 90832, 90833, 90834, 90836, 90837, 90838, 99233, 99232, 99231

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) (cont.)

AND

Place of service code

Code	Location
53	Community mental health center

Scenario 10:
Electroconvulsive therapy with any provider type and with appropriate place of service code

Electroconvulsive therapy	
CPT®/CPT II	90870
ICD-10 Procedure	GZB0ZZZ, GZB2ZZZ, GZB4ZZZ
SNOMED	284468008, 23835007, 10470002, 313019002, 1010696002, 231079005, 231080008, 1010697006, 11075005, 313020008

AND

Place of service code

Code	Location		
03	School	**19**	Off-campus outpatient hospital
05	Indian Health Service free-standing facility	**20**	Urgent care facility
07	Tribal 638 free-standing facility	**22**	On-campus outpatient hospital
09	Prison/correctional facility	**24**	Ambulatory surgical center
11	Office	**33**	Custodial care facility
12	Home	**49**	Independent clinic
13	Assisted living facility	**50**	Federally qualified health center

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) (cont.)

Code	Location		
14	Group home	**52**	Psychiatric facility – partial hospitalization
15	Mobile unit	**53**	Community mental health center
16	Temporary lodging	**71**	Public health clinic
17	Walk-in retail health clinic	**72**	Rural health clinic
18	Place of employment – worksite		

Scenario 11: Telehealth visit with any provider type and the appropriate place of service code

Visit setting unspecified

CPT®/CPT II	90847, 90853, 99238, 99239, 90875, 90876, 99223, 99222, 99221, 99255, 99253, 99254, 99252, 90849, 90791, 90792, 90845, 90840, 90839, 90832, 90833, 90834, 90836, 90837, 90838, 99233, 99232, 99231

AND

Place of service code

Code	Location
02	Telehealth
10	Telehealth

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) (cont.)

Scenario 12: Substance use disorder services	
CPT®/CPT II	99408, 99409
HCPCS	H0001, H0022, H0050, H0007, H0005, H0015, H0016, H0047, H2036, H2035, G0396, G0397, T1006, T1012, G0443
SNOMED	827094004, 720175009, 707166002, 20093000, 720176005, 713127001, 370776007, 428211000124100, 711008001, 445662007, 774091000, 763302001, 450760003, 774090004, 445628007, 763104007, 704182008, 772813001, 865964007, 763233002, 87106005, 23915005, 182969009, 64297001, 67516001, 266707007, 792901003, 792902005, 310653000, 414054004, 414056002, 61480009, 720174008, 56876005, 720177001, 414283008, 414501008, 713107002, 713106006, 370854007, 415662004, 385989002, 386449006, 386450006, 386451005
UBREV	0906, 0944, 0945
Scenario 13: Substance abuse counseling and surveillance	
ICD-10 Diagnosis	Z71.41, Z71.51 (do not include lab claims (claims with POS 81))

Required exclusion(s)

Exclusion	Time frame
• Members in or using hospice services • Members who died	Any time during the measurement year

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) (cont.)

Tips and best practices to help close this care opportunity

- This measure focuses on follow up after an ED visit: See patients within 7 days
- If a situation arises where a patient is unable to be seen within7 days, then they need to have an appointment within 30 days of discharge
- Please use Practice Assist, POCA or Reports to identify members with 2 or more eligible chronic conditions and history of ED visits; increase engagement with patients with multiple chronic conditions to avoid unnecessary ED visits
- Provide patients with alternative options to ED locations including urgent care, telehealth or in-person office visits
- Remind patients to schedule an office visit or telehealth follow-up within 7 days post ED visit as a way to ensure all patients are engaged
- Encourage the use of telehealth appointments when appropriate
- If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the number on the back of the patient's health plan ID card or search liveandworkwell.com

Statin Therapy for Patients With Cardiovascular Disease (SPC-E)

New for

Added

- Added to the SPC inclusion section criteria to identify persons with ASCVD diagnosis, and expanded ASCVD diagnosis criteria to allow diagnosis in the measurement period or the year prior to the measurement period

Updated

- SPC will now only be referred to as SPC-E and will be an electronic measure only

Removed

- Removed required exclusion for persons enrolled in an I-SNP or LTI
- Removed sex specific age bands

Definition

- Percentage of members ages 21–75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:
  - Received statin therapy: Members who were dispensed at least 1 high- or moderate-intensity statin medication during the measurement year
  - Statin adherence 80%: Members who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period
  - **Note**: This adherence component does NOT apply to CMS Star Ratings for Medicare members; only the "Received statin therapy" component is required to be compliant for the SPC Star Measure
  - **Important note:** The treatment period is defined as the earliest prescription dispensing date in the measurement year for any statin medication of at least moderate intensity through the last day of the measurement year.

