Medicare & Medicaid Quality Compliance

A Comprehensive Guide to HEDIS, STAR Ratings, and Value-Based Programs for Maximum Reimbursement

Authored by

Jeremy Ryan

CEO & Founder

Code Pause Inc.

OutsideINsights

November 2025

Version 1.0

Executive Summary

The healthcare quality landscape is undergoing unprecedented transformation. With Medicare Advantage quality bonus payments exceeding $12.7 billion in 2025 and mandatory Medicaid Core Set reporting now in effect, providers and payers must adopt sophisticated, data-driven compliance strategies to maximize reimbursement while delivering superior patient outcomes.

This whitepaper provides a comprehensive analysis of the quality programs governing Medicare and Medicaid reimbursement, including:

1. **Medicare Advantage STAR Ratings:** Understanding the 45-measure framework, weighting changes for 2026, and the pathway to 4+ star performance
2. **HEDIS Specifications:** Navigating the transition to Electronic Clinical Data Systems (ECDS) and optimizing hybrid reporting
3. **Medicaid Quality Programs:** Complying with mandatory Core Set reporting and state quality strategy requirements
4. **Provider Incentives:** Maximizing MIPS scores and avoiding the 9% negative payment adjustment
5. **Actionable Strategies:** Best practices for entering 2026 and beyond with sustainable quality improvement workflows

Key Finding: Plans achieving 4+ stars receive a 5% benchmark bonus, translating to an average of $372 per enrollee in 2025—a figure that has more than doubled since 2015.

I. Medicare Advantage STAR Ratings Program

Financial Impact and Bonus Structure

The Medicare Advantage STAR Ratings program represents one of the most significant quality-linked payment mechanisms in American healthcare. Understanding its financial implications is essential for strategic planning.

Benchmark Bonus Structure

- **4+ Star Rating:** 5% increase to benchmark payment
- **Double Bonus Counties:** 10% increase for urban areas with high MA enrollment and low FFS spending
- **New Plans:** 3.5% benchmark increase while establishing performance history

2025 Program Statistics

- Total quality bonus payments: $12.7 billion (approximate)
- Average bonus per enrollee: $372 (more than doubled since 2015)
- Enrollees in bonus-receiving plans: 26 million (≈75% of MA enrollment)

2026 STAR Ratings Framework

The 2026 Star Ratings include a maximum of 9 domains comprising up to 45 measures. MA-PD contracts are measured on all 9 domains, while MA-Only contracts are measured on 5 domains (33 measures) and PDPs on 4 domains (12 measures).

Measure Weighting System for 2026

Critical Change: Patient experience/complaints and access measures decreased from weight 4 to weight 2 for 2026.

Weight	Measure Type	Impact
5	Improvement Measures	**Highest**
3	Outcome & Intermediate Outcome Measures	**High**
2	Patient Experience/Complaints & Access (reduced from 4)	Medium
1	Process Measures (screenings, vaccines, care management)	Standard

Triple-Weighted Measures (Weight = 3) – Highest Priority

These outcome and intermediate outcome measures carry some of the greatest impact on overall star ratings and should receive priority attention:

Part C (Medical)

- Diabetes Care – Blood Sugar Controlled (Intermediate Outcome)
- Controlling Blood Pressure (Intermediate Outcome)
- Plan All-Cause Readmissions (Outcome)

Part D (Pharmacy)

- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS antagonists)
- Medication Adherence for Cholesterol (Statins)

New Measures for 2026

Kidney Health Evaluation for Patients with Diabetes (KED): Assesses whether adults with diabetes receive both eGFR and uACR testing.

CMS modeling for 2026 suggests projected thresholds in the following range:

- 4-star performance: around 62%
- 5-star performance: around 74%

Note: Final 2026 Star Ratings cut points for KED will be published by CMS in October 2025 and may differ from these projections.

Improving or Maintaining Physical Health: Returning after specification changes; weight = 1 for 2026, increasing to weight = 3 for 2027

Improving or Maintaining Mental Health: Returning after specification changes; weight = 1 for 2026, increasing to weight = 3 for 2027

II. HEDIS (Healthcare Effectiveness Data and Information Set)

Overview and Governance

HEDIS, maintained by the National Committee for Quality Assurance (NCQA), provides the approved method for auditing the HEDIS production process, including information systems capabilities assessment and evaluation of compliance with HEDIS specifications. NCQA is transitioning to fully digital measurement by 2030.

Data Collection Methods

Administrative Method

Transaction data or other administrative data are used to identify the eligible population and numerator. The reported rate is based on all members who meet eligible population criteria and who are found through administrative data to have received the required service.