Statin Therapy for Patients With Cardiovascular Disease (SPC-E) (cont.)

SPC inclusion (event, diagnosis or both)

Event	Time frame of event or diagnosis
• Myocardial infraction (MI) • Coronary artery bypass graft (CABG) • Percutaneous coronary intervention (PCI) • Other revascularization	Year prior to the measurement year

Diagnosis	Time frame of event or diagnosis
• Ischemic vascular disease (IVD) • At least 2 diagnoses of ASCVD on different dates of service	Both measurement year and year prior to the measurement year

Medications

To comply with this measure, 1 of the following medications must have been dispensed:

Drug category	Medications	
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	• Pravastatin 40–80 mg • Lovastatin 40-60 mg • Fluvastatin 40–80 mg • Pitavastatin 1–4 mg

Statin Therapy for Patients With Cardiovascular Disease (SPC-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members who died • Members receiving palliative care: Z51.5 • Myalgia, myositis, myopathy or rhabdomyolysis diagnosis: 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, M79.10, M79.11, M79.12, M79.18	Any time during the measurement year
• Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81 • Dispensed at least 1 prescription for clomiphene • End-stage renal disease (ESRD): N18.5, N18.6, Z99.2 • Dialysis: 90935, 90937, 90945, 90947, 90997, 90999, 99512 • Members with a diagnosis of pregnancy: O00.101, O99.019, O99.210, O99.340, O99.810, O99.820, Z33.1, Z34.00, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93 • In vitro fertilization	Any time during the measurement year or the year prior to the measurement year
• Myalgia or rhabdomyolysis caused by a statin: 16524291000119105, 16524331000119104, 16462851000119106, 787206005	Any time during the member's history through Dec. 31 of the measurement year

Statin Therapy for Patients With Cardiovascular Disease (SPC-E) (cont.)

Required exclusion(s) (cont.)

Exclusion	Time frame
Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: • Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81) • Advanced Illness: Indicated by 1 of the following: – At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). – Dispensed dementia medication donepezil, donepezil-memantine, galantamine, rivastigmine or memantine	• **Frailty** diagnoses must be in the measurement year and on different dates of service • **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year

Statin Therapy for Patients With Cardiovascular Disease (SPC-E) (cont.)

Unstructured data for SPC-E measure:

Practice Assist allows practices to upload unstructured data to close measure gaps for the Statin Therapy for Patients With Cardiovascular Disease (SPC) measure.

Upload to Practice Assist

1. Access Practice Assist by signing in to the UnitedHealthcare Provider Portal
2. Go to **Medication Adherence** in care opportunities
3. Find the patient and click **Manage Patient**
4. Go to the **Please upload supporting documentation field** and upload the document
5. *Click Select Care Opportunities and check Statin Therapy for Patients with Cardiovascular Disease*
6. Save and submit

Statin Therapy for Patients With Cardiovascular Disease (SPC-E) (cont.)

Tips and best practices to help close the "Received Statin Therapy" care opportunity for UnitedHealthcare Medicare Advantage Plan members.

- Log on to Practice Assist to review members with open care opportunities
  - Select **Medication Adherence** to view your patient list
  - Members without a high- or moderate-intensity statin fill this year will be marked with a "Gap" under the SPC measure
- Importance of taking a statin: American Heart Association (AHA) and American College of Cardiology (ACC) suggest people with clinical atherosclerotic cardiovascular disease (ASCVD) take a high-intensity statin therapy or maximally tolerated statin therapy. Statins can reduce the risk of heart attack and stroke, even in patients who do not have high cholesterol. Meta-analysis with 5 randomized controlled trials have shown that high-intensity statins reduced major vascular events by 15% compared with moderate-intensity statin therapy in patients with clinical ascvd.[2] According to AHA/ACC, the larger the LDL-C reduction, the larger proportional reduction in major vascular events.
- If member has intolerance or side effects such as myalgias, if clinically
  - A different statin that is hydrophilic (e.g., rosuvastatin or pravastatin)
  - A lower dose such as a moderate- intensity dose statin than previously tried
  - Reducing the frequency
- For members who meet exclusion criteria, a claim using appropriate ICD-10 code must be submitted ANNUALLY if applicable
  - Only statins satisfy the measure; other cholesterol medications suchas ezetimibe or PCSK9 inhibitors do not satisfy the measure
- Consider extended day fills (e.g., 90- or 100- day supply) or send to home delivery
- Consider prescribing a high- or moderate-intensity statin, as appropriate. If you determine medication is appropriate, please send a prescription to the member's preferred pharmacy.
  - To close the SPC care opportunity, a member must use their Part D insurance card to fill 1 of the statins or statin combinations in the strengths/doses listed in the "Medications" table on the previous page by the end of the measurement year.
- Prescriptions filled through cash claims, discount programs (such as GoodRx), and medication samples will not close the measure

Concurrent Use of Opioids and Benzodiazepines (COB)

New for 2026

- No applicable changes for this measure

CMS Weight: 1
P4P Weight: Info.

Definition

Percentage of Medicare Part D beneficiaries ages 18 and older (as of Jan. 1, 2025) with concurrent use of prescription opioids and benzodiazepines.

Note: Lower rates represent better performance.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
P4P Thresholds	> 19%	≤ 19% to >15 %	≤ 15% to >11 %	≤ 11% to > 7%	≤7 %

Eligible population criteria

Members with 2 or more prescriptions claims for opioids on different dates of service with ≥ 15 cumulative days' supply during the measurement year. The Index Prescription Start Date (IPSD) or date of first fill must be ≥ 30 days from the last day of the measurement year (i.e., between Jan. 1 through Dec. 2).

- Claims can be for the same or different opioids
- For multiple opioid claims with the same date of service, use the longest days' supply
- For multiple opioid claims with different dates of service, sum the days' supply for all the prescription claims

Numerator criteria

The number of members from the eligible population with:

- ≥ 2 prescription claims for any benzodiazepine with different dates of service

AND

- Concurrent use of opioids and benzodiazepines for ≥ 30 cumulative days during the measurement period

Concurrent Use of Opioids and Benzodiazepines (COB) (cont.)

Compliance

To be compliant with this measure, concurrent use of opioids and benzodiazepines must be avoided or limited to less than 30 cumulative overlapping days during the measurement period.

Drug classes

Drug class	Medication		
Opioids	Benzhydrocodone Buprenorphine Butorphanol Codeine Dihydrocodeine Fentanyl	Hydrocodone Hydromorphone Levorphanol Meperidine Methadone Morphine	Opium Oxycodone Oxymorphone Pentazocine Tapentadol Tramadol
Benzodiazepines	Alprazolam Chlordiazepoxide Clobazam Clonazepam Clorazepate	Diazepam Estazolam Flurazepam Lorazepam Midazolam	Oxazepam Quazepam Temazepam Triazolam

Note: Includes combination products. Excludes injectable formulations, sublingual sufentanil (used in supervised setting) and single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine Implant kit subcutaneous implant and all buprenorphine/naloxone combination products).

Concurrent Use of Opioids and Benzodiazepines (COB) (cont.)

Exclusion(s)

Exclusion	Time frame
• Members with at least 1 day of hospice coverage • Members diagnosed with cancer • Members diagnosed with Sickle Cell Disease – Sickle Cell ICD_10 code list: D57.00, D57.01, D57.02, D57.03, D57.04, D57.09, D57.1, D57.20, D57.211, D57.212, D57.213, D57.214, D57.218, D57.219, D57.40, D57.411, D57.412, D57.413, D57.414, D57.418, D57.419, D57.42, D57.431, D57.432, D57.433, D57.434, D57.438, D57.439, D57.44, D57.451, D57.452, D57.453, D57.454, D57.458, D57.459, D57.80, D57.811, D57.812, D57.813, D57.814, D57.818, D57.819 • Members diagnosed with palliative care – Palliative care ICD_10 code: Z51.5 • Members diagnosed with cancer-related pain treatment - Cancer-related pain ICD_10 code: G89.3	Any time during the measurement year

Concurrent Use of Opioids and Benzodiazepines (COB) (cont.)

Tips and best practices to help close this care opportunity

- Avoid prescribing a benzodiazepine to a patient already taking an opioid
- Evaluate concurrent use of benzodiazepine and opioids and consider discontinuing one of the medications or using alternative therapy as appropriate; keep in mind a gradual tapering of the medication may be needed
- Educate patients about the risks of taking opioids and benzodiazepines concurrently
- Help patients explore alternative methods for managing pain
- Coordinate care with all of the patient's treating providers to avoid co-prescriptions
- Identify at-risk members using UnitedHealthcare reporting tools
- Consider leveraging provider practice EMR system to assist with identifying at-risk members, avoiding co-prescribing that could lead to concurrent use, limiting/reducing default quantifies and refills
- CMS offers 5 central principles for co-prescribing benzos and opioids:
  - Avoid initial combination by offering alternative approaches
  - If new prescriptions are needed, limit the dose and duration
  - Taper long-standing medications gradually, and discontinue whenever possible
  - Continue long-term co-prescribing only when necessary and monitor closely
  - Provide rescue medication (e.g., naloxone) to high-risk patients and their caregivers

Additional resources

For additional tips and best practices to close this care opportunity, please refer to these 3rd-party resources:

- *CDC.gov: CDC Clinical Practice Guideline for Prescribing Opioids for Pain*
- *Journal of General Internal Medicine: Joint Clinical Practice Guideline on Benzodiazepine Tapering: Considerations When Risks Outweigh Benefits*
- *CMS.gov: Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines*

Concurrent Use of Opioids and Benzodiazepines (COB) (cont.)