Hybrid Method

Organizations look for numerator compliance in both administrative and medical record data. This method is being phased out for several measures as programs transition to ECDS-only reporting.

ECDS (Electronic Clinical Data Systems)

The data sources for ECDS include Electronic Health Records (EHRs), Health Information Exchanges (HIEs), Case Management Systems, and Administrative Claims. Traditional hybrid measures transitioning to ECDS-only will no longer use the annual chart retrieval process—all compliance from medical records must be processed through prospective supplemental data and standardized digital feeds.

Key MY 2025 Changes

NCQA continues to advance the ECDS reporting standard. According to the MY2025 technical update, the following measures are now ECDS-only:

- Cervical Cancer Screening (CCS)
- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Colorectal Cancer Screening (COL-E)

Critical HEDIS Measure Categories

Category	Key Measures
Prevention & Wellness	Breast Cancer Screening, Colorectal Cancer Screening, Cervical Cancer Screening, Childhood Immunization Status, Immunizations for Adolescents
Chronic Disease Management	Glycemic Status Assessment for Diabetes, Controlling Blood Pressure, Statin Therapy for CVD, Kidney Health Evaluation for Diabetes
Behavioral Health	Follow-Up After ED Visit for Mental Illness, Follow-Up After Hospitalization for Mental Illness, Antidepressant Medication Management
Medication Adherence	PDC for Diabetes Medications, PDC for RAS Antagonists (Hypertension), PDC for Statins (Cholesterol)

III. Medicaid Quality Programs

Mandatory Core Set Reporting

A landmark shift occurred in 2024 when reporting of the Child Core Set and behavioral health measures on the Adult Core Set became mandatory for all states, the District of Columbia, Puerto Rico, U.S. Virgin Islands, and Guam. CMS issued the final rule in August 2023 outlining these requirements.

Three Mandatory Core Sets

1. **Core Set of Children's Health Care Quality Measures:** Full set mandatory for Medicaid and CHIP
2. **Behavioral Health Measures (Adult Core Set):** Mandatory; other Adult Core Set measures remain voluntary but strongly encouraged
3. **Health Home Core Sets:** Mandatory for states with health home programs

> **For 2025 reporting: approximately 50 mandatory and optional measures must be calculated and reported to CMS, stratified by race/ethnicity, sex, and geography.**

Managed Long-Term Services and Supports (MLTSS)

CMS is the measure steward for 15 nationally standardized LTSS quality measures. The MLTSS and FFS LTSS measures are aligned pairs with unique technical specifications focused on different delivery systems.

MLTSS Measure Categories

- **MLTSS-1:** Comprehensive Assessment and Update
- **MLTSS-2:** Comprehensive Person-Centered Plan and Update
- **MLTSS-3:** Shared Person-Centered Plan with Primary Care Provider
- **MLTSS-4:** Reassessment and Person-Centered Plan after Inpatient Discharge
- **MLTSS-5:** Falls Risk Screening, Assessment, and Plan of Care

HCBS Quality Measure Set

The Ensuring Access to Medicaid Services final rule (CMS 2442-F), published in May 2024, requires states to report every other year, beginning in 2028, on the HCBS Quality Measure Set.

State Quality Strategy Requirements

Federal regulations at 42 CFR § 438.340 require each state Medicaid and CHIP agency contracting with MCOs, PIHPs, PAHPs, and/or PCCM-Es to develop and maintain a managed care quality strategy. Strategies must be submitted to CMS every 3 years and address network adequacy, quality metrics, performance targets, and continuous improvement goals.

IV. Provider Quality Programs: MIPS/QPP

Merit-based Incentive Payment System (MIPS)

The 2025 performance year marks the ninth year of the Quality Payment Program. Under MIPS, participating clinicians receive an overall score of 1–100 points based on performance across four categories. This score determines whether they receive positive, neutral, or negative payment adjustments to Medicare Part B reimbursement.

2025 Key Parameters

- **Performance Threshold:** 75 points (to avoid negative adjustment)
- **Maximum Negative Adjustment:** −9%
- **Maximum Positive Adjustment:** Up to approximately +4.69% for a score of 100, based on the statutory scaling factor. Actual realized upward adjustment may be lower because CMS must maintain budget neutrality across the program.
- **Data Completeness:** 75% threshold maintained through 2028

MIPS Category Weights

Category	Weight	Max Points
Quality	30%	30
Cost	30%	30
Promoting Interoperability	25%	25
Improvement Activities	15%	15

MIPS Value Pathways (MVPs)

MVPs represent a voluntary alternative reporting pathway to traditional MIPS. CMS finalized 6 new MVPs for 2025 related to ophthalmology, dermatology, gastroenterology, pulmonology, urology, and surgical care. While MVP reporting remains voluntary, CMS is working toward transitioning more clinicians into MVP-style reporting to simplify and align measures around clinical themes.