COB measure medications and potentially safer alternatives

The Centers for Medicaid and Medicare Services (CMS) has a new Part D measure that focuses on concurrent use of medications that are deemed a serious safety concern. The measure is Concurrent Use of Opioids and Benzodiazepines (COB).

Refer to the following chart for potentially safer alternatives to consider when evaluating drug therapy for your patients who are on concurrent therapy of opioids and benzodiazepines.

Measure name	Therapeutic class	Measure medications	Common indications	Potential alternatives* (if clinically appropriate)
COB opioids and benzodiazepines	Opioids	Benzhydrocodone, buprenorphine, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol	Pain	Acetaminophen, ibuprofen, naproxen, topical analgesics Nonpharmacologic alternatives: Ice, heat, elevation, rest, immobilization, exercise, physical therapy, acupuncture, chiropractic, meditation, cognitive therapy
COB opioids and benzodiazepines	Benzodiazepines	Alprazolam, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, estazolam, flurazepam, lorazepam, midazolam, oxazepam, quazepam, temazepam, triazolam	Insomnia	Trazodone, melatonin (OTC) Nonpharmacological treatment: Sleep hygiene, cognitive behavioral therapy
			Anxiety	Buspirone Nonpharmacological treatment: Cognitive behavioral therapy

Medication Adherence for Cholesterol (MAC)

New for 2026

Updated

CMS Weight: 1
P4P Weight: 3

- MAC will be single-weighted for MY 2026 per CMS Technical Notes (triple-weighting will resume in MY 2027)
- This measure will be risk adjusted for age, sex, LIS/DSNP, disabled
- This measure is no longer adjusted for Inpatient (IP) and Skilled Nursing Facility (SNF) stays

Definition

Percentage of members ages 18 and older who adhere to their cholesterol (statin) medication at least 80% of the time in the measurement period.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 84%	≥ 84% to <88%	≥ 88% to 90%	≥ 90% to < 93%	≥ 93%
P4P Thresholds	< 85%	≥ 85% to <89%	≥ 89% to <91%	≥ 91% to < 94%	≥ 94%

Compliance

To comply with this measure, a member must have a proportion of days covered (PDC) of 80% or higher for their statin medication in the measurement period.

Exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • End Stage Renal Disease (ESRD): I20.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 • Dialysis	Any time during the measurement year

Medication Adherence for Cholesterol (MAC) (cont.)

Tips and best practices to help close this care opportunity

- Improve health literacy. Talk with members about why they're on a statin medication, and how it's important to take their medication as prescribed and get timely refills.
- Assess adherence barriers. Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- Discuss continued therapy. If ongoing therapy is appropriate, talk with members about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
- Consider extended days' supply prescriptions. When clinically appropriate, consider writing 3-month supplies for prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue.
    - o For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill
    - – For members who qualified for the measure denominator:
        - o Pay attention to allowable days remaining and days of therapy missed year-to-date (YTD) in your PCOR or in Practice Assist. Members should have a zero or greater allowable days remaining (ADR) at the end of the measurement period.
    - – Members can't achieve 80%Proportion of Days covered (PDC) when the allowable days is less than zero. ADR must be zero or higher for a member to be adherent.
- Prescribe low-cost generics. When clinically appropriate, prescribe low-cost generic medications to help reduce out-of-pocket costs. For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Confirm instructions. Check that the directions on members' prescriptions match your instructions. If the dose or frequency is changed
- Use prescription benefit at the pharmacy. Only prescription fills processed with a member's health plan ID card can be used to measure a member's adherence to their medication.
- Stay organized. Encourage members to use a pillbox to keep organized and to set an alarm on their phone or clock as a reminder to take their medication.
- Join a reminder program. Ask members to sign up for a refill reminder program at their pharmacy, if available.

Medication Adherence for Diabetes Medications (MAD)

New for 2026

CMS Weight: 1
P4P Weight: 3

Updated

- MAD will be single-weighted for MY 2026 per CMS Technical Notes (triple-weighting will resume in MY 2027)
- This measure will be risk adjusted for age, sex, LIS/DSNP, disabled
- This measure is no longer adjusted for Inpatient (IP) and Skilled Nursing Facility (SNF) stays

Definition

Percentage of members ages 18 or older who are adherent to their diabetes medications at least 80% of the time in the measurement period.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 83%	≥ 83% to <86%	≥ 86% to 89%	≥ 89% to < 92%	≥ 92%
P4P Thresholds	< 84%	≥ 84% to <87%	≥ 87% to <90%	≥ 90% to < 93%	≥ 93%

Compliance

To comply with this measure, a member* must have a proportion of days covered (PDC) of 80% or higher for their diabetes medication(s) in the measurement period. These classes of diabetes medications are included in this measure:

- Biguanides
- DPP-4 inhibitors
- GLP-1 receptor agonists
- Meglitinides
- SGLT2 inhibitors
- Sulfonylureas
- Thiazolidinediones

*Members who take insulin using their Part D benefit are not included in this measure

Exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • End Stage Renal Disease (ESRD): I20.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 • Dialysis	Any time during the measurement year
• One or more prescription claim for insulin with their Part D benefit	Any time during the treatment period

Medication Adherence for Diabetes Medications (MAD) (cont.)

Tips and best practices to help close this care opportunity

- Improve health literacy. Talk with members about why they're on a diabetic medication, and how it's important to take their medication as prescribed and get timely refills.
- Consider extended days' supply prescriptions. When clinically appropriate, consider writing a 3-month supply of prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue
- For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Prescribe low-cost generics. When clinically appropriate, prescribe low-cost generic medications to help reduce out-of-pocket costs. For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Members can't achieve 80% Proportion of Days covered (PDC) when the allowable days is less than zero. ADR must be zero or higher for a member to be adherent.
- Assess adherence barriers. Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- Discuss continued therapy. If ongoing therapy is appropriate, talk with members about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
  - Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill
  - For members who qualified for the measure denominator:
- Pay attention to allowable days remaining and days of therapy missed year-to-date (YTD) in your PCOR or in Practice Assist. Members should have zero or greater allowable days remaining (ADR) at the end of the measurement period
- Confirm instructions. Check that the directions on members' prescriptions match your instructions. If the dose or frequency is changed, please void the old prescription and send a new one to the member's pharmacy.

Medication Adherence for Hypertension (RAS Antagonists) (MAH)

New for 2026

CMS Weight: 1
P4P Weight: 3

- MAH will be single-weighted for MY 2026 per CMS Technical Notes (triple-weighting will resume in MY 2027)
- This measure will be risk adjusted for age, sex, LIS/DSNP, disabled
- This measure is no longer adjusted for Inpatient (IP) and Skilled Nursing Facility (SNF) stays

Definition

Percentage of members ages 18 or older who adhere to their hypertension (RAS antagonist) medication at least 80% of the time in the measurement period.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 84%	≥ 84% to <88%	≥ 88% to 91%	≥ 91% to < 93%	≥ 93%
P4P Thresholds	< 85%	≥ 85% to <89%	≥ 89% to <92%	≥ 92% to < 94%	≥ 94%

Compliance

- To comply with this measure, a member* must have a proportion of days covered (PDC) of 80% or higher for their hypertension (RAS antagonist) medication in the measurement period. RAS antagonist medications include:
- Angiotensin II receptor blockers (ARBs)
- Angiotensin-converting enzyme (ACE) inhibitors
- Direct renin inhibitors

Exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • End Stage Renal Disease (ESRD): I20.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 • Dialysis	Any time during the measurement year
• One or more prescription claim for sacubitril/valsartan (Entresto) with their Part D benefit	Any time during the treatment period

Medication Adherence for Hypertension (RAS Antagonists) (MAH) (cont.)

Tips and best practices to help close this care opportunity

- Improve health literacy. Talk with members about why they're on a diabetic medication, and how it's important to take their medication as prescribed and get timely refills.
- Consider extended days' supply prescriptions. When clinically appropriate, consider writing a 3-month supply of prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue
  - o For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Prescribe low-cost generics. When clinically appropriate, prescribe low-cost generic medications to help reduce out-of-pocket costs. For some health plans, members have $0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have $0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Members can't achieve 80% Proportion of Days covered (PDC) when the allowable days is less than zero. ADR must be zero or higher for a member to be adherent.
- Assess adherence barriers. Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- Discuss continued therapy. If ongoing therapy is appropriate, talk with members about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
  - – Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill
  - – For members who qualified for the measure denominator:
- Pay attention to allowable days remaining and days of therapy missed year-to-date (YTD) in your PCOR or in Practice Assist. Members should have zero or greater allowable days remaining (ADR) at the end of the measurement period
- Confirm instructions. Check that the directions on members' prescriptions match your instructions. If the dose or frequency is changed, please void the old prescription and send a new one to the member's pharmacy

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

New for 2026

CMS Weight: 1
P4P Weight: Info.