Advanced Alternative Payment Models (APMs)

Qualified Participants (QPs) in Advanced APMs may earn incentive payments and are exempt from MIPS. Advanced APMs bear risk determined by CMS, require reporting on quality measures, and mandate the use of certified EHR technology (CEHRT).

V. Actionable Strategies for 2026 and Beyond

The organizations that embed quality measures into daily practice—not just annual reviews—will be best positioned to thrive under CMS's ever-rising standards.

For Medicare Advantage Plans

Immediate Actions (Q4 2025 – Q1 2026)

1. **Prioritize Triple-Weighted Measures:** Focus resources on medication adherence (PDC), blood pressure control, blood sugar control, and readmissions reduction.
2. **Prepare for KED Measure:** Implement workflows to ensure diabetic patients receive both eGFR and uACR testing; embed prompts in diabetes care protocols and EMR order sets.
3. **Adjust for Weight Changes:** Reallocate resources as patient experience measures drop from weight 4 to 2; clinical outcomes now carry greater relative importance in overall Star Ratings.
4. **Implement Year-Round HEDIS Strategy:** Move beyond annual compliance cycles to continuous gap closure and proactive outreach.

Strategic Initiatives (2026–2027)

- Invest in AI-assisted documentation technology to increase M.E.A.T. (Monitor, Evaluate, Assess, Treat) compliance at point of care.
- Prepare for Health Equity Index rewards beginning in the 2027 Star Ratings.
- Build robust prospective supplemental data pipelines as ECDS becomes mandatory for more measures.
- Note that Improving/Maintaining Physical and Mental Health measures increase to weight 3 in 2027—begin preparation now.

For Medicaid MCOs

Compliance Priorities

1. **Meet Core Set Deadlines:** Ensure all mandatory Child Core Set and Adult behavioral health measures are reported by December 31 annually.
2. **Implement Stratification:** 2025 requires stratification for at least 25% of mandatory measures; 2026 increases to at least 50%.
3. **Prepare for HCBS QMS:** Biennial reporting begins 2028; build measurement and data integration infrastructure now.
4. **Align with State Quality Strategy:** Ensure MCO quality goals support state-level objectives and regulatory requirements.

MLTSS Enhancement

- Standardize comprehensive assessment and person-centered planning documentation.
- Implement automated tracking for reassessment after inpatient discharge (MLTSS-4).
- Develop falls risk screening protocols integrated into care management workflows.

For Providers (MIPS Participants)

Avoiding Penalties

- Target a minimum of 75 points to avoid the −9% payment adjustment.
- Ensure 75% data completeness across all reported measures.
- Verify CEHRT (Certified EHR Technology) compliance and interoperability requirements.
- Consider specialty-specific MVPs for streamlined and more clinically relevant reporting.

Clinical Documentation Best Practices

Highly accurate and thorough clinical documentation lays the foundation for successful quality reporting. Documentation should include:

- Patient name, date of birth, and date of service
- Provider signature and credentials
- Complete description of services rendered
- Structured EMR templates to capture HEDIS-relevant data elements
- Appropriate coding that reflects services actually provided

VI. Conclusion: Building Sustainable Quality Programs

The healthcare quality ecosystem continues to evolve toward greater accountability, digital measurement, and health equity. Organizations that treat compliance as a year-round operational priority—rather than an annual reporting burden—will achieve superior outcomes for both patients and financial performance.

Key takeaways for sustained success:

1. **Invest in Infrastructure:** Build robust data pipelines connecting EHRs, HIEs, and payer systems to support real-time quality measurement.
2. **Embrace Digital Transformation:** NCQA's goal of fully digital HEDIS measurement by 2030 requires immediate preparation for ECDS reporting.
3. **Prioritize High-Impact Measures:** Focus resources on triple-weighted outcome measures that disproportionately influence star ratings and reimbursement.
4. **Address Health Equity:** Prepare for stratified reporting requirements and Health Equity Index rewards.
5. **Collaborate Across Stakeholders:** Payer–provider partnerships with shared quality goals and aligned incentives produce the best outcomes.

The path forward requires strategic investment, operational discipline, and genuine commitment to patient outcomes. Organizations that embrace this challenge will not only achieve financial success but will deliver meaningfully better care to the populations they serve.

What This Means for Practitioners

Frontline clinicians, behavioral health providers, and care teams are the engine that makes quality performance real. For practitioners, this whitepaper translates into several concrete implications:

Documentation is Financially and Clinically Critical

- Every blood pressure reading, depression screen, follow-up visit, and medication reconciliation has downstream impact on HEDIS, Stars, and MIPS.
- Incomplete notes, missing diagnoses, or vague assessments can mean lost quality credit—even when excellent care was provided.