- No applicable changes for this measure

Definition

The percentage of Medicare Part D beneficiaries ages 65 and older (as of Jan. 1, 2026) with concurrent use of 2 or more unique (different active ingredient) anticholinergic (ACH) medications. Includes members with at least 2 fills of each medication on different dates of service in the targeted drug class during the measurement period. Concurrent use is defined as overlapping days' supply for at least 30 cumulative days during the measurement period.

Note: Lower rates represent better performance.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
P4P Thresholds	> 13%	≤ 13% to >9%	≤ 9% to >7 %	≤ 7% to > 4%	≤4 %

Eligible population criteria

Members with ≥ 2 prescriptions claim for the same anticholinergic medication (same active ingredient) on different dates of service in 2025. Members are not included in the denominator if:

- Continuous enrollment criteria is not met (no more than 1 gap in enrollment of up to 31 days during the measurement year)
- Earliest date of service for any target medication claim is < 30 days from the end of 2025 (Jan. 1 through Dec. 2)

Numerator criteria

The number of patients from the eligible population with:

- ≥ 2 unique ACH medications (different active ingredients) with each ACH medication having ≥ 2 prescription claims on different dates of service during 2025

AND

- Concurrent use (overlapping days' supply for ≥ 2 unique ACH medications) for ≥ 30 cumulative days during the measurement year

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Compliance

To be compliant with this measure, concurrent use of 2 or more anticholinergics must be avoided or if necessary limited to less than 30 days during the measurement year

Drug classes

Drug class	Medication		
Antihistamines	• Brompheniramine • Chlorpheniramine • Cyproheptadine	• Dimenhydrinate • Diphenhydramine (oral) • Doxylamine	• Hydroxyzine • Meclizine • Triprolidine
Antiparkinsonian Agents	• Benztropine	• Trihexyphenidyl	
Skeletal Muscle Relaxants	• Cyclobenzaprine	• Orphenadrine	
Antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (> 6 mg/day) • Imipramine	• Nortriptyline • Paroxetine
Antimuscarinic (urinary incontinence)	• Darifenacin • Fesoterodine • Flavoxate	• Oxybutynin • Solifenacin • Tolterodine	• Trospium
Antipsychotics	• Chlorpromazine • Clozapine	• Olanzapine • Perphenazine	

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Drug class	Medication	
Antispasmodics	• Atropine (excludes ophthalmic) • Dicyclomine • Clidinium-chlordiazepoxide	• Homatropine (excludes ophthalmic) • Hyoscyamine • Scopolamine (excludes ophthalmic)
Antiemetics	• Prochlorperazine	• Promethazine

Note:
- Includes combination products that contain a target medication listed and the following routes of administration: buccal, nasal, oral, transdermal, rectal, and sublingual. Injectable and inhalation routes of administration are not included (not able to accurately estimate days' supply needed for measure logic). For combination products that contain more than one target medication, each target medication (active ingredient) should be considered independently.
- Chlordiazepoxide is not a target medication as a single drug.

Exclusion(s)

Exclusion	Time frame
• Members with at least 1 day of hospice coverage during the measurement period	Any time during the measurement year

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Tips and best practices to help close this care opportunity:

- Identify patients taking 2 or more anticholinergic medications
- Review indication, duration of therapy and evaluate if potential risk of continued therapy outweighs the benefit
- Evaluate concurrent use of anticholinergic medications and consider discontinuing one of the medications or using alternative therapy as appropriate
- Identify at-risk members using UnitedHealthcare reporting tools
- Consider leveraging provider practice EMR system to assist with identifying at-risk members, avoiding co-prescribing that could lead to concurrent use, limiting/reducing default quantifies and refills
- Educate patients and caregivers about the risks and side effects of using multiple anticholinergic medications including cognitive decline and what to do if they experience side effects
- Take a holistic patient approach when evaluating appropriateness including patient goals, current guidelines and co-morbid conditions

Additional resources:

For additional tips and best practices to close this care opportunity, please refer to these 3rd-party resources:

- **American Geriatrics Society (AGS): American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults**
- **PharmD Live: Anticholinergic Medications in the Beers Criteria**
- **HealthinAging.org: Learn More: Alternatives for Medications Listed in the AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults**
- **Patient Safety Network: STOPP/START criteria for potentially inappropriate prescribing in older people: version 3**

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Poly-ACH measure medications and potentially safer alternatives

The Centers for Medicaid and Medicare Services (CMS) have a new Part D measure that focuses on concurrent use of medications that are deemed a serious safety concern. The measure is Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH).

Refer to the following chart below for potentially safer alternatives to consider when evaluating drug therapy for your patients who are on concurrent therapy of 2 or more anticholinergics.

Measure name	Therapeutic class	Measure medications	Common indications	Potential alternatives* (if clinically appropriate)
Poly-ACH anticholinergics	Antihistamines	Brompheniramine, chlorpheniramine, cyproheptadine, dimenhydrinate, diphenhydramine, doxylamine, hydroxyzine, meclizine, triprolidine	Seasonal allergies symptoms	Second-generation antihistamine (e.g., levocetirizine, desloratidine, loratidine) Intranasal steroid (e.g., fluticasone, mometasone) Intranasal antihistamine (e.g., azelastine) Intranasal normal saline (OTC)
			Anxiety	Buspirone
			Pruritus	Second-generation antihistamine (e.g., cetirizine, loratidine) Topical steroid (e.g., alclometasone)
			Nausea	Ondansetron

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Poly-ACH measure medications and potentially safer alternatives

Measure name	Therapeutic class	Measure medications	Common indications	Potential alternatives* (if clinically appropriate)
Poly-ACH anticholinergics	Antiemetics	Prochlorperazine, promethazine	Nausea/ Vomiting	Ondansetron
			Cough/Cold	OTCs: Guaifenesin, dextromethorphan, cough/throat lozenges
	Gastrointestinal (Antispasmodics)	Atropine, clidinium-chlordiazepoxide, dicyclomine, homatropine, hyoscyamine, scopolamine	GI motility disorders-constipation, diarrhea	Lactulose oral solution, Linzess, lubiprostone OTCs: Miralax, Benefiber, Senna, Metamucil, docusate, loperamide
	Skeletal muscle relaxants	Cyclobenzaprine, orphenadrine	Muscle spasms	Tizanidine, acetaminophen, ibuprofen, naproxen, topical analgesics Nonpharmcologic treatment: Stretching, heat/ice, physical therapy, TENS unit
	Antimuscarinics (Urinary Incontinence)	Darifenacin, fesoterodine, flavoxate, oxybutynin, solifenacin, tolterodine, trospium	Incontinence/ overactive bladder	Gemtesa (vibegron), Myrbetriq (mirabegron) Nonpharmacological treatment: Bladder training, scheduled voids, limit caffeine, etc.

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Poly-ACH measure medications and potentially safer alternatives

Measure	Therapeutic class	Measure medications	Common indications	Potential alternatives* (if clinically appropriate)
Poly-ACH anticholinergics	Antidepressants	Amitriptyline, amoxapine, clomipramine, desipramine, doxepin (>6mg/ day), imipramine, nortriptyline, paroxetine	Depression	Bupropion, vilazodone, mirtazapine
			Insomnia	Mirtazepine, trazodone, melatonin (OTC) Nonpharmacological treatment: Sleep hygiene, cognitive behavioral therapy
			Neuropathic pain	Lidocaine patch Nonpharmacologic treatment: Exercise, physical therapy
			Migraine prophylaxis	Propranolol
	Antiparkinsonian Agents	Benztropine, trihexyphenidyl	Parkinson disease	Carbidopa/levodopa combinations, amantadine, rasagiline, ropinirole, pramipexole, selegiline
			Drug-induced extrapyramidal symptoms	
	Antipsychotics	Chlorpromazine, clozapine, olanzapine, perphenazine	Schizophrenia	Lurasidone, paliperidone, ziprasidone

Statin Use in Persons With Diabetes (SUPD)

New for 2026

Updated

- Members who do not meet numerator compliance or have additional exception criteria and have at least 1 prescription claim during the measurement period using their Part D benefits for either a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (Repatha or Praluent) or bempedoic acid (Nexletol), will be removed from the denominator

CMS Weight: 1
P4P Weight: 1

Definition

Percentage of Medicare members with diabetes ages 40-75 who receive at least 1 fill of a statin medication during the measurement period using their Part D benefit. Members with diabetes are defined as those who have at least 2 fills of diabetes medications during the measurement year.

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
Latest CMS Thresholds	< 81%	≥ 81% to <85%	≥ 85% to 89%	≥ 89% to < 93%	≥ 93%
P4P Thresholds	< 82%	≥ 82% to <86%	≥ 86% to <90%	≥ 90% to < 94%	≥ 94%

Compliance

To comply with this measure, a member with diabetes must have a fill for at least 1 statin or statin combination medication in any strength or dose using their Part D benefit during the measurement year.

Formulary tier	Medications		
Tier 1*	• Atorvastatin • Lovastatin • Pravastatin • Ezetimibe-simvastatin	• Simvastatin • Rosuvastatin • Amlodipine-atorvastatin	• Fluvastatin
Tier 3**	• Livalo®		

*Lowest copay of all tier levels
**Tiers for these medications may be different for group retiree plans

Statin Use in Persons With Diabetes (SUPD) (cont.)