Chronic Disease Management Will Be Under a Microscope

- Diabetes, hypertension, CKD, and cardiovascular disease are at the center of triple-weighted measures and KED.
- Expect more prompts and standing orders for labs (eGFR, uACR), statins where indicated, and tighter glucose and blood pressure control.

Behavioral Health Follow-Up is a High-Stakes Measure

- Timely follow-up after ED visits or inpatient stays for mental health and substance use disorders is now a major quality focus.
- Practitioners may see more alerts and scheduling pressure to complete 7- and 30-day follow-ups.

Digital Data Quality Matters as Much as Clinical Judgment

- Care "does not count" for quality scores unless it is captured in discrete fields that feed HEDIS/ECDS.
- Using structured fields (problem lists, medication lists, vitals, lab results) instead of only free-text notes will directly influence quality performance.

Health Equity and Stratification Will Increase Scrutiny

- Measures will be compared across race/ethnicity, sex, and geography.
- Clinicians may be asked to support targeted outreach or tailored interventions for populations experiencing gaps in outcomes.

Practical Next Steps for Practitioners

✓ Lean into EMR templates built for HEDIS measures.
✓ Complete all recommended labs and follow-ups when appropriate.
✓ Use problem lists and diagnosis coding that accurately reflect patient risk and conditions.
✓ Engage care managers and quality staff as partners rather than "compliance police."

Bottom line: Good documentation and consistent follow-through on evidence-based care are now inseparable from both quality and reimbursement.

What This Means for Payers & Health Plans

For Medicare Advantage plans, Medicaid MCOs, and commercial payers, the trends outlined in this guide are not abstract—they directly shape revenue, regulatory risk, and market competitiveness.

Star Ratings and Quality Bonuses Are Strategic Revenue Levers

- Achieving or maintaining 4+ Stars unlocks a 5% benchmark bonus and higher rebate dollars, with average bonus payments of ~$372 per member in 2025.
- Small changes in adherence, readmissions, or chronic disease control can produce large financial swings.

Mandatory Medicaid Reporting Raises the Compliance Floor

- All states and territories must now report Child Core Set and behavioral health measures, with growing stratification requirements.
- Plans must ensure clean data flows from providers to states and from states to CMS.

HEDIS is Becoming Digital-First

- Hybrid chart-chasing is shrinking. ECDS and supplemental data pipelines are now essential infrastructure.
- Plans will need robust partnerships with providers, EHR vendors, and HIEs to ingest and normalize clinical data at scale.

Health Equity is Becoming a Financially Material Metric

- The Health Equity Index and stratified reporting will expose performance gaps by race/ethnicity, sex, and geography.
- Plans that invest early in equity-focused interventions will gain advantage in both Stars and regulatory perception.

Provider Enablement is Now a Core Competency

- Plans cannot "HEDIS their way" to high performance without helping providers document and close gaps.
- This includes point-of-care alerts, training, simplified measure explanations, and transparent feedback dashboards.

Operational Priorities for 2026–2027

✓ Map all triple-weighted measures and build targeted interventions.
✓ Stand up or strengthen supplemental data ingestion and ECDS-ready architecture.
✓ Integrate quality performance into network management, incentive design, and contracting.
✓ Invest in analytics that tie clinical actions to financial impact (e.g., "each 1% improvement in adherence is worth $X in bonus dollars").

Bottom line: Quality programs are no longer just compliance—they are a core business strategy for payers and health plans. Plans that build durable, data-driven quality operations will outperform in both revenue and member outcomes.

About the Author

Jeremy Ryan is the CEO and Founder of Code Pause Inc. and OutsideINsights, bringing over 25 years of frontline healthcare experience in Emergency Medicine and crisis response to the healthcare technology space.

Code Pause Inc. specializes in crisis intervention and management solutions, developing innovative approaches to close the feedback loop between clinical intent and patient outcomes.

OutsideINsights is a real-time outcomes intelligence platform that captures and analyzes patient experiences between clinical visits, enabling providers and payers to optimize quality metrics and improve care delivery.

Contact Information

Code Pause Inc.
Crisis Intervention & Management Solutions
www.CodePause.com
Info@CodePause.com

OutsideINsights
Real-Time Outcomes Intelligence

Disclaimer

This whitepaper is provided for informational purposes only and does not constitute legal, financial, or regulatory advice. Healthcare regulations change frequently, and organizations should consult with qualified compliance professionals and legal counsel for guidance specific to their circumstances. All data and statistics are sourced from CMS, NCQA, and other authoritative federal sources as of November 2025.