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members who have filled a PSCK9 inhibitor or bempedoic acid • using Part D benefits during the measurement year and do not have a statin fill or other exclusion • End Stage Renal Disease: I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 • Dialysis: Z91.15, Z99.2 • Beneficiaries with rhabdomyolysis or myopathy: G72.0, G72.89, G72.9, M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9, M62.82 • Lactation: O91.03, O91.13, O91.23, O92.03, O92.5, 092.13, O92.70, O92.79, Z39.1 • Pregnancy (1000+ codes) ***: O00.101, O09.00, O10.011, O20.0, O30.331, O99.019, O99.210, O99.340, O99.810, O99.820, Z33.1, Z34.00, • Z34.83, Z34.90, Z34.91, Z34.92, Z34.93 • Fertility: Captured via a pharmacy claim for Clomiphene adjudicated with Part D coverage • Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69 • Polycystic ovary syndrome (PCOS): E28.2 • Pre-diabetes: R73.03, R73.09 • Members who have filled a PSCK9 inhibitor or bempedoic acid using Part D benefits during the measurement year and do not have a statin fill or other exclusion	Any time during the measurement year

*Lowest copay of all tier levels
**Tiers for these medications may be different for group retiree plans
*** Not complete ICD 10 list

Statin Use in Persons With Diabetes (SUPD) (cont.)

Tips and best practices to help close this care opportunity:

- Consider prescribing a statin, as appropriate. If you determine a statin medication is appropriate, please send a prescription to the member's preferred pharmacy.*
- Importance of taking a statin: American Diabetes Association (ADA), American Heart Association (AHA) and American College of Cardiology (ACC) suggest people with diabetes take a moderate statin therapy without calculating a 10-year ASCVD risk. In patients with diabetes and higher cardiovascular risk, a high-intensity statin is reasonable. Statins can reduce the risk of heart attack and stroke, even in patients who do not have high cholesterol. Patients with type 1 and type 2 diabetes have increased prevalence of lipid abnormalities that leads to increased risk of developing atherosclerotic cardiovascular disease (ASCVD).1-2 Statin use in patients with diabetes has shown to decrease incidence of cardiovascular events by 21% per 39 mg/dL decrease in LDL and decrease mortality by 9% per 39 mg/dL.3
- Prescription must be filled through Part D insurance card to close this care opportunity. Prescriptions filled through cash claims, discount programs (such as GoodRx) and medication samples will not close the measure.
- If member has intolerance or side effects such as myalgias, if clinically appropriate, consider:
  - A different statin that is hydrophilic (e.g., rosuvastatin or pravastatin)
  - A lower dose statin than previously tried
  - Reducing the frequency
- For members who meet exclusion criteria, a claim using appropriate ICD-10 code must be submitted ANNUALLY if applicable
- Only statins satisfy the measure; other cholesterol medications such as ezetimibe or PCSK9 inhibitors do not satisfy the measure
- Consider extended day fills (e.g., 90- or 100-day supply) or send to home delivery

*Member may use any pharmacy in the network, but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Co-pays apply after deductible.

Patient Experience Survey

Definition

Measures evaluates plan members who complete a telephonic survey focus on how patients experienced or perceived key aspects of their care with their provider.
The survey results cover the Consumer Assessment of Healthcare Provider & Systems Survey (CAHPS) and Health Outcomes Survey (HOS) categories: Getting Needed Care, Care Coordination, and Doctor/Patient Conversations

Measures:

Getting Needed Care

P4P Weight: 2

Questions:

- How easy was it to get an appointment with your personal doctor as soon as you needed?
- Did you have any difficulty getting a referral to see a specialist from your doctor?

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
P4P Thresholds	< 86%	≥ 86% to <90 %	≥ 90% to <93 %	≥ 93% to < 95%	≥ 95%

Patient Experience Survey (Cont.)

Care Coordination

P4P Weight: 2

Questions:

- Did your doctor seem informed and up to date about the care you received from a specialist?
- Did your doctor or other health provider review all your prescription medications with you?
- Did you receive a follow-up from your doctor's office after any blood test, x-ray or other test completed?

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
P4P Thresholds	< 86%	≥ 86% to <89 %	≥ 89% to <92%	≥ 92% to < 94%	≥ 94%

Doctor Patient Conversations

P4P Weight: Info

Questions:

- Did your doctor or other health provider talk to you about how to prevent falls or treat problems with balance or walking?
- Did your doctor or other health provider talk to you about ways to better control leaking of urine?
- During your visit did your doctor or other health provider advise you to start, increase or maintain your exercise level?

	1-Star ★	2-Star ★★	3-Star ★★★	4-Star ★★★★	5-Star ★★★★★
P4P Thresholds	< 54%	≥ 54% to <59%	≥ 59% to <63%	≥ 63% to < 68%	≥ 68